THE ORIGINS AND DEVELOPMENT OF COLLECTIVE BARGAINING BY NURSES IN BRITISH COLUMBIA 1912-76

by

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BN., McGill University, 1972

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE in THE FACULTY OF GRADUATE STUDIES (The Department of Health Care and Epidemiology)

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
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Date October 15, 1981
Collective bargaining by nurses in British Columbia began in the mid 1940's, but the origins of concern about the terms and conditions of employment of nurses are identified as existing prior to the founding of the Registered Nurses Association of British Columbia.

The Board and Annual minutes, 1912-76, of the Association were examined and selected materials such as journals and interviews were reviewed to triangulate the validity of the data. Applying grounded theory (Glaser and Strauss, 1967) to the data, dominant and secondary themes reflecting the Association's activities and concerns emerged. Analysis of the themes generated the categories of control of the work force, control of work practice and control of the work environment. That is, during the period under study, the Association struggled to exercise control over an uncertain environment. A series of strategies which the Association pursued are examined. Two groups within the Association are identified: cosmopolitans and locals (Merton, 1957). Discontent amongst the locals, the importance of which was recognized by the cosmopolitans resulted in the efforts of the Association shifting to concentrate on the control of the work environment. This process resulted in the entry of the Association into collective bargaining.
The categories which emerged from the data were compared with selected literature on nurses in Canada, England and United States. The interpretation of the minutes, and additional sources appears to be validated by this comparative evidence. Consideration of selected paradigms from the literatures of social policy analysis and sociology was undertaken in an attempt to explain the events, processes, and trends (Smith, 1976) in a larger context.

The study concludes with a consideration of the ideologies of nursing and the role these ideologies played. Geertz's (1964) interpretation of the role of ideology is used to examine the evolution of these ideologies. The evolution of the ideologies of both the cosmopolitans and locals is traced to vocationalism, in the tradition of Nightingale. Vocationalism conferred a sense of sanctity on both the patient and the nurse. Professionalism succeeded vocationalism and focused on the clinical procedures and observations resulting in the loss of sanctity of both the nurse and patient (Williams, 1974). Latterly an ideology accepting collective bargaining as a means of negotiating the quality of nursing care, which has both vocational professional aspects, and the economic reward of the nurse has emerged.

Adherence to vocational and professional ideologies in the face of changes in the health care system such as the end of private duty nursing, the development of a hierarchy in nursing, the increased use of technology and the establishment of a third party payment scheme as well as changes in society such as the recognition of the
inequitable role of women, and discrepancies in the value of certain types of work in relation to economic reward impeded the entry of nurses into collective bargaining. Ultimately, the strain (Geertz, 1964) felt by the locals resulted in confrontations with hospitals and government. As a consequence the first strike votes (1957, 1959) endorsed by the Association occurred. Success in improving the economic reward of nurses through collective bargaining has continued in the 1960's and 1970's. It remains to be seen whether issues related to the vocational and professional nature of nursing will be negotiated, and with what success. These data and their interpretations should provide important basic information for health policy makers in British Columbia.
# TABLE OF CONTENTS

**ABSTRACT**

**TABLE OF CONTENTS**

**LIST OF TABLES**

**ACKNOWLEDGEMENTS**

**ABBREVIATIONS**

## CHAPTER 1 Introduction

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Purpose</td>
<td>1</td>
</tr>
<tr>
<td>The Problem</td>
<td>2</td>
</tr>
<tr>
<td>The Significance</td>
<td>3</td>
</tr>
<tr>
<td>The Data Base</td>
<td>4</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>4</td>
</tr>
<tr>
<td>Methodology</td>
<td>5</td>
</tr>
<tr>
<td>A Profile of the Text of the Study</td>
<td></td>
</tr>
</tbody>
</table>

## CHAPTER 2 The Failure of Moral Suasion: 1912-42

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction: Events, Processes, and Trends</td>
<td>7</td>
</tr>
<tr>
<td>The Struggle for Registration: 1912-18</td>
<td>10</td>
</tr>
<tr>
<td>Education: The Essential Minimum: 1919-32</td>
<td>16</td>
</tr>
<tr>
<td>Disparity: The Rise of Militancy: 1933-42</td>
<td>27</td>
</tr>
<tr>
<td>Conclusion: The Failure of Moral Suasion</td>
<td>43</td>
</tr>
</tbody>
</table>

## CHAPTER 3 To Protect the Quality of Nursing: 1943-76

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>44</td>
</tr>
<tr>
<td>The Legitimation of Collective Bargaining:</td>
<td>46</td>
</tr>
<tr>
<td>1943-54</td>
<td></td>
</tr>
<tr>
<td>The Legitimation of Militancy: 1955-64</td>
<td>66</td>
</tr>
<tr>
<td>Adjustments to Growth: 1965-76</td>
<td>80</td>
</tr>
<tr>
<td>Conclusion: To Protect the Quality of Nursing: 1943-76</td>
<td>97</td>
</tr>
</tbody>
</table>

## CHAPTER 4 Methodology

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>99</td>
</tr>
<tr>
<td>Problems of Social Research</td>
<td>99</td>
</tr>
<tr>
<td>Grounded Theory</td>
<td>102</td>
</tr>
<tr>
<td>The Application of Grounded Theory to the Data</td>
<td>116</td>
</tr>
<tr>
<td>Conclusion</td>
<td></td>
</tr>
</tbody>
</table>
### CHAPTER 5 Analysis and Discussion

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>118</td>
</tr>
<tr>
<td>The Concept of Control</td>
<td>119</td>
</tr>
<tr>
<td>Negotiation with Internal Forces: 'Cosmopolitans and Locals'</td>
<td>121</td>
</tr>
<tr>
<td>Negotiation with External Forces</td>
<td>126</td>
</tr>
<tr>
<td>Postures of Control</td>
<td>134</td>
</tr>
<tr>
<td>Conclusion</td>
<td>137</td>
</tr>
</tbody>
</table>

### CHAPTER 6 Literature Review

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>139</td>
</tr>
<tr>
<td>Control of the Work Force</td>
<td>140</td>
</tr>
<tr>
<td>Control of Work Practice</td>
<td>144</td>
</tr>
<tr>
<td>Control of the Work Environment</td>
<td>151</td>
</tr>
<tr>
<td>Conclusion</td>
<td>171</td>
</tr>
</tbody>
</table>

### CHAPTER 7 Explanations: Negotiations with External Forces

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>173</td>
</tr>
<tr>
<td>Negotiation with External Forces: A Case of Dynamics without Change</td>
<td>174</td>
</tr>
<tr>
<td>Negotiation the Importance of Legitimacy</td>
<td>179</td>
</tr>
<tr>
<td>Control Contexts, Negotiation and Social Order</td>
<td>183</td>
</tr>
<tr>
<td>Negotiation and Societal Process</td>
<td>188</td>
</tr>
<tr>
<td>Conclusion</td>
<td>190</td>
</tr>
</tbody>
</table>

### CHAPTER 8 Ideological Shift: The Attempt to Resolve Chronic Strain

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>191</td>
</tr>
<tr>
<td>The Role of Ideology</td>
<td>191</td>
</tr>
<tr>
<td>The Origins and Evolution of Nursing's Ideological Stance</td>
<td>193</td>
</tr>
<tr>
<td>Conclusions: Omens for the Future</td>
<td>203</td>
</tr>
</tbody>
</table>

### REFERENCE LIST

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference List</td>
<td>206</td>
</tr>
</tbody>
</table>

### REFERENCE NOTES

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference Notes</td>
<td>223</td>
</tr>
</tbody>
</table>

### APPENDIX A Correspondence Concerning Access to the Board and Annual Minutes of the Registered Nurses Association of British Columbia

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Correspondence</td>
<td>224</td>
</tr>
</tbody>
</table>

### APPENDIX B Biographical Notes

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biographical Notes</td>
<td>228</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Nursing Statistics for British Columbia, 1918-38</td>
<td>22</td>
</tr>
<tr>
<td>2.2</td>
<td>Selected Data on the Terms and Conditions of Employment of Nurses in British Columbia and Canada, 1929-43</td>
<td>39</td>
</tr>
<tr>
<td>3.1</td>
<td>Selected Data from Recommended Personnel Practices of the RNABC, 1946-68</td>
<td>72</td>
</tr>
<tr>
<td>3.2</td>
<td>The Growth of Certified Bargaining Units of Registered Nurses within the RNABC, 1947-76</td>
<td>81</td>
</tr>
<tr>
<td>4.1</td>
<td>Categories and Properties Emerging from the Data</td>
<td>115</td>
</tr>
<tr>
<td>5.1</td>
<td>Postures of Control Assumed by the RNABC, 1912-76</td>
<td>120</td>
</tr>
<tr>
<td>5.2</td>
<td>Strategies for External Negotiation of Specific Issues Used by the RNABC, 1912-76</td>
<td>129</td>
</tr>
</tbody>
</table>
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# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCHA</td>
<td>British Columbia Health Association (formerly British Columbia Hospitals' Association)</td>
</tr>
<tr>
<td>BCHIS</td>
<td>British Columbia Health Insurance Scheme</td>
</tr>
<tr>
<td>BCRNA</td>
<td>British Columbia Registered Nurses' Association</td>
</tr>
<tr>
<td>CNA</td>
<td>Canadian Nurses' Association</td>
</tr>
<tr>
<td>GNABC</td>
<td>Graduate Nurses' Association of British Columbia</td>
</tr>
<tr>
<td>RNABC</td>
<td>Registered Nurses' Association of British Columbia</td>
</tr>
</tbody>
</table>
CHAPTER 1

Introduction

The development of collective bargaining by nurses in British Columbia is the subject of this study. Nurses have been viewed as striving to professionalize (Katz, 1969; Krause, 1977; Wilensky, 1964) and as such, collective bargaining has been viewed as the antithesis of professional behavior (Jacox, 1971). However, collective bargaining by nurses in British Columbia is now an accepted part of the dynamics of the health care system in British Columbia and in Canada.

The Purpose

Professionalism and participation in collective bargaining may be viewed as opposing ideological stances in which ideology refers to "a manner or context of thinking characteristic of an individual group or culture" (Webster's Third New International Dictionary, 1971). The adoption of collective bargaining by nurses in British Columbia can be viewed as a reflection of a change in the thinking of nurses possibly representing a shift in ideology from professionalism to unionism perhaps as a result of changing relationships within society (Etzioni, 1968).

Blishen (1969) studying physicians in Canada has shown that the ideology of physicians in Canada could be analyzed, and their responses to strain could be identified. Similarly, it
was hoped that a study of the Association representing the nurses of British Columbia could produce data to explain the apparent shift in ideology of nurses.

The Problem

The research problem is stated as a question. How was it that the Registered Nurses' Association of British Columbia, which seemed to have pursued the goal of professional status for many years, decided to shift from an ideology of professionalism to an ideology of unionism?

The Significance of the Study

It is intended that this study increase the understanding of the ideological basis of nurses in British Columbia. Since nurses represent a major portion of the work force in health care in British Columbia, an understanding of their ideological position is important in any understanding of the functioning of the health care system. In addition, this study represents a contribution to the writing of nursing history, a much neglected activity (Newton, 1965; Nursing Research, 1972; Safeir, 1978) and to the writing of one women's occupation, also a much neglected activity (Marie, 1980).
The Data Base

Possible sources of data were considered. The RNABC Bulletin is available from 1948. This did not seem to cover an adequate period of time since the first union activity in hospitals recorded by the Labour Division of the RNABC is 1943 (Registered Nurses' Association of British Columbia, Labour Relations Division, 1977). Ultimately, permission to review the Board and Annual Minutes of the Association was requested and granted (Appendix A). These minutes begin in September 1912 and June 1913 respectively.¹

Originally, it was the intention to review the minutes from 1940-1976 in detail doing only a cursory review of the minutes from 1912-39. However, it became clear that this material was too rich to be ignored, and would contribute to the strength of this study. Thus the minutes were reviewed from 1912-76 when the separation of the professional Association and the Labour Relations Division occurred.

The study of the minutes was augmented by using other sources such as the News Bulletin of the RNABC, the published Annual Minutes of the Association, 1946-76, the Annual Minutes of the British Columbia Health Association (formerly the British Columbia ¹References to the minutes of the Board and the unpublished minutes of annual meetings are by date only. Occasionally it was necessary to distinguish between the Executive Council of the Board, the Board and unpublished annual minutes and this is done where necessary.
Hospitals' Association) and interviews. It is assumed that issues reaching the Board and publications represent a degree of importance that grants a certain validity to the content.

Limitations of the Study

This study is limited in contextual depth by several factors. There is an unevenness in the detail recorded in the minutes of the Association. Further, access to the documents of the Association was limited to the Board and Annual Minutes and thus supporting documents reviewed by board members were not available for study. As well, there is a profound and disturbing lack of archival material about nursing in British Columbia. All of these factors may have contributed to an incomplete or inaccurate interpretation of the events and their meaning which are presented in this study.

Methodology

Various methodologies were considered, but after consideration it became clear that while the research question should stand, the approach should be open. Thus grounded theory (Glaser and Strauss, 1967) was the research methodology used to analyze the minutes of the RNABC and related documents. Grounded theory is defined as "the discovery of theory from data systematically obtained and analyzed in social research" (pp.1). Grounded theory promotes the emergence of relevant concepts and hypothesis directly out of the data. In this study the constant comparative method was the
the mode of qualitative analysis. The purpose of the constant comparative method is the generation of conceptual categories and their properties from the data. The building of grounded substantive theory is the goal. Substantive theory is theory that develops a specific substantive or empirical area of social inquiry. In this study the focus was the substantive area of a provincial nursing organization, with study concentrated on the issues of concern to the members of the organization over time. This is contrasted with formal theory developed from a formal or conceptual area of social inquiry. There will be no attempt to develop formal theory from the data.

A Profile of the Study

This study is reported in eight chapters. The first chapter presents the introduction to the study in which the problem of the apparent shift in ideology from professionalism to unionism by nurses in British Columbia is identified. A brief discussion of the purpose, the problem, the data base and the limitations and methodology of the study are presented.

Chapters Two and Three comprise the narrative. The narrative is based on the findings in the minutes of the Association and related sources. The narrative is organized by chronology and by theme. A natural division occurred between 1912-42 and 1943-76 and therefore the narrative is divided into two chapters.
The methodology of grounded theory and its application to study is presented in Chapter Four. An analysis of the findings of this study is presented in Chapter Five. Chapter Six constitutes the literature review and considers only selected material that discusses the major themes which emerged from the data. The literature review is directed at identifying convergences and similarities with the national and international literature as well as forming a comparison group for the nurses of British Columbia. Chapter Seven presents selected paradigms from the literature of social policy and sociology in an effort to explain the events, processes and trends (Smith, 1976) identified in this study in the larger context of society. Chapter Eight returns to the theme of the role of ideology and the ideological response of nurses in British Columbia.
CHAPTER 2

The Failure Of Moral Suasion: 1912-42

Introduction: Events, Processes, and Trends

As the review of the minutes of the Registered Nurses' Association of British Columbia proceeded, it became evident that the origins of collective bargaining lay in the roots of the practice of nursing in British Columbia. Following Glaser and Strauss's (1967) suggestion, the themes of importance to the Association were allowed to emerge from the data. These themes are presented in the form of a narrative in segments of approximately 10 years to allow for convenient review. The strategy for organizing the themes was suggested by an analysis of social change made by Smith (1976). The purpose of this chapter and the following chapter, is to present a narrative of the themes of the activities and concerns of the Association. From the themes the importance of certain events, processes, and trends and their relationship to the development of collective bargaining became evident.

Smith (1976) proposes the use of calendar events, medium term processes and long term trends as a means of organizing temporal sequences. Events are studied by "detailed analysis of archival records, to the day to day, or ... month to month, relationships between individuals and groups which generate and compose particular pattern substitutions" (Smith, 1976 pp.17). Processes are defined as "sequences of intermediate duration, such as ... social movements, urbanisation and migration...". 'Process' refers to typical clusters in sequences of events and
refers to the 'rules' or typical sequences of events (Smith, 1976, pp.17). Smith suggests decades are useful time frames to study processual change, while trends refer to long term change. The study of processual change is seen as the crucial link between 'micro-events' and 'longeval trends'(pp.18).

The themes identified from the minutes are events and processes which appear to have differing levels of importance during the period under study: 1912-1976. The relationship of one theme to another suggested a change in the ideology of the nurses of British Columbia. Smith (1976, pp.12) suggests that "change consists of temporal, event referring, motion of spatial patterns resulting in a clean difference from the preceeding pattern...social change is permanently historical in nature, ... is essentially concerned with sequences of events and movements in space and time; and hence...that change cannot be studied apart from the historical record". Thus, Smith (1976 pp.13) defines change as a"succession of events which produce over time a modification or replacement of particular patterns or units by other normal ones...". Change in the cultural sphere is seen as the most autonomic as well as the most pervasive. The concept of cultural change covers several sets of patterns"... knowledge and techniques, ...ideas and beliefs...customary behavior and rituals...all are layers of communication and style" (Smith, 1976 pp.22). The themes and their relationships one to another
over time which emerge from the data become the processes which represent change in the ideological stance of the Association. It is the understanding of these processes and their relationships which contributed to the development and sorting of categories and properties which explain the events.

The events and processes of the early years of the Association have been described (George, 1969) as occurring in three phases:

1) 1912-1918, the struggle for registration,
2) 1922-1930, the closing of substandard schools of nursing,
3) 1933-1944, the problem of working conditions of nurses.

The review of the minutes of the RNABC supports this general division. However, although the RNABC continued to be preoccupied with the problem of the working conditions of nurses up until 1976 and beyond, the period 1933-1976 is too complex to be taken as a single period. Consequently this period is divided into four distinct segments:

1) 1932-1942, during which time the working conditions of nurses became generally recognized as deplorable and the cause of much illness amongst nurses.

2) 1943-1954, during which time collective bargaining was legitimized by the national and provincial associations,

3) 1955-1964, during which time there was confrontation with hospitals and government. Strike threats and conciliation occurred.
4) 1965-1976, during which time change in the organizational structure of the Association was made to meet the demands of participation in province-wide collective bargaining.

The themes that run through the chronology, while sometimes major, are at other times secondary. They are registration, education, terms and conditions of employment, and the organizational structure of the Association. Related themes include private duty, student nurses, subsidiary workers, safety to practice, quality assurance, health and safety of nurses, social security and the terms and conditions of employment of senior nursing staff. Throughout the narrative these themes are presented as dominant themes of primary interest at any given time or as secondary themes. The period 1912-42 is presented in this chapter, while the following chapter presents the period 1943-76.

The Struggle for Registration 1912-18.

The Registered Nurses' Association of British Columbia was founded as the Graduate Nurses' Association of British Columbia in September, 1912 when representatives of the Vancouver Graduate Nurses' Association, the Victoria Nurses' Club and the New Westminster Graduate Nurses' Association met. Their objective was to form a provincial nurses' association and to engage in the "preparation and presentation to the government of a Bill providing for the registration of nurses" (September 10, 1912).

The Association established a preliminary examining board, a fee structure for entrance to the Association, an interim
form, of registration and then set about lobbying the government for passage of a Bill to register nurses believing that "all who work should be registered, not in a spirit of militancy, but as a protection for the public" (April 13, 14, 1914). Because there was concern that "no one was to be prevented from nursing, but would be prevented from claiming to be a registered nurse" (October 11, 1913), there was support to register two grades of nurses, the graduate and the untrained or household nurse. The category of the household nurse was subsequently dropped, but a grandfather clause was added to limit registration of the 'experienced nurse' for the three years following passage of the Bill.

Lobbying for registration began in 1913, and was conducted by meeting with the Cabinet and Members of the Legislative Assembly and by the sending of letters and postcards to MLA's. Support was solicited from the Local Council of Women, the Medical Associations and prominent members of the community. Consideration of the Bill was repeatedly delayed, ostensibly to allow the government to give its full consideration to the war effort (February 15, 1915). In 1916 renewed effort resulted in the government refusing to sponsor the bill.

Mr. H. H. Watson (M.L.A. Vancouver) member of the opposition, was approached to sponsor the bill. During debate in
committee, amendments proposed by Dr. H.E. Young (member of the Cabinet, and a "close personal" friend of the Premier (Ormsby, 1958, pp.356; 392) put the Association under direct control of the College of Physicians and Surgeons and made provision for the registration of midwives and maternity nurses. "Heated and acrimonious debate" is reported to have occurred (Doctors to pass upon nurses' regulation, 1916; Nurses' measure is cause of contention, 1916; Bill will meet the situation, 1918).

Debate centered on opposition to "creating a closed corporation and virtual monopoly to members of (the) association" (Declare Bill too arbitrary, 1916) and the "proposed amendment of putting nurses under the guardianship of the doctors", and "the fact that the Bill would not limit charges to be made and it might be that people of moderate means would be forced to do without the services of a nurse" (Doctors to pass upon ..., 1916). Editorial comment suggested that the proposed Bill was "more stringent than any of the other enactments of its class... was not a result of public demand... and thus was not necessary". It was argued that "nursing is an honourable and useful profession. It can stand on its own merits without any legislative prop" (The nursing profession, 1916). Ultimately the Bill was withdrawn rather than let it pass with the amendments.

Renewed lobbying by postcard and the solicited support of Dr. Wesbrook of the University of British Columbia (December 20, 1917) resulted in a revision of the Bill. The Local Council of
Women supported the Bill but wanted to "protect those who practiced midwifery and sick nursing with no training but who had passed a simple government test" (March 22, 1918). These proposals were not integrated into the revisions. Nor were "the objectionable features of the 1916 Bill". The Bill was presented as "a means whereby a properly trained and qualified nurse may indicate to the public ... that she is an efficient nurse... (had) received training" and "passed exams", but "allowed graduate nurses and those graduating from proper training schools to be registered without passing exams for the next three years" (Bill will meet the situation, 1918). The Bill passed April 23, 1918 and seemed to have brought a sense of satisfaction and optimism to the Association.

Secondary themes.

While the Registration Bill was the dominant issue in this period, the Association was also engaged in its own development as an organization. Annual meetings were initiated in 1913, dealing with an agenda which included the working business of the Association, the postgraduate education of its members and cultural activities. The war effort included volunteering for duty, the preparation and packaging of dressings, the collection of funds by tag days for a home for returning nurses and the sending of Christmas remembrances to nurses overseas. The federal government's action in sending nurses not registered with the Canadian National Association of Trained Nurses to overseas duty created an internal furor. The protest was referred
from the fledgling association back to the Victoria Nurses' Club because "it was felt it would be a mistake to send a protest from the Provincial Association...since the appointments had been made in Victoria" (September 25, 1914).

A cursory review of the early issues of the Canadian Nurse shows that practising nurses were concerned about their working conditions and rates of pay (The Canadian Nurse, 1907, pp.149-150; 645-646; 1908, pp.324-325). Nurses in British Columbia were also concerned about the eight hour day and rates of pay. The issue of the eight hour day seems to have erupted at Vancouver General Hospital in February, 1919. The Association's minutes report receipt of a letter from Dr. MacEachern, Superintendent of VGH, regarding the eight hour day for nurses and "regretting that outside organizations had attempted to interfere with the management in this regard ... also expressing the hope that the GNABC would take up this question .... Miss Randal (Registrar) ... urged that nurses take a firm and definite stand regarding this. Miss McKenzie spoke strongly in favor of the eight hour day but felt that this should be arranged by the hospitals and nursing organizations and not by Trades and Labor Unions ...." (February 18, 1919). Helen Randal was made convenor for a committee to interview Mr. Jarvis, the Attorney-General Mrs. Ralph Smith, MLA and "any other members that it seemed necessary:..." . Helen Randal reported that she "felt that progress had been made, and if the hospitals took this up and made provision for it themselves that
in all probability the government would take no action concerning nurses" (March 7, 1919). This may be a reference to the impact of the Minimum Wage Act of 1919 (BCHA, 1919, pp.164) which affected hospital employees other than nurses and student nurses.\(^1\) It is however consistent with a tactic of moral suasion evident throughout the work of the Association. The eight hour day committee was formed by the Association as requested by the Canadian Association of Trained Nurses (April 29, 1919).

**Summary.**

Despite interest in improving working conditions at the grassroots and with the leadership at provincial and national levels, the major effort of the Association was directed towards the establishment of the registration of nurses. Voluntary registration was achieved in 1918 and the Association's first Registrar, Helen Randal\(^2\), was appointed. Helen Randal was to hold this position until 1941. Under her leadership, the Association shifted its efforts to the improvement or closure of substandard schools of nursing.

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\(^1\) In 1911 the California legislature enacted eight hour legislation for women workers. In 1915, this was held to be applicable to student (although not graduate) nurses. American nursing was split on whether this type of legislation classified nurses as labourers, and whether this was a good thing for the profession. Mary Adelaide Nutling of Teachers College, Columbia University supported eight hour legislation and labour's intervention to shorten nurses' hours (Ashley, 1976, pp.40-47).

\(^2\) See Appendix B for biographical note.
Interest in nursing education began with the formation of a committee to investigate the educational standards of training schools in British Columbia in 1916. In 1919, Helen Randal recognized the need to make a survey of the nursing schools of British Columbia. The annual surveys began in 1921.

In 1918 training schools were described as being conducted in hospitals with as few as 15 beds with a staff of two registered nurses. Entrance requirements were two years of high school education. In 1921, the two year course was lengthened to three years (Creasor, 1952, pp.60). Ethel Johns, speaking at the BCHA Annual Convention of 1920 is quoted as saying "In Canada today any person or group of persons may assemble a number of sick persons under a roof and call it a hospital. Further, they may inaugurate a nursing school. (There are) no standards ensuring competent instruction, (or) proper living and working conditions ... (Johns, 1920, pp.9).

Throughout the 20's and 30's the Survey Reports were presented in optimistic tones: "(There is) an improvement in every department

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3 Alberta Creasor, Address of the President, Annual Meeting, Registered Nurses' Association, 1954.

4 See Appendix B for biographical note. Margaret Street's biography of Ethel Johns (Watch - fires on the mountains; the life and writings of Ethel Johns. Toronto: University of Toronto Press, 1973) provides an insight into the formative years of professional nursing in Canada and the United States.
of the schools, ... deep interest in the provincial exams ... a clearer consciousness of the responsibilities of the Hospital Boards to the training schools (April 17, 18, 19, 1922)... better housing, equipment and classwork... new nurses' homes (are being) built (April 2 and 3, 1923)... (There is) increasing uniformity amongst training schools.. (April 18, 1927)... gratifying to report ... only twelve nursing schools remain (October 1, 1932).^ During this period effort was directed to improving the educational process by developing a standard curriculum and by the hiring of a travelling dietician to teach dietetics, notably in the smaller schools.

Despite the optimism expressed in the Association minutes, a review of the annual minutes of the British Columbia Hospital Association for this period makes a more explicit and pessimistic statement about the concerns of the nursing leaders of the day. Helen Randal, in addressing the 1920 Nursing Session of the BCHA described the 1919 Survey of Schools by stating that while she met with the "greatest courtesy and consideration", in "too many of our hospital Board officials there was practically a total lack of real understanding that our nurses

^ It is not known how many schools of nursing existed in British Columbia. Weir (1932, pp.278-9) reports there were 17 in 1930. Paulson (1981) suggests that originally there may have been 23. Non-approved schools (which were unable to meet the standards set by the Association) were known to operate at Merritt in the 1930's (Paulson, 1981) and Grand Forks (Eatson, 1938, pp.57). These graduates could not register under the Registered Nurses Act.
entered the hospitals as pupils, or that as a school there was a definite contract entered into between the probationer and the hospital, that she was to have a definite course of study...that while the Boards realized, and expressed themselves in favour of shorter hours, better housing, more instructors and better supervision by graduate nurses. There was still the painful showing on the books of a deficit... (Thus) a direct appeal must be made to the Provincial Government for a definite sum to be spent on the education of nurses alone. Cheap nursing to the advantage of the hospital and to the detriment of the pupils has been gradually taken as something too common to notice". Helen Randal concluded with these recommendations:

a) presentation of the case to our Legislature of the right of training schools in hospitals to be financed in part by government money,

b) standard curriculum and inspection of schools to be enforced,

c) training school hours or accommodation for nurses to be sadly deficient - rooms crowded, generally in hospital buildings where no opportunity for recreation was provided - no rooms for laboratory, diet kitchen or study provided (Randal, 1920, pp. 24-26).

One year later, at the BCHA meetings, Ethel Johns re-iterated that "the present shortage of pupils ... is a direct consequence of old methods of exploitation ... "the killing of the goose that laid the golden eggs" (Johns, 1920, pp. 9).

Resolutions of the BCHA, in 1919 and subsequent years called for the government take-over of public hospitals, increased government
funding, and direct government contribution to the education of nurses. (BCHA, 1919, pp.112; 1921, pp.43; 1938, pp.20; 1949, pp.126).

Because discussion of the proceedings of the Annual Meetings of the BCHA is more detailed than the GNABC minutes, a stronger commitment by the leaders of the profession to improve working and living conditions is illustrated in the BCHA minutes. These same leaders repeat a commitment to a strategy of "beginning) our propaganda for better nursing conditions...with the Boards of the schools for nurses connected with our hospitals..." (Randal, 1920, pp.25).

Other concerns in education included the establishment and support of a scholarship fund for nurses at McGill University (October 14, 1918), establishing a public health program at the University of British Columbia (January 10, 1920) and the establishment of post-graduate education in teaching and supervision of nursing (September 12, 1931).

The Weir Report.

The problem of "the nurse in her relationship to the hospital, the medical profession and the public at large" (Cameron in Weir, 1932, pp.5) resulted in the striking of a joint committee of the Canadian Nurses Association and the Canadian Medical Association in 1927. In 1929, George Weir, then Head of the Department of Education, University of British Columbia, was charged with the
responsibility of "get(ting) at as many facts regarding the problems of nursing conditions as possible"... (Weir, 1932, pp.7). Weir undertook a quantitative survey to illustrate the life of the private duty nurse, the public health nurse and the institutional and student nurse. He found nurses lived an unduly harsh life, with high unemployment and illness rates, an educational system which was geared to the running of a hospital not the education of students, and an economic gap between the patient of moderate means and the nurse. As a solution to the complex of problems facing nurses and the public seeking care he recommended socialized medicine and that nursing education become an integral part of the state education system. Weir persisted that "nursing should be regarded as a profession, however immature in the attainment of professional standards, rather than as a potential member of a trades union" (Weir, 1932, pp.65).

The profession responded by promoting publicity of the report by interviewing editors of Vancouver, Victoria and New Westminster papers (November 20, 1931) and by setting up study groups throughout the province. Newspaper coverage was comprehensive and sympathetic (Health insurance and socialized nursing are strongly urged, February 20, 1932, pp.1; 10).

As early as 1919 discussions within the Association had considered state medicine and state nursing, and the implications for nursing.\(^6\) Initially "the general feeling seemed to be much

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\(^6\)A Legislative commission of the government of British Columbia was appointed to investigate Health Insurance in 1919. No action was taken (Shillington, 1972, pp.40).
against State Medicine" (January 10, 1919) but with the appointment of a Provincial Royal Commission on State Health Insurance and Maternity Benefits in 1928 and with the publication of the Weir Report strongly endorsing state medicine as a solution to the problems of education and employment of nurses, the position changed to support. A Committee of the Association worked on health insurance until the late 1940's.

Secondary themes:

The secondary themes of this period include the development of an organizational structure of the Association, the terms and conditions of employment and the health of nurses. The Association set up the Private Duty, Public Health and Education Committees as standing committees in 1922. This reflects not only an employment pattern but areas of interest to nurses. Private duty within the home or hospital was the usual form of employment of nurses. Public Health was gaining increased recognition especially following the influenza epidemics of 1919, but employed relatively few nurses. Hospitals were staffed largely by student nurses. Weir (1932, pp.290-291) recommended that an approved school of nursing have "full time trained instructor". Thus the composition of the Education Committee, a chairman and "all those actively engaged in nursing education" (April 17, 18, 19, 1922) is less surprising than might be supposed.

It is possible to reconstruct an approximate distribution
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Nursing Statistics for British Columbia, 1918-38

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a Wright, 1958, pp.78 The sudden increase in Registered Nurses was due to the grandfather clause of the Registered Nurses Act.

b RNABC, December 21, 1921
c Canadian Nurse 1928, pp.488
d RNABC, April 19,1928
e Census of Canada, 1921, pp.32-33
f Weir, 1932, pp.279
g RNABC, November 8, 1929
h Latham and Kess, 1980, pp.69
i Eaton, 1938, pp.9
j Eaton, 1938, pp.65
k Eaton, 1938, pp.10.

Note. The census tract does not define graduate nurse, and this number probably includes nurses who were not registered. 'Registered nurses' may have been inactive because they were unemployed, not seeking employment or because they lived outside the province. 'Private duty nurses' are probably those who registered with the Association as available for private duty or were members of the Private Duty Section. The number of private duty nurses stated in this table is probably falsely low because only 17% of private duty nurses were placed by an Association Registry (Weir, 1932, pp.346).
of graduate and student nurses by using several sources (see Table 2.1). These numbers must not be regarded as absolute. The lack of numerical data available in the Association's minutes made the use of varying sources necessary.

Terms and conditions of employment have three aspects: the hours of duty, the organization of care, and the role of students. Discussions of the eight, ten, and eleven hour day occur with increasing frequency towards 1932. The Private Duty Section endorsed the eight hour day (January 18, 1930) but it is difficult to establish how widespread the acceptance of this was, since endorsement of the eight hour day repeatedly occurred until the mid 1940's. It must be remembered that an eight hour day meant eight working hours spread over ten or twelve, or more hours. Nurses were working up to twelve or more hours spread over sixteen hours (Eaton, 1938, pp. 36-39) or in the case of private duty nurses, twenty-four hours (Weir, 1932, pp. 386). Private duty nurses received about 17% of their work through the Association Registry and the remainder through private registries or physicians (Weir, 1932 pp. 386). These nurses were often working in hospitals where the hours of work were set by the institution. Weir found the employment situation of this group to be woeful. The actual average employment period for private duty nurses in British Columbia was 29.7 weeks per annum, (with a Canadian average of 14.3 weeks unemployed) 4.5 weeks of illness and 3.3 weeks of vacation. These nurses were unable to save any earnings and received indirect subsidy by living
at home (Weir 1932 pp.66-96). Fears were expressed at the Depression would encourage nurses to work twelve hour shifts for additional remuneration (January 19, 1934). Thus, although the Association actively supported private duty nursing by operating a Registry, the Association may not have had significant influence over the hours private duty nurses worked.

During this period there is no mention, within the Association, of concern for the terms and conditions of employment of public health nurses. It is not possible to reconstruct hours of work or working conditions for public health nurses from the Weir Report (Weir, 1932, pp.118-143). Esther Paulson\(^7\)(1981) recalls working a 5\(\frac{1}{2}\) day-week in the mid 1930's in the Kootenay district. Home visits were done on Sundays as the need arose. Weir does show that near full employment of public health nurses existed, that very little sickness occurred (.9 weeks per annum) and that it was possible to save a modest amount of their earnings (Weir 1932, pp.123-154). Institutional nurses enjoyed similar employment and illness rates as public health nurses, but over half were unable to save anything from their earnings (Weir, 1932 pp.102-109). Student nurses were clearly the worst off, working twelve hour days, often too fatigued to study, and suffering a high illness rate (Weir, 1932, pp.168-181). There is no discussion of the earnings of student nurses in the Weir report.

\(^7\)See Appendix B for biographical note
With high unemployment rates amongst private duty nurses, even before the Depression it is not surprising that the Association pressed for changes in the organization of the delivery of care. The Association encouraged hourly nursing and group nursing as a means of increasing the employment of nurses by making nursing care less costly to the patient (November 20, 1931, March 15, 1932). Hourly nursing was a method of hiring nurses for short intervals over a period of time, while in group nursing one private duty nurse cared for several hospitalized patients at once. Effort was made to reduce the annual enrollment of student nurses, then approximately 1/2 - 1/3 of the work force (see Table 3.1). It was argued that hiring graduate nurses was cheaper than the cost of educating students (BCHA, 1931, pp.101). Thus the Association pressed for the reduction in the size of schools in order to employ graduate nurses, and further urged that hospitals consider "very carefully the employment of married nurses" (September 26, 1930). These tactics can be assumed to have had considerable impact on the shift of employment of graduates from private duty to institutional nursing.

The relationship of the health of nurses and hours of work was understood by the nursing leaders, even though there is little direct reference to this in the GNABC minutes. The BCHA meetings of 1931 (pp.34) quote the superintendent of Tranquille Sanatorium as stating that "15-20% of the female patients... were pupil nurses in training in this province". Weir reports that, in British Columbia of 123 students surveyed, 31.7% had more than five days off duty through illness in the previous 6 months (9.3% had 25 days of illness; among
the highest in Canada) (Weir, 1932, pp.173). Helen Randal, in an eloquent statement during a debate on the eight hour day,

"explained that since 1912 she had been very closely associated with both student and graduate nurses, and had seen the ill effects of long working hours. She could safely say that a large proportion of tuberculosis among nurses had been brought about through the breaking down of the nurses' health due to long hours not only in the wards but in the intensive study they have to make in order to bring them up to the standard which is expected of them in this generation" (Randal, 1938, pp.53).

Summary.
The interval 1918-1932 represented a period of intense commitment to the reform of nursing through changes in the system of educating nurses. While progress was made in improving or closing substandard schools, the roots of the problem, inadequate financing of health care and nursing education, remained unchanged. Consequently there was no improvement in the working conditions of nurses, whether graduate or student nurses. Until the pressures of World War II were felt in the early 1940's, unemployment and working conditions became the predominant concern of the Association.

8 The high incidence of tuberculosis amongst student nurses was not unique to British Columbia. The "Province of Saskatchewan...records show that the incidence of tuberculosis among nurses...was approximately 10% higher than the normal expectancy for tuberculosis in young women between 19 and 24 years of age" (BCHA, 1939 pp.57).

9 Ferguson, (1935, pp.134) states "the incidence of breakdown among nurses in training in general hospitals during the period 1930-1933 was 12.7 per thousand. This is twelve times the incidence of tuberculosis morbidity among the general population...It is eight times the incidence found...among normal school students..."The high rate of tuberculosis amongst nurses was attributed" to the fact that nurses are exposed to frequent and larger doses of tuberculosis infection from unexpected sources". There is no discussion of working conditions as a precipitating factor.
The struggle to improve the terms and conditions of employment was the dominant theme of this period. Secondary themes include mandatory registration, education and organizational change within the Association.

Background.

The possibility of a provincial health insurance scheme resolving the employment problems of nurses remained until 1937. The Royal Commission on Health Insurance did not directly support the inclusion of nursing services in the scheme, but did support adequate hospital funding (Davie, 1932). George Weir entered politics in 1933, became Minister of Education and later, Provincial Secretary responsible for health. The Association greeted the news with a letter of congratulations "realizing his inestimable value to all professions of his platform of vocational education" (November 24, 1933). As Provincial Secretary, with responsibilities for health, Weir put forth "A Plan of Health Insurance for British Columbia" in 1935. This was followed by Hearings Committee in the same year (Peebles, 1935).

The Association was actively involved in the process (November 30, 1934; February 22, 1935; April 22, 1935) and repeatedly reiterated the need for the funding of adequate nursing service in home or in the hospital. Grace Fairley, Superintendent of Nurses at Vancouver General Hospital sat on the Committee (Peebles, 1932, pp.12). A bill was prepared, amended following demands by the medical profession and
the Manufacturers' Association, and passed in March 1936. The plan was to go into effect March 1937, but despite support from a plebiscite held during the election of that year, the plan was indefinitely postponed (Taylor, 1978 pp.6). The doctors supported the principle of health insurance but rejected the proposed scheme because it "omits all the very people in the community who most need it..." and because payment was to be by capitation rather than fee-for-service (A Brief Analysis, 1937, pp.97-100).

Action by the Association.

The Association attempted to exert its influence for an improvement of working conditions on behalf of private duty, institutional and student nurses by 1) trying to persuade private duty nurses to support an eight hour day, 2) attempting to control hiring practices of the Registry, itself supported financially by the Association, 3) using "moral suasion" with hospital boards and the BCHA on behalf of institutional and student nurses, and 4) giving support to legislated change by frequent communication with the appropriate cabinet members. This activity was most prominent after completion of work on health insurance. Thus the minutes read that "...The Registrar (be authorized)...to write to various nurses' local associations and hospital centres endorsing the principle of the eight hour day (April 22, 1935)...hospital boards be asked to put an improved time schedule into effect...The Council endorses the policy of allowing sufficient time for meals on the eight hour day service without alteration of
the regular fee..." (April 3, 1937).

The eight hour day for nurses was debated at length at the Annual Meetings of the BCHA in 1937 and 1938. "A serious shortage of nurses in Eastern Canada was reported to be due to the institution of the eight hour day in Eastern United States and the consequent migration of nurses. "Labour trouble in hospitals...in Canada ...(with) "two strikes of their employees" was also reported (BCHA, 1937, pp. 71-72). In 1938, the BCHA had a protracted debate on the eight hour day for nurses and the costs of implementation. (BCHA, 1938, pp.20-22; 50-59). A motion of the Canadian Nurses' Association supporting an eight hour day for nurses which was sponsored by a member of the Nursing Section of the BCHA was ruled out of order. The context of the minutes suggests the exercise of convenient stalling tactics in ruling the motion out of order (BCHA, 1938, pp.75-77). Newspaper reports of the 1938 meeting record that the Nursing Section of the BCHA was "generally sympathetic" to the 48 hour week for nurses, but makes no reference to the rejection of the resolution supporting the eight hour day by the general assembly of the Hospitals' Association (Working time for nurses is subject of debate, 1938).

Action in the political arena

In the meantime, the hours of nurses had become a political issue. E.E. Winch, CCF(Burnaby) presented a private members bill to 10 E.E. Winch initiated debate in the Legislature on the working conditions of nurses in 1935 (Steeves, 1960, pp.100-101).
regulate the hours nurses worked under the Hospital Act. George Weir, as Provincial Secretary assured the member that the "problem was being handled by the government...(and really)... came under the Board of Industrial Relations not the Hospitals Act...". The Honourable G.S. Pearson, Minister of Labour, is reported as stating that "the government is very sympathetic to the conditions of nurses...(and) had been studying (the problem) for two years, ... improvements had been made in some hospitals. With these assurances, E.E. Winch withdrew the bill (Nurse's bill is withdrawn, 1937). This debate promoted a strong rebuttal from "Nurse, Comox" in the letters to the editor. The nurse wrote"... (in) almost every hospital in the province nurses are being seriously overworked, and (are) leaving hospital service with ambition crushed and health broken... as a man hired to work in the interests of the province...some explanation might be in order... Dr. Weir's reply was a calculated flaunting of public opinion" (Overworked nurses, 1937).

One year later the CCF re-introduced the bill and precipitated "short sharp debate in which the Opposition pressed the government to supply the eight hour day law and other benefits for graduate and students nurses in hospitals....(the eight hour day) was declared not feasible on account of finances" (House Kills CCF bill, 1938). H.E. Winch in supporting his father's bill is quoted as saying "the entire public should bear the burden of the hospitals, not just the nurses... G.S. Pearson, Minister of Labour admitted nurses are the subject of
abuse...(but) nurses are generally well looked after... most hospitals are run by boards of directors ... anything wrong would have been complained (about)... we know hospitals need more money...(we are) moving further in B.C. in the field of social legislation than any other province in Canada...but don't push it too far" (Bill giving better conditions, 1938).

On October 1, 1937, Mrs. Rex Eaton was appointed to Chair the "Advisory Committee on Labour Conditions in Hospitals" by the Provincial Secretary, G.M. Weir, with the consent of the Minister of Labour, G.S. Pearson. The Committee was charged with the responsibility of investigating and reporting upon "wages, hours of work, conditions of work, and other labour conditions in hospitals"; recommending "reasonable minimum standards of wages, hours of work, and working conditions...(such that) working conditions in hospitals are not unreasonable, that wages paid are fair and that the general labour conditions are such as not to be detrimental to the health of the persons employed", and to estimate the increase in the operating costs of hospitals should the recommendations be implemented. (Eaton, 1938 pp 1-3).

The committee surveyed 49 public and publically supported hospitals and six private hospitals ranging in size from 1374 beds to less than 35 beds. The report of the Advisory Committee was presented

Public hospitals such as the tuberculosis sanatorium (Tranquille) and the mental hospital (Riverview) were the direct administrative and financial responsibility of the Provincial Secretary. Publicly supported hospitals received financial support for the costs incurred in caring for charity patients. There was no direct government responsibility assumed in the administrative or financial aspects of these hospitals. Private hospitals were independent of government financial assistance. In an annual report of the RNABC to the CNA, it was reported that there were 72 hospitals staffed with graduate nurses (Fairly, 1938, pp.444-445).
to the Provincial Secretary and the Minister of Labour October, 1938. It would appear from the Association minutes that the Report was not immediately available (May 19, 1939). The hours of work are described as "intolerably long". The nurses are quoted as "understand(ing)" the pressing need for new buildings... sympathiz(ing) with the financial burdens of hospitals... (but as)... believe(ing) that very often they form the group which absorbs economies made necessary by other demands and that the very fact that they can be depended upon to render service without protest and without drastic action has kept them working hours of such length that their health suffers and normal essential social activities are denied to them" (Eaton 1938, pp.12-13).

Day duty ranged from 43-65 hours per week with a half day off weekly, while night duty ranged from 48-84 hours per week. Time off night duty was extremely limited: 29 hospitals (total 49 reporting) had no evenings or nights off duty, while 20 hospitals granted up to one night off each week. Night duty lasted four-five weeks at a time occurring one month in every three or four months. On call and overtime was recognized as seriously interfering with time off duty, as was the spread of working hours, often over 15 and even 16 hours a day. The social isolation of nurses resulting from hours of duty and the requirement by most hospitals of living in residence (for both graduate and student nurses), the poor accommodation and the absence of recreational facilities were recognized as a serious problem. Salaries ranged from $30.00 - $80.00/month plus room, board and laundry expenses valued at $25.00/month (Eaton, 1938, pp.12-37).
The Report recommended an eight hour day, 96 hour fortnight (thus allowing 'split shifts' to continue),\textsuperscript{12} reduction of on-call and overtime, and a salary of $60.00 monthly plus room, board and laundry expenses as a minimum wage. Deduction for food, lodging and laundry were stipulated, as was an hourly rate for part-time staff. It was recommended that no charge be made for breakages of equipment. The nurse was to provide her own uniforms. No recommendations were made for the amount of vacation time to be granted but the importance of holidays was recognized. Hours of work recommended for students were similar to those of graduates, but with the proviso that class time be included in "hours of work". The "average nurse" was seen to be "working for hours which have long since been considered intolerable both by the average worker and the general public." The committee discussed the problem of the health of nurses and "undue fatigue" that was evident. Nurses were seen as "combin(ing) physical effort with grave responsibilities and emotional strain... afford(ing) reason for a shorter day than the average worker...". While the committee was unwilling to make "any conclusive statement... concerning the actual percentage of cases of tuberculosis in this occupation as compared with percentages found in other occupations" the committee accepted that a person in a state of constant fatigue becomes liable to the contraction not only of tuberculosis but of other illnesses to which a nurse is particularly exposed". Recommendations were made to establish and maintain health

\textsuperscript{12}The Committee stated that it would like to recommend a straight eight hour day as a minimum but since "no occupation has the hours of work confined by legislation to less than a 12 hour - spread...(which)has been in effect... since December, 1937 when the Hours of Work Act was amended to that effect... the Committee considers that it must hesitate before recommending... a more rigorous requirement concerning the spread of hours than is now set out in the Hours of Work Act" (Eaton, 1938 pp.37).
records of nurses and to teach and practice preventive measures in the case of infected patients. (Eaton, 1938, pp.21-25).

The Advisory Committee concluded that there was a general consensus amongst nurses, the Association, the BCHA, and the public, that nurses' hours must be shortened. With the agreement of the Council of the Association, the Advisory Committee recommended that nurses' hours and wages be regulated under the Female Minimum Wage Act and that the hours of work of students be regulated under the Trades Schools Act (Eaton, 1930, pp.30-31). The option of amending the Registered Nurses' Act to allow the Association to enforce regulations concerning students' hours of work was discussed and discarded. The role of the Association in regard to students had been directed to methods of training, although the Association had encouraged voluntary reduction of students' hours with some success. However, the Executive Council of the Association stated that the success of their work depended greatly upon the sympathetic and friendly co-operation of hospital boards and administrators. If at any time such relationships were destroyed by a disagreeable situation about the hours of work it might interfere with the progress they wished to make along educational lines. The Members of the Council of Nurses are themselves administrators dealing with Hospital Boards along many lines and may not be in a position to take a completely independent stand without paying a certain price for firmness. The Council has only one punitive measure to take against the hospital not conforming to the regulations of the Registered Nurses' Act, and that is to remove the training school from the approved list. Needless to say, such action would not be taken until abuses had become flagrant and uncontrollable. (Eaton, 1938, pp.60-62).
Strike action.

Within seven months of the submission of the Eaton report, an outburst of militancy culminated in the first strike of nurses in British Columbia. Nine graduates and undergraduates of a staff of twelve walked out at St. Joseph's Hospital, Comox. The press report of a statement issued by the nurses declares:

"Nearly a month ago there was presented to the advisory board of St. Joseph's Hospital, Comox the following requests:

- an 8 hour day be adopted
- 2 weeks annual vacation, and annual allowance of two weeks' sick leave with pay
- greater care and selection of meals
- a monthly allowance of $2.50 for laundry.

After several weeks the graduates were conceded 2 weeks' vacation with pay and the $2.50 for laundry only after a year of service. No allowances were made for the undergraduate nurses who have been receiving less consideration than the maids. Feeling that rest was the most important, it was decided to forego all demands if we could have one day a week off duty, which would still leave a minimum 54 hour week day shift and 70 hour week night shift. This request was refused. Nothing was done in haste or without due consideration. There was ample time given the advisory board to correct conditions. (Nurses walk out at Comox, 1939).

13 Two nurses resigned from a coastal hospital due to inadequate equipment in 1907. Newspaper reports suggested that the nurses should have appealed under the Industrial Disputes Act passed that year. The nurses may not have done so either because of ignorance of the Act or because they considered it to be legislation for unionists, and thus non-professional (Strike of nursing staff at Marble Bay Hospital, 1907).

14 By the way of comparison of the working conditions at St. Joseph's Comox with the data from the Eaton Report, 45% of hospitals surveyed are reported to have had nurses working similar hours for day duty, with 27.4% and 23.5% hospitals reporting less and more hours worked. Two hospitals reported considerably more hours worked. For night duty, 22% hospitals reported similar hours while 42% and 36% reported fewer and more hours worked (Eaton, 1938, pp.13-5).
The hospital was reported as "working under emergency conditions, caring for 50 patients with three nurses, two interns, nuns and citizens who volunteered" (Nurses posts being filled, 1939). As well "... the hospital ladies auxiliary...(is) assisting in the kitchen and other work." Two nurses were sent from St. Paul's Hospital, Vancouver to assist (Nurses' protest investigated, 1939). Sister Walberga, Superior of Sisters of St. Joseph is quoted as saying "We are very, very sorry this thing has happened... but we are getting along nicely now (Two new nurses arrive, 1939)... They were all good girls... perhaps they were a little impulsive and acted imprudently... we are willing to give them better conditions, we know they deserve them...but, most of our patients are on relief or too poor to pay... the government grant is insufficient" (Nine nurses quit, 1939).15,16

Colin Cameron (MLA, CCF, Comox), attempted to interview the "hospital board on the question and succeeded in presenting the nurses' case to two of the members ... he was assured that the board could do nothing for the nurses and they stated that it was impossible for them to participate in a public meeting at which the question would be discussed (Two new nurses arrive at Comox, 1939). An official of the Association was quoted as "having no official report on the matter" and that there had been "no request for an investigation" (Nurses protest investigated, 1939, pp.2). In the minutes of the Association Colin Cameron

15 In 1936, provincial and municipal funds met more than 40% of the total cost of operating all government aided hospitals in British Columbia." (Ward in Eaton, 1938, pp.84).
16 Medical indigency was conservatively estimated to be 25% in Canada in 1936 (Baillie, 1940).
is noted to have been "refused permission to speak to the (Annual) General meeting (about) the recent strike at St. Joseph's Comox" (April 15, 1939). After one week the strike ended with the Board of the hospital agreeing to an eight hour day, six day week, and two weeks vacation with pay. "Previously the nurses were on duty up to twelve hours or more daily, without provision for a day-off or vacation" (Nurses at Comox return to duty, 1939).

### The Association's response.

Although the Association was in the midst of its Annual Meeting during the strike, there is no direct reference to it in the minutes of the meeting or in newspaper reports of the meeting. The president of the Association, Miss Duffield, is quoted as 'speaking on the need to improve working conditions for nurses... (because) until better conditions are obtained, the full benefit of nursing knowledge and training cannot be made available (Nurses urged by president to seek better conditions, 1939). The official Association response may be intimated from the decision that "(a) letter be sent to the nurses who left the hospital... drawing to their attention the seriousness of their action and disapproval of the council and that a copy of this letter be sent to the Sisters of Comox Hospital... and that (the) letter be formulated by the Association lawyer and (the) whole matter be referred to the Legislation Convenor" (May 19, 1939). No further reference is made to the strike. However, reference to correspondence with George Weir on the matter of nurses' hours and students' working conditions was persistent and lengthy (September 16, 1938, November 22, 1940, April 19,
The Association recommended an eight hour day, six day week, and a maximum of 96 hour fortnight. In addition, students were to have one day off a week, lecture periods within the 96 hour fortnight, on-call duty limited to one eight hour period per week, and not less than three weeks vacation annually. Finally "no school of nursing or hospital shall be permitted to collect any fee from any person for the work of any student nurse who may have been assigned by the school of nursing or hospital to special duty nursing" (August 18, 1942). These recommendations are consistent with the recommendations of a 1938 committee of the CNA (Canadian Nurses Association, 1943, pp. 40).

With the release of the Report on Labour Conditions the Association had more contact with Mrs. Eaton. She suggested "the alternatives to effect change in schools of nursing were 1) opening the Registered Nurses' Act to include definite regulations, and the assumption of responsibility of the RNABC for enforcement... or... 2) bring schools under the Trades' Schools Act with government regulation... (she) advised the RNABC to retain control... (September 12, 1940)... (she) is reported to have made clear the necessity of improvement by voluntary or compulsory means (October 18, 1940). Again, eighteen months later it was "noted that Mrs. Eaton felt the Council of the RNABC should take a more active part in efforts to bring about the eight hour day.... (it was moved)... that the Registrar send a letter to the hospital which was not making an honest effort to effect
Table 2.2

Selected Data on the Terms and Conditions of Employment of Nurses in British Columbia and Canada, 1929-43

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<tr>
<th>Terms and Conditions of Employment</th>
<th>BC 1929</th>
<th>Canada 1938</th>
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Note: For sake of comparison with the 1943 data, the cash value of board, lodging and laundry estimated by Weir and Eaton has been subtracted from the salaries as stated in the original material.
the eight hour day - thus using "moral suasion" of this Council to bring pressure to bear on this institution" (January 28, 1942). Mrs. Eaton predicted, in an address to the Canadian Nurses Association Biennium 1940, that "there was a self-sacrificing spirit about nurses that might ... work to their own disadvantage ... the danger ... was that (during war time) nurses would be caught up in a great wave of self-sacrifice, and would forget their duty to endeavor to advance their profession ... such an attitude ... would be a short-sighted policy" (Standard of hours and wages for nurses poor, Calgary Daily Herald, 1940). The problem of working conditions in hospitals was not unique to British Columbia. A Federal Conference on labour conditions in hospitals was called in 1942 (October 21, 22, 1942), but there is no further reference to this meeting in the minutes. Table 2.2 summarizes selected data on the terms and conditions of employment of nurses 1929-43.

Secondary Themes.

The secondary themes for this period include registration, the subsidiary worker, education and organizational change. The Weir Report brought interest in national registration for nurses, but nothing ever came of this (April 23, 1937). Renewed consideration was given to mandatory licensure of all those who nurse for hire. This concern was initiated by the CNA (November 2, 1934; January 10, 1939) following recommendations from the Weir Report. With the outbreak of war, and the predictable shortage of nurses, the question of the role, function and training of subsidiary workers became pressing (November 25, 1941; January 28, 1942; October 21, 1942). In 1935 the Act was opened to
re-name the GNABC the Registered Nurses’ Association of British Columbia and to "legalize the requirement of Junior Matriculation for admission to a Training School" (Kerr, 1944, pp 5). Having established that there were sufficient qualified students prepared to enroll in a nursing school the standards for entrance were raised as an indirect means of improving the educational standing of graduate nurses.

In 1938 a committee was struck to examine the organization of local nursing associations. Reorganization into chapters and districts along geographic lines was proposed. The chapters and districts were to function as authorized branches of the Association. The Association responded to a request for advice "as to the stand local (nursing) organizations should take in discussion and voting on political issues in their local council of women affiliation (by suggesting they) not vote ...unless authorized by the Nursing Association ..." (March 24, 1939).

The role the Association played in the placement of nurses in employment changed during this period. Since its founding, the Association had maintained a Registry of private duty nurses. Experiments in hourly and group nursing were conducted with the support of the Association in the early 30's, but were abandoned by 1935. In 1941 a Placement Bureau Committee was formed to assist both nurses and employers (November 28, 1941). The Registry and Placement Bureau were combined in 1943 and a Director of Placement Services appointed.
The Bureau was funded by federal grants and an increase in membership fees.

Summary.

Despite the difficulties and frustrations of the Depression and subsequent years, the Association minutes for this period do not have a sense of futility. The struggle for improved employment practices was the dominant theme. While the Association was active in pressing for changes in working conditions through negotiation with the government and BCHA, it was the nurses of Comox who demanded and received changes in their working conditions. The Association had little concrete success in their efforts.

Secondary themes include mandatory registration, education and organizational change within the Association. The change in organizational structure both increased the control the Association could exert on its members, and created a mechanism to promote a responsiveness of the Association to its membership. While the Bureau operated as an employment service it represented a change in organizational structure which coincided with a continued shift in employment of nurses from private duty to institutional or wartime service during a period of increasing shortage of nurses. Thus there developed an organizational mechanism to deal with the employment problems of nurses.
Conclusion: The Failure of Moral Suasion: 1912-42

In 1912 a small group of nurses formed the Graduate Nurses' Association of British Columbia to press for the registration of nurses. Voluntary registration was achieved in 1918. The Association then shifted its attention to education and the closure of substandard schools of nursing.

While the terms and conditions of employment were acknowledged to contribute to the ill health of nurses, the great economic Depression of the 1930's inhibited any action. The impact of the closure of schools and the Depression was to decrease the proportion of students to registered nurses and to increase the numbers of nurses employed by institutions. Private duty continued to be an important employment option. By 1937 the working conditions of nurses had become a political issue and a provincial survey of hospital employed nurses was conducted by a government appointed committee. In April, 1939 a strike of nurses at St. Joseph's Hospital, Comox occurred. The Association responded by sending a letter disapproving of their action. On the basis of data in the Weir Survey (1932), the Eaton Report (1938) and the survey by the Canadian Nurses Association (1943) it is apparent that the terms and conditions of employment of nurses had changed imperceptibly since before the Depression and, given the inflationary impact of World War II had in fact dropped below pre-depression levels.

The formation of chapters and districts within the Association facilitated communication within the Association. World War II began, creating a shortage of nurses and exacerbating the terms and conditions of employment of nurses.
CHAPTER 3

To Protect the Quality of Nursing 1943-76

Introduction

The Second World War brought full employment and improved income levels to the work force of the nation. Although wages, hours of work and living conditions within hospitals had improved (Agnew, 1943, pp.28-30), the unrest and dissatisfaction felt by nurses was known to the Association (October 19, 1946). A Survey of Nursing conducted by the CNA under the auspices of the Canadian Medical Procurement and Assignment Board identified that "even though there has been an upward trend in salaries paid to nurses since the outbreak of the war, ... these salaries do not compare favourably with those paid to many other professional groups, in normal times. They are far below wartime salary scales, even though maintenance is included... A shortage of nurses is not surprising under these conditions" (CNA, 1943, pp.34). Post-war inflation also contributed to dissatisfaction with salaries (RNABC, Labour Relations Division 1978, pp.4). A persistant critical shortage of nurses lasted until the early 1950's. Overt pressure for action came from increased unrest amongst nurses and the attempts of labour unions to organize nurses (November 3, 1943).

\[1\]"...add(a) clause (to printed material concerning Labour Relations) pertaining to protecting the quality of nursing...(May 2, 1951).
The secondary themes for these three decades include registration, education, private duty, subsidiary workers, health and safety of nurses, social security, terms and conditions of employment of senior nursing staff.


The shortage of nurses.

The shortage of staff precipitated by the war exacerbated the problems of the working conditions of nurses. Initially the shortage was considered a wartime phenomenon, but when it continued after the war, the Association and the public became "truly alarmed" (Wright, A. Report ..., 1947, pp.2; Nursing shortage in Canada described as nearing national emergency, 1950).

During the war the Association attempted to ease the shortage by encouraging married nurses to work, ignoring the employment of nurses not eligible to register (November 28, 1941), issuing temporary permits to nurses who had been eligible to register at the time of graduation but were no longer eligible (November 19, 1942), encouraging the employment of private duty nurses as general staff nurses in hospitals, actively discouraging private duty nurses from enrolling in the private duty directory unless "very legitimate reasons" were given (Braund, 1945 pp.19), and fostering the use of subsidiary workers to augment or replace professional nursing staff (April 14, 1944). The airlines were requested not to hire nurses as stewardesses (April 24, 1942). The
Association requested permission to amend the Act to permit lowering the age for entry into schools of nursing (April 24, 1942). Political pressure was exerted to shorten the period of training for students. However, these efforts were resisted (January 5, 1944). Students were permitted to marry service men and continue their training (April 15, 1943). Friction developed between part-time and full-time nurses who were "liable to resent the sacrifice of all the best hours of work which are delegated to the part-time workers" (April 14, 1944).

The shortage of nurses occurred even though there was a 16.2% increase of general duty nurses and 22.4% increase of supervisors and head nurses. The corresponding national figures are 18% and 10%. The largest increase for any full-time group was that of the paid ward aides; this group showed a 52.2% increase" (Canadian Hospital Council, 1943, pp.7-8). This is a national figure; no provincial data are presented.

Following the war the shortage was described as due to increases in population, the increased use of hospital beds, high rates of bed occupancy and new responsibilities assigned to nurses (April, 14 1944). The impact of the eight hour day, the return of the married nurses to the home, and an increase in the number of nurses employed in public health, tuberculosis control, and in government-aided and Veterans' hospitals were also seen as adding to the shortage. The "stimulus of the glamour of the war" had been lost and "despite an increase in the supply of nurses by 70%" since 1941, the shortage was seen as "a result of long years of inadequate salaries and unsatisfactory working conditions" (Mallory, 1947, pp.3). Estimates of nurses needed
to correct the shortage did not account for the increased number of nurses needed to improve the working conditions of student nurses (Wright, Report. 1947, 2-5).

As late as 1947, it was reported that "the dependence of hospitals upon students for service has not decreased...some...students are working 48 hours each week with classes and study periods added. Seven to seven night duty and 24 hour duty in contagion have not yet been entirely eliminated...(there) has been an effect on student recruitment...during the war years less than 75% of students who entered schools of nursing remained to complete the course" (Wright, 1947, pp.1). Again in 1948, the Committee on Education made a "plea for (a) 48 hour week including classes, a maximum 44 hour week to decrease to 40 hour week in one year; with night and evening duty restricted to 12 weeks of each, ... sick time and other protective measures. ... If care (is) exercised to eliminate non-nursing and non-educational duties, shortened hours of experience will not be detrimental to the educational program of the schools" (Wright, 1948, pp.6-7).

Student nurses bore much of the burden of the shortage of nurses. While individual groups of nurses were improving their working conditions, students were in an unprotected position since they were "exempt from regulation governing hours and conditions of work for employees" (Mallory, 1948, pp.4) Despite the permissive role accorded the Lieutenant-Governor in Council in the regulation of student nurses'
hours by revisions to the Act in 1942, as an outcome of the Eaton report, no action was taken (Wright 1948, pp.6-7; May 28, 1948). A Student Nurses' Association was formed in 1947 and is remembered as being active in working to improve their conditions, (Smith, 1981) although there is no evidence of this in the annual reports for this period. A partial solution to the conflict between a student's service and education was the block system whereby students were in a period of education or service for blocks of time. (June 23, 1949).

The continued shortage of nurses following the war gave nurses a sense of security in formulating their demands for improved salaries and working conditions. Over the next three decades the organizational structure that evolved moved from the status of a committee to that of an autonomous organization under the Association.

**The first steps towards collective bargaining.**

The problem of the affiliation of nurses with trades and labour unions was first referred to the executive committee of the CNA by the Registered Nurses' Association of Ontario in June, 1942. The principle of collective bargaining by national and provincial associations of nurses was approved by this committee in November, 1943. A Labour Relations Committee of the CNA was formed at this time. The committee studied the question of labour relations and the nursing profession (Beith, 1944, pp.692-693; 693-695).
In 1943 the CNA requested information from the provincial associations about nurses in trade unions. "A reply was sent to the effect that no unions of nurses existed in BC" (February 25, 1943). This was followed by a request for the convenor of the Legislative Committee of the CNA asking for "suggestions in giving guidance to the provinces" (May 28, 1954). The Association responded with a series of questions about the role, function and relationship of nurses, employers, and Associations in collective bargaining (January 19, 1944). In the fall of 1943 the Association formed a committee to study the question of the membership of nurses in labour organizations.

For the leaders of the Association the concerns were expressed as "It is not better to accept membership in labour organizations and guide the thinking and action of the group for our own protection?... Should we not attempt to strengthen our own professional organization so that it may give nurses the protection and support offered by labour organizations to their own members" (October 20, 1943)? As the executive of the Association continued to study the issue, the problems were redefined as 1) "if nurses were advised not to join trade unions, what assurance of support could come from Provincial or National Associations, 2) what were the mechanics of entering trade union activity 3) what are the potential conflicts to professional standards should nurses join trade unions (objection to "punching clocks," "strike action"), 4) if the Association did not take on the role of collective bargaining, what would be the relationship between trade unions and the Association" (January 5, 1944; March 1, 1944).
The grassroots saw the issues in more pragmatic terms. Meetings amongst "small groups" of the general nursing section identified the problems as: 1) lack of compensation in case of accident while on duty, 2) lack of provision for sick time, 3) no uniformity in salaries, 4) no graded salary for years of experience" (December 1, 1943).

The Executive Council of the Association "endorsed the recommendation of the Executive of the CNA ... that the members .. approve the principle of collective bargaining ...(and) that collective bargaining be conducted through the national and provincial nursing associations" (January 5, 1944). This resolution was later passed at the 1944 Biennial Meeting of the CNA but was rejected at the annual meeting of the RNABC (April 14, 1944). The resolution read "whereas one of the objects of the Association is to raise the standards of nursing within the province; and whereas in order to do so it is necessary to see that its members get adequate remuneration for their services ... be it resolved that the Council ... take whatever steps that may be necessary to ensure that the Council or its nominees ... be appointed bargaining representatives for any of its members or groups of its members, in any proceedings under the Industrial Arbitration and Conciliation Act or the Wartime Labour Relations Regulations". The general membership did pass a resolution "that the individual nurse, when approached by associations having affiliation or possible affiliation with labour unions, be advised that the Council of Registered Nurses of British Columbia strongly recommends that no action be taken by the individual nurse at the present time until more
information is available" (April 14, 1944).

The 1946 Annual Meeting of the RNABC, on the recommendation of the Labour Relations Committee of the Association reversed its rejection of the Association's role in collective bargaining. Stressing "unity of purpose" ... to achieve progress in the nursing profession", the committee reported that "it is felt that every member of the Association should be acquainted with the role that the ... (Association) is prepared to assume in helping its members secure satisfactory working and living conditions with adequate remuneration". The major problem identified in achieving this goal was that an organization having both employees and employers as members could not be named as the bargaining agent for a group of employees. However, under wartime Labour Relations Regulations (PC1003) under the Federal Government, an employee group was able to elect bargaining representatives by majority vote who were not required to be members of that employee group. Thus, the Select Committee on Labour Relations was created to "inform themselves on Labour Relations" and "act as a bargaining agent on behalf of its members if so requested"² (Copeland, 1946, pp.1-3; March 5, 1946). The committee was composed of the Registrar, the Director of the Placement Service, the Chairman of the Provincial Legislation Committee and the Chairman of the Labour Relations Committee (Copeland, 1947, pp.1-4).

²The passing of the British Columbia Industrial Conciliation and Arbitration Act, 1947 recognized the RNABC as a "Labour organization" and as the bargaining authority providing that 51 percent of the nurses on the staff were RNABC members (November, 12, 1948; Wright, Select ... 1949, pp.71).
The functions of the committee were outlined as:

(1) to serve on request, in an advisory capacity, individual nurses or groups of nurse employees on matters related to employment conditions, with the objective of assisting nurse employees to prevent or overcome difficulties by democratic and businesslike procedure.

(2) In situations where nurse employees have been unable to effect an agreement with their employer, to arrange conferences with the employer, at which nurse employees would be represented.

(3) In situations where all other measures have failed, and upon the request of a majority of the affected employee group of nurses, to set up a bargaining group (representative of the affected nurse employee group and the Select Committee) which would obtain certification and proceed with negotiations" (Wright, Select ....1947, pp. 1-2).

The "prevention of difficulties rather than the correction" as the primary role of the labour relations program of the Association was frequently stressed (Wright, 1949 pp.71; Merrick, 1951, pp.78). The committee's duties included "to study and report on all matters affecting employer-employee relations and to serve in an advisory capacity ... on all matters relating to labour relations" (April 22, 1949). This committee later combined with the Placement Service Committee and became known as the Committee on Employment Relations to conform to changes in the CNA committee structure (November 15, 1952).

At the 1946 annual meeting of the Association the role of the Labour Relations Committee of the CNA was described by Esther M. Beith (Convenor of Legislation Committee, CNA). "As a committee it has no authority, its primary function being to co-ordinate the thinking of the
provinces. It has concerns with personnel practices, including collective bargaining, with a continuing study of the effects of affiliations with trades unions, and with securing information and interpretation of labour legislation (which) affects or may effect nurses. The nursing associations were seen to have "secured registration, the eight hour day and six day week, affected improvements in standards and conditions of service and approved the principle of collective bargaining". Esther Beith rejected the criticism by some nurses that the Association had failed them, arguing that the accomplishments in improving working conditions had been made despite ten years of depression and six years of war. "If we stand together, we can write our own labour legislation". She identified interest in collective bargaining as resulting from "1) the trend towards nurses working in more and larger groups, 2) the fear created by the depression and 3) the conviction of strength which the shortage has given nurses". Esther Beith acknowledged that, under current legislation, difficulties existed, but argued that the national or provincial associations should be the bargaining agents for their membership, or if this were not possible, collective bargaining should be undertaken with the approval of the Association. Any affiliation with trade unions was rejected: "union methods are not applicable to nursing .... no such thing as strike action is possible for nurses. Nurses should be interested in trades unions from a public relations and public understanding viewpoint; not with the motive of getting something for ourselves, but because of our interest in fellow workers and the benefits they will
derive from social legislation", although she acknowledged the trend toward participation by professionals in unions. The fear was expressed that association with trades unions would "lower the prestige and (the) strength of professional associations. This fear was repeatedly expressed throughout this period (April 14, 1944; January 24, 1947; February 13, 1950). In the midst of this presentation Esther Beith is quoted as saying:

Each nurse entered the profession of her own free will under known conditions. We know that life may depend upon the service that we can give. Street cars may stop and start again but if nursing service is withdrawn and the patient dies, there is no second chance. This point is illustrated by a story of Dr. Fleming who, while on vacation, was continually called upon to attend patients. When Mrs. Fleming remonstrated - argued that he has the same right to a vacation as other workers, Dr. Fleming replied: "I should have thought of that before I went into medicine" (Beith, 1946, pp.1-4).

In concluding her remarks, Miss Beith stated "the State Nurses' Association of California is the bargaining agent for its members and has obtained the best conditions of work that nurses have anywhere" (Beith, 1946, pp.1-4)³.

³In 1937 the American Nurses' Association recommended "that nurses not join unions" but suggested that in their professional associations nurses have the instruments best fitted and equipped to improve every phase of their working and professional lives" (Anderson cited in Metzger, pp.34-35 in 1946 collective bargaining by district and state chapters was in 1946. Collective bargaining by district and state chapters was accepted in 1946. (Bullough, 1971, pp.273-288).
The Setting of Standards for the Terms and conditions of Employment.

The Annual Meeting of 1946 heard one other report important to this study. The Executive Secretary (Alice Wright)⁴ presented the principles of personnel practices which formed the basis of bargaining on the terms and conditions of employment.

Since the formation of the Association, fee schedules of private duty nurses had from time to time been revised by committee, presented to the private duty section and voted upon and accepted as the current fee schedule. The Placement Service Committee took on this role when the sections were dissolved and the Placement Bureau was formed in 1941. While the committee continued to put forth a private duty fee schedule until 1966, it expanded its role to study "employment problems ... and to coordinate the efforts of ... those ... concerned with the employment of nurses" (April 15, 1943).⁵ Prior to this, a province-wide survey of employment and living conditions was authorized by the Executive Secretary and the Director of the Placement Service (April 24, 1942). This survey formed the basis of revisions of the Recommended Personnel Practices drawn up in 1944 and approved by the BCHA annual meeting and the RNABC. The Recommended Personnel Practices were then distributed to the constituency of each organization (April 26, 1946). The pattern of joint approval of Recommended Personnel Practices continued until 1956. (April 5, 1944; Beckett, 1964) On the basis of the information in the survey (not available) the "principles of personnel practices ..."

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⁴ See Appendix B for a biographical note.
⁵ It is this committee that is referred to as a Labour Relations Committee in Creasor, (1954, pp.4) and Beckett, (1964), since there is no reference to a Labour Relations Committee in the minutes of 1942.
(representing) ... the thinking and wishes of the great majority of our members" were presented. (April 5, 1944).

The philosophy which underlies the principles and recommendations now presented is that nurses and their employers have a mutual interest in and responsibility for fulfilling the purposes for which health institutions and agencies exist; these are (1) to care for the sick and (2) to promote the health of all citizens.

With this in mind, the principles upon which desirable and reasonable policies of personnel practices for nurses may be developed can be outlined as follows:

1. Nurses, like all other human beings, need opportunities for satisfaction in service and for self-development.

2. Acceptable living and working conditions, with recognition of good service, result in a more efficient and interested worker, with consequent improvement in service.

3. The hours of work should not exceed those of other salaried, professional workers; should be considered in relation to the physical, intellectual and psychological strains under which nurses work; should be such that efficiency is not impaired and should make possible participation in the social and cultural life of the community.

4. The length of vacation should be such as would permit the building up of physical reserve and resistance to infection and should compensate for the irregularity of hours and free time.

5. A definite policy of continuance of salary during time lost through illness is protective of the health of the nurse, her patients and her co-workers.

6. A nurse is entitled to the right accorded other workers of choosing where she lives and has her meals.

7. When it is necessary for nurses to accept accommodation provided by the employing institution, such accommodation should ensure privacy and comfort and should provide for normal social living.
8. An employee health program is economically sound and operates to increase efficiency.

9. Deductions for room and board should be in relation to the cost to the institution and should reflect the differences in the quality of the accommodation provided.

10. The cost of laundering uniforms should be borne by the employing institution, in keeping with the practice in other occupations where the wearing of a uniform is required.

11. Salary schedules for nurses should be based on the value of the service rendered, irrespective of the charitable functions of the employing institution.

12. The basic minimum salary should ensure a standard of living in keeping with the nurse's professional status and make it possible for nurses to take advantage of educational opportunities and to provide for retirement.

13. A contributory pension plan results in increased loyalty to the employing institution, lifts and maintains morale and has a stabilizing effect.

14. Married nurses should have equal opportunities for employment.

15. Stated terms of employment tend to eliminate dissatisfaction and unrest.

16. Staff relationships should be such that the nurse will feel free to take her problems and grievances to the member of the administrative staff to whom she is responsible.

17. A staff education programme aids in the more rapid and effective orientation of new employees, tends to increase the interest in and understanding of the functions of the employing institution and promotes unity of staff and improved employee-employer relationships. (Wright and Braund, 1946, pp.1-3).
The Recommendations were organized under the following headings:

- Hours of Work
- Vacation
- Sick Leave
- Residence
- Salaries
- Marital Status
- Permanancy
- Temporary General Duty Staff
- Staff Health Program
- Pension Plans
- Terms of Employment

(Wright and Braund, 1946, pp.1-5).

The outcomes.

In 1947 the Labour Relations Committee reported that "with the adoption of the recommendations on personnel practices, the RNABC had outlined a set of standards that would be the first step in educating the employer group and the public, as well as the nurses themselves, to the need for improved conditions and would give all parties a fair basis on which to judge existing conditions". The major task of the committee was described as "acquaint(ing) the members ... of the ways in which they might become more informed of means and methods whereby they might help themselves and their fellow workers to obtain better economic security through the channels in operation with the RNA. Some nurses were apparently unaware of or indifferent to such means and were willing to turn to outside sources such as organized labour unions for assistance"(Copeland, 1947, pp.1-4).

The introduction of compulsory hospital insurance by the province did not ease the financial difficulties of the hospitals.
Indeed Evelyn Mallory foresaw that the impact of hospital insurance would prevent hospitals from materially increasing the size of the nursing budget without approval of the Hospital Commission and that salaries to nurses would probably be subjected to some degree of control by the Hospital Commission "although nurses were urged to cooperate" in the introduction of hospital insurance (Mallory, 1949, pp.9-10).

During this period nurses tended to live in residence, and, it is implied that some were required to live in residence. The facilities within the residence and the rate charged for room and board were both issues for collective bargaining. Nurses were charged increased rates for room and board as salaries increased or were charged for room and board they did not use. This remained an issue until 1956.

The issue of marital status interfering with permanent employment was contested as early as 1946, but for some groups employment practices prevented the full time employment of married nurses until 1955 (City will hire married nurses, 1955).

In a discussion of the problem of statutory holidays falling in a vacation period, it was recommended that extra days not be requested "as (there is) ... evidence of feeling on the part of employers that nurses' longer vacation is perhaps not justified". At the same meeting, "threats of mass resignation were seen as "violations of professional service, and in the opinion of the public constitute(d) strike action ... (and thus were) disapproved of" (April 3, 1948).
Wage demands did not change between 1952-55, although the hours of work were recommended to be reduced from 44 to 40 per week (McKenna, 1952, pp.68; Hood, 1955, pp.82). By 1954, the resolutions from the floor were challenging the Recommended Personnel Practices to increase basic rates of pay (May 21, 1954). In an effort to obtain a 44 hour week for students the Association approached the Minister of Health to request provision for a budget sufficient to allow improved working conditions for students (October 11, 1951).

The ideological shift.

In reviewing the Presidential Addresses of the Association it is evident that the leadership were well aware of the shift in ideology of the Association. Evelyn Mallory, addressing the 1949 Annual meeting acknowledged that while some were "not too happy about the use of the term 'bargaining' ... the process (of) reaching a mutually satisfactory solution ... is a democratic and sane procedure ... That the thinking and action of nursing associations have undergone marked change in regard to employer-employee relationships is evidenced by a comparison of articles appearing in nursing journals about ten years ago with those appearing to-day. For example, here is a quotation from the May 1938 issue of "The American Journal of Nursing".

Nursing occupies a unique place in the minds of the people. It is one of respect, even of affectionate respect. To our people the nurse is essentially a giver -- a giver of comfort. This fundamental concept psychologically is at war with the need of the individual nurse for reasonable working conditions and for economic security. It is also at war with the methods of unions.

Compare that with the following quotation from the March 1949 number of "The Trained Nurse and Hospital Review" (in which a meeting of representatives of the American Nurses' Association is reported):

...neither as an individual nor as an association does the nurse compromise the ethical standards of her
profession when she attains economic benefits by means of collective bargaining.

Collective bargaining is not only a means of settling employment terms but can be a means of improving relationships in general, between employers and nurses, so that they may work together to provide optimal nursing care.

Some of us may not even yet be any too happy about the use of the term 'bargaining' but the process, that of gathering around a table to talk through difficulties with a view to reaching a mutually satisfactory solution that process is a democratic and a sane procedure, and one that we approve of very much (Mallory, 1949, pp.8).

In 1953, Esther Paulson described the objectives and activities of the Association as:

(1) to implement and protect standards in nursing education and practice to meet prevailing community needs

(2) by providing two registries for private duty nursing in two of the three largest cities in the province and a placement service for other types of nursing positions throughout the province.

While the primary purpose of these resources is to serve our registered members, the public is also served through the placement of nurses, private duty, institutional and public health, where needed in the communities throughout B.C.

(3) By providing a labour relations programme to obtain and safeguard suitable working conditions and acceptable personnel practices for our members through direct conferences with employees.6

Esther Paulson closed her address by stressing the challenge of meeting "the public interest" inherent in a "privileged profession" such as nursing and by urging nurses to work for and live for their profession" (Paulson, 1953, pp.3-6).

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6 Employee was changed to "employer" by E. Mallory former owner of the copy of the Annual Meeting Minutes, June 5-6, 1953 used for this study.
Secondary themes.

The secondary themes for this period are the issue of pensions for nurses, the increased difficulty of employment of private duty nurses, and the education and licensure of subsidiary workers, and registration. The issue of pensions for nurses had been of concern to the Association for a number of years. As early as 1932, nurses were being urged to make their own arrangements for insurance (May 27, 1932). In the face of high unemployment and low income clearly this was difficult. With the advent of the Municipal Superannuation Act and the Hospital Insurance Act, making virtually all hospitals public institutions, pressure by the Association on the Hospital Services Commission continued, but to no avail (May 25, 1950; June 22, 1951).

The Association had increasing difficulty keeping the Vancouver and Victoria directories operating even with the direct financial assistance of the Association. By 1956 private duty represented 7½% of the membership but required 25% of the Association budget to operate the Directory. (Stewart, 1956, pp.58). Under pressure of shortage of nurses during wartime, practical nurses were in effect doing private duty (November 3, 1943). This practice was condemned (November 16, 1950). The difficulty of finding employment for private duty nurses was in part due to a less pressing shortage of nurses, but also due to "changes occurring in medical practice and in (the) organization within hospitals effect(ing) the use of private duty nurses"(December 9, 1948), and the fact that the Social Assistance Department would not pay for
private duty nursing when patients required constant care (December 19, 1953; January 23, 1954). (Recovery rooms for post-anaesthetic care were not in general use at that time and intensive care units were yet to come). By 1967 both Victoria and Vancouver Directories had been closed; the function being taken over by the private duty nurses themselves. (December 16, 1966).

Concern over the role and function of subsidiary workers resulted in the formation of a Government Committee on Nursing chaired by Mrs. Rex Eaton. This activity resulted in instituting courses for orderlies and practical nurses (Wright, 1951, pp.42), and licensure of practical nurses. The College of Physicians and Surgeons endorsed the principle of "practical nurses administering such treatments as are necessary in the sick room under the direction of the attending physicians" which included the administration of drugs (October 18, 1952). This was opposed by the Association and the BCHA (December 13, 1952).

The Association continued to be concerned about the number of nurses who were not registered. The Act licensing practical nurses was described as 'permissive' and not affecting non-registered graduate nurses (June 23, 1951). Non-registered nurses were refused access to the Association's private duty directory (November 1, 1947) and not permitted to participate in the affairs of the Association. Nurses were encouraged to register by direct pressure from the Association and by indirect
pressure through the hospitals. "Letters were sent to all hospitals and the Hospital Association urging that all nurses be encouraged to register... and that a salary differential of $10/month be instituted for non-registered nurses" (January 13, 1949).

Summary.

The first few years of experience in collective bargaining can be seen as tentative explorations in the exercise of power. An awareness of the response of employers, the public and the government led the Association to hold the line on nurses' demands in several instances. While discussions between the Association and the BCHA on Recommended Personnel Practices and direct negotiation with employers resulted in improvements in the terms and conditions of employment, the gains were not sufficient to satisfy the grassroots workforce. The evidence presented in the narrative suggests that although the Association took a new role in undertaking collective bargaining, there was a residual reliance on paternalism, the mutual role of the nurse and the employer, and on professionalism to mollify demands. Pressure from the grassroots, because of the increased recognition of economic disparity forced the Association to take stronger action in the late 1950's.
The Legitimation of Militancy: 1955-64

Introduction.

The period 1954-64 brought increased confidence to the Association's activities in collective bargaining. Collective bargaining expanded such that in 1951, a full time labour relations officer, Evelyn Hood, was hired. Nora Patton succeeded Evelyn Hood in 1970. Other personnel were hired incrementally throughout the next 20 years. By the late 1950's the process of collective bargaining had become increasingly professionalized with hospitals hiring negotiators and with experiments in regional and provincial bargaining. Contract issues were concerned largely with salaries, hours of work, sick time and pensions. The 40 hour week was widespread in public hospitals, and universal in provincial and federal hospitals in British Columbia by 1955 (Hood, 1955, pp.49-50).

Contract settlements during this period often required conciliation procedures. The rejection of a conciliation report by several hospitals led to strike action in 1957. The first grievance that went to arbitration was in 1959 (Hood, 1960, pp.69).

The outcome of collective bargaining was frustrated by hospital budget freezes ordered by the provincial government. As a result of hospital budget freezes there was no guarantee that hospital deficits, in part due to contract settlements, would be financed by the government. Budgetary restraint adopted by the
hospitals led to increased concern about the standards of nursing care. This become a dominant theme of the Association by the 1970's. The first instances of conflict between professional role of the Association and outcomes of activity in labour relations occurred in this period.

Secondary themes for this period include education, registration, terms and conditions of employment for senior nursing staff and the health and safety of nurses.

Background.

Ormsby, (1958, pp.486-489) describes the climate of British Columbia prior to the introduction of hospital insurance in 1949, as a "class divided society in which "probably one-third of its population hoped to see ... the introduction of a socialist system ... which the majority of the voters favoured a free enterprise system. Paradoxically ...they expected the government to provide more social assistance" (pp.486). The demand became so insistent that the Johnson-Anscomb (Liberal-Conservation) coalition was compelled to introduce hospital insurance in 1948. Taylor (1978, pp.167-169) describes the establishment of the British Columbia Hospital Insurance Service and the administrative nightmare that resulted from "the combination of lack of advanced planning, inadequate time for training of new staff, and two complicated collections systems".

"Many were uninsured. Many who had paid premiums received no entitlement card; some who had not paid, did receive them; the
change of employer and change of address procedures bogged down ... A proportion of the uninsured were hospitalized and unable to pay their bills; hospitals' costs increased, as did their deficits' (pp. 167-8). Criticism from the public, the press, and acrimonious debate in the legislature led to formal inquiries, resignations of the minister responsible and the transfer of the executive director of BCHIS. Under a new minister, Lloyd Detwiller from the provincial Finance Department was appointed commissioner of BCHIS. Co-insurance payments were introduced. Approximately 85% of hospital accounts were insured accounts. The imposition of co-insurance, premium increases in 1950 and 1951, charges of inefficiency in the administration of the insurance scheme and rumors of a split in the Liberal-Conservative Cabinet over the scheme made hospital insurance the most bitterly emotional and controversial issue in the 1952 election campaign" (pp.168). The new Social Credit party led by W.A.C. Bennett won the election. A number of changes were made to the plan, and by early 1954, "the system was working tolerably well" (pp.168). However, a political decision to abolish premiums for hospital insurance and increase the social services retail tax from three to five percent was made. "All efforts were now directed to the development of the hospitals system, improvement of standards, and the refinement of the system of paying hospitals for insured services" (pp.169).

In Taylor's terms British Columbia"paid part of the tuition costs in educating Canadian governments in the formulation of effective policies and administrative procedures in this most complex of the social insurances" (pp.169). The collection of premiums as well as the reimbursement of hospitals, and their budgetary systems were problems.
Hospitals were resistant to government interference in the budgetary arena. The Hospital's Association was not strong in its ability to represent the interests of the hospital to the government. Pressure from unionized hospital employees, under the leadership of Bill Black was developing, the introduction of hospital insurance removed the ideological constraint of "charitable" work from the employees of these institutions. At the same time, financial support for hospitals was limited. Competition for available revenue came from W.A.C. Bennett's commitment to the development of the natural resources of the province and in his desire for a balanced budget. Freezes on hospital budgets were levied in 1956 and 1959 and only lifted when outstanding payments to local businesses resulted in the business community applying pressure to the government, notably in the face of the election of 1956 (Detwiller, 1981).

With the introduction of the Hospital Insurance and Diagnostic Services Act in 1957, the federal government entered the funding of health care, a provincial responsibility under the British North America Act. In exchange for meeting certain federal standards to qualify the federal government provided funds for hospital and diagnostic services within hospitals on a cost shared basis. The policy of cost sharing (the 50¢ dollar) was extended to cover medical services under the Medical Care Act of 1966 (inaugurated in July, 1968). Cost sharing as a formula for federal support of health care was discontinued when block funding and more latitude in provincial government personal and corporate income tax rights was granted to the provinces in 1977.
This was done to decrease federal financial commitments to increasing health care costs (Soderstrom, 1978; Taylor, 1978, Van Loon, 1978).

The growth of collective bargaining.

An assessment of the rate of growth of collective bargaining by nurses in the province is difficult. Table 3.1 represents an amalgamation of information from annual reports of this period. Only the total numbers of registered nurses and the number of groups of nurses who became certified are known.\(^7\)

It is evident from the minutes that the process of collective bargaining consumed much of the time and energy of the Executive Secretary and staff of Personnel Services. By 1961 the Select Committee on Labour Relations had given up its function of preparing Recommended Personnel Practices to the Director of Personnel Services (Hood, 1961 pp.1064-1065). Staff representatives from each bargaining unit contributed to the development of the Recommended Practices through regional meetings with the Director of Personnel Services. The Executive Committee of the Association continued to review the Recommended Practices before presenting them to the Annual Meeting for endorsement. It was not uncommon for chapters to communicate their concerns about the Recommended Practices directly to the Executive Committee (January 2, 1957; March 30, 1957; May 31, 1961; November 4, 1961; June 22, 1963; November 21, 1964).

\(^7\) Neither the RNABC nor the Labour Arm of the Association is able to provide this information (Patton, N. Personal Communication, January 1980; Grice H. Personal Communication, July 1980).
Negotiations were first spread over four months, and then nine months of the year (Hood, 1955, pp.49-50). Concern was expressed over the tendency of the hospitals employing labour relations consultants to do their bargaining. The Association saw direct negotiation with members of the hospital or public health board as an opportunity to iron out "misunderstandings and points of friction" as well as a chance to "hear management's problems and points of view ... result (ing) in better understanding and respect on both sides .... A professional negotiator thrives on disagreement and cannot possibly know the varying situations that exist in different institutions" (Hood, 1955, pp.49-50). Regional bargaining was seen as making "working conditions and salaries more uniform..." but had the disadvantage of "loss of personal contact with the individual boards (that denies us the opportunity to interpret nursing and nurses' problems to them)"(Hood, 1958, pp.70).

The Executive Council of the Association rejected province-wide bargaining in 1958 (March 29, 1958) but a year later was "willing to recommend...that ... the Association participate in a plan for province wide bargaining on a trial basis and with the understanding that bargaining will not be handed over to a professional negotiator" (October 17, 1959). "Province-wide bargaining ... proved to be successful. Many nurses ... expressed satisfaction with this method of negotiating agreements. With uniform salaries nurses are able to make their choice of employment on factors such as type of community, interpersonal relationships within the hospital and working conditions that permit reasonable job satisfaction" (Hood, 1961, pp.62). With similar misgivings the Association agreed to standardize
Table 3.1
Selected Data from Recommended Personnel Practices of the RNABC, 1946 - 68

<table>
<thead>
<tr>
<th></th>
<th>1946(^a)</th>
<th>1947(^b)</th>
<th>1948(^c)</th>
<th>1952(^d)</th>
<th>1956(^e)</th>
<th>1964(^f)</th>
<th>1968(^g)</th>
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</thead>
<tbody>
<tr>
<td><strong>Hours</strong></td>
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<tr>
<td>Weekly</td>
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<td>44</td>
<td>44</td>
<td>40</td>
<td>40</td>
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<tr>
<td>Days off/week</td>
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<td>1(\frac{1}{4})</td>
<td>1(\frac{1}{4})</td>
<td>1(\frac{1}{2})</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hours between shifts</td>
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<td>16</td>
<td>16</td>
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<td><strong>Vacation</strong></td>
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<tr>
<td>Days paid/annually</td>
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<td>28</td>
<td>10</td>
<td>11</td>
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<td>Statutory holidays paid</td>
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<td>10</td>
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<td><strong>Sick Leave</strong></td>
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<tr>
<td>Days paid/monthly</td>
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<td>1(\frac{1}{4})</td>
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<td>1(\frac{1}{3})</td>
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<td><strong>Salaries-Basic Monthly Rate</strong></td>
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<tr>
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<td>$150</td>
<td>$220</td>
<td>$250</td>
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<td>head nurse</td>
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<td>supervisor(A)</td>
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<td>$180</td>
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<td>$285</td>
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<td>instructor</td>
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<td>$170</td>
<td>$245</td>
<td>$265</td>
<td>$424</td>
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<td>(university preparation)</td>
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<td>Public Health</td>
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<td>(university preparation)</td>
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<tr>
<td><strong>Private Duty - Rate per shift</strong></td>
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<tr>
<td>(for care duty in hospital)</td>
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<td><strong>Increments - monthly</strong></td>
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<td>Bachelor's Degree</td>
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<td>$10</td>
<td>$10</td>
<td>$25</td>
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<td>$25</td>
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<tr>
<td><strong>Experience</strong></td>
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\(^a\) Wright and Braund, 1946, pp. 3-5
\(^b\) RNABC, Personnel practices, 1947, pp.3-5.
\(^c\) RNABC, Suggested revision of RNABC recommendations on personnel practices, 1948
\(^d\) McKenna, Revision of personnel practices, 1952, pp.66
\(^e\) Hood, Report of revision of recommendations on personnel practices, 1956, pp.78.
\(^f\) RNABC, Proposed recommended personnel practices, 1964, pamphlet.
\(^g\) RNABC Proposed recommended personnel practices, 1968, pamphlet.
contracts across the province (April 7, 1962).

Contract Issues.

The contract issue that created the greatest debate was salaries. Concern was raised by the North Cariboo Chapter that "bargaining to increase nurses' salaries should cease for the time being in B.C... otherwise nurses will be talking themselves out of those jobs and be replaced by nursing aids" (September 15, 1954). There is no record of this issue coming to an Annual Meeting, however no increase in salaries was requested in 1955. The only request was for a change in the increment structure for years of service. This was not accepted by many hospitals, and the issue did not go to conciliation because it was not considered important enough.

The British Columbia Hospital Insurance Service, which had become the government funding agency for the hospitals of the province ordered a freeze on all hospital salaries thus nullifying the increments built into the previous year's contract. In order to honour the contract, many hospitals had large deficits. This deficit was alleviated when the government agreed to accept 1/3 of the deficit incurred. The hospitals were permitted to recognize 1956 salaries in 1957 if agreements were in effect. Nurses were described as most sympathetic to the financial difficulties that the hospitals have been experiencing but have been very concerned when budget cuts have an adverse effect on nursing care. Many hospitals have drastically cut nursing staffs, sometimes at the insistence of the Government and at other times, in an effort to balance the budget. The nurses are unhappy about their inability to give good nursing and feel the care that patients are receiving is not always even safe nursing. They find it difficult to derive satisfaction in doing a job that is less than adequate and frustration
results when work is never finished (Hood, 1956, pp.75).

This is contrasted with the requests from Port Alberni nurses "in excess of Recommended Personnel Practices". There is no record of how this was handled (January 27, 1957). However the minutes of the Executive Council record that "whereas basic pay has been $235.00 since 1953, and has not kept pace with other levels of work or professions... that basic pay be raised to $275 or $300 (a month)". A proposal to carry increments from one job to another was rejected as jeopardizing the older nurse (March 30, 1957). The recommended basic salary was set at $250/month (Hood, 1957, pp.83.)

Negotiation Breaks Down.

On the basis of these recommendations, negotiations were again undertaken. Events led to a rejection of the conciliation board's report by several hospitals. The Executive Council, with the assistance of a labour lawyer, identified four courses of action: publicity, mass resignation, strike, and do nothing. Because a "united effort" was seen as "most important" and because "strike action presented a definite framework within which to work," strike action was supported by the Association (Rossiter, 1957, pp.799; June 1, 1957). However this was not an easy decision for the Executive Council. Originally a motion supporting strike action or resignation was carried, while a motion stating a preference for strike action was withdrawn; in effect leaving the course of action open to the nurses themselves (June 1, 1957). Ultimately, strike
votes were taken in three hospitals and the Association supported this action on the basis of "supporting the request for arbitration rather than for an increase in their own salaries" (July 9, 1957).

The Executive Secretary met with the local chapters of the BCMA to "inform them of the situation ... not to seek their support". The strike vote was supported on the grounds that the recommendations were fair and just. The doctors objected to the inadequate financing of hospitals and deplored the government's policies of hospital financing. Following the strike votes plans were made to staff the hospitals for emergency care only and directed all offers of help to representatives of the nurses (July 9, 1957).

A similar situation arose in 1959 when a conciliation board report was rejected by eight hospitals (January 22, 1959). A meeting with the Cabinet was sought. "It was the consensus that there was no hope for an early hearing... all possible means of averting (the) threat of a strike or strike action were explored...(it was) agreed that neither the hospitals nor the government would consider revising their stand until the nurses had shown that they are prepared to invoke the full strength of labour legislation. ... (It was agreed) that the Executive Committee stand behind the nurses in whatever action, within the provisions of labour legislation, is found to be necessary in forcing acceptance of the Conciliation Board Report. ... It was agreed that (in a letter to the Cabinet) it be stated that the attitude of the nurses involved prohibits further delay on the part of the Executive... (also that) letters be sent to all hospital boards involved, pointing
out the resentment the Executive feels in the fact that nurses are being used by the hospitals as a tool to fight financial difficulties".

The final motion was passed when the President of the Executive Council cast the deciding vote in favour (January 22, 1959),

Both crises were resolved when, shortly before the strike was to take effect, the government provided increased funds to the hospitals (Hood, 1959, pp.58). Again, in 1962 the Association supported the nurses of VGH in strike action. Throughout this period the Association pressed the government for binding arbitration for nurses, without success.

Outcomes.

While collective bargaining improved the incomes of nurses, nurses were confronted with the budgeted shortage of staff and the growing recognition of conflict between the professional and labour relations roles of the Association.

Although nurses' salaries were touted as the best in Canada (Nurses' salaries best in Canada, 1957) concern was raised within the Association and in public about the supply of nurses and the adequacy of patient care due to the "arbitrary way in which BCHIS set down regulations in limiting size of staff in all hospitals in B.C..., many patients are not receiving adequate nursing care and, in spite of this, nurses are working many hours overtime..." (March 3, 1956). This concern resulted in the formation of a committee on Standards of Hospital Nursing Care. The committee was to "inquire into safe
nursing practices and indicate safe standards of nursing care (March 4, 1961; Small, 1962, pp.49-50). Later, the RNABC and BCHA formed a joint committee to examine standards of care and "define" the extent and limitations of nursing practice" (Fisher, 1964, pp.57-58). The budgeted shortage of nurses was recognized as a contributing problem (November 21, 1964). The problem of standards of care re-emerges as 'safety to practice' and becomes a dominant theme of the Association in the 1970's.

Conflict between the professional and labour relations roles of the Association first surfaced when a representative of the Association was "sought for the professional nursing group, not for nurses as employees of hospitals" to sit on a committee of BCHIS (February 19, 1949). The Executive of the Association recognized that chapters of the Association were having "difficulty distinguishing between Chapter business and matters for negotiation..." (November 4, 1961). These types of conflicts ultimately led to the division of the organization into Professional Affairs and Labour Relations by which functioning and financing were separated.

Secondary themes.

The secondary themes for this period include education, registration, terms and conditions of employment for senior nursing staff and the health and safety of nurses. The theme of the education of nurses was quiescent during this period except to introduce refresher courses for nurses who had not practiced for ten or more
years (May 26-27, 1960).

Registration remained an issue and was dealt with in two ways. Ways and means of stimulating interest in employers requiring registration for employment were considered (May 15, 1956). At the same time, salary differentials for registered and non-registered nurses were negotiated (Hood, 1957, pp. 83).

The terms and conditions of employment for senior nursing staff had been of intermittent concern for many years. Concern is first recorded when directors of nursing were fired without due notice (June 3, 1920; January 29, 1927). The tentative position of directors of nursing is suggested in the Eaton Report (1938, pp. 61-62). Concern over the duties and responsibilities of directors of nursing resulted in the circulation of a statement to directors, hospital administrators and chairman of hospital and public health boards. The issue of salaries for senior nursing personnel resulted in the formation of a committee to give advice to nurses or employers for specific senior positions in hospitals (March 10, 1962; October 24, 1964). A long standing observer of the nursing administration group attests to the general vulnerability of directors of nursing, the high attrition rate of holders of the position and the increasing isolation of this group from association activities (McCann, 1981).

From the inception of organized professional nursing, the rate of tuberculosis amongst nurses was the main focus of concern for the health and safety of nurses. The advent of voluntary group insurance prompted many hospitals to give up caring for sick nurses
at minimal or no cost to nurses (October 18, 1940). Until the advent of compulsory hospital insurance, 1949, nurses were in a difficult position because they had no provincial employee group through which to join voluntary insurance schemes. Under collective bargaining, nurses were "expected to carry hospital insurance and where possible, complete medical insurance" through the provincial hospital insurance scheme and through private insurance agencies (Hood, 1953, pp.82). The Association directed its efforts to the establishment and maintenance of health records of students and the coverage of various diseases by the Workmen's Compensation Board: tuberculosis (September 6, 1950), staphlococcal infections (January 21, 1956), salmonella (February 2, 1957) and infectious hepatitis (March 9, 1957). The RNABC agreed with WCB that compensation for mental illness should not be recognized by WCB (February 13, 1960).

Summary.

The period 1955-1964 saw an evolution on the part of the Association on the subject of strikes. The Association moved from the approval of a strike on the grounds of supporting the principle of conciliation by both parties to the acceptance of striking for economic benefit. It would appear that this change was precipitated by pressure from grassroots nurses, although it is clear that nurses were not unified in their response to the issues of the terms and conditions of employment. Coincident with this change in ideology was the beginning of a conflict in professional and union roles of the Association.
Adjustments to Growth: 1965-76

Introduction.

The period 1965-76 is dominated by structural changes in the organization of the Association and by influences external to the Association that affected the process of collective bargaining.

The growth of collective bargaining amongst nurses affected the Association by increasing the volume and complexity of work related to collective bargaining. Although province-wide bargaining established a uniformity in the major components of the contract, secondary issues were negotiated with each institution.

The organizational changes were a direct result of the growing complexity of the business of the Association and a growing awareness of the potential of conflict between the labour relations role of the Association and the traditional roles of the Association.

Secondary themes for this period include education, registration, safety to practice, discipline, social security and subsidiary workers.

Changes in the preparation for bargaining.

The preparation of Recommended Personnel Practices went through several changes between 1942/43-1971. Initially Recommended Personnel Practices were prepared by the Executive Secretary. From 1946-50 the contract demands were prepared by the Committee on Labour Relations and later by the Director of the Personnel Service
TABLE 3.2

The Growth of Certified Bargaining Units of Registered Nurses Within the RNABC 1946-76

<table>
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<th>1946</th>
<th>1956</th>
<th>1966</th>
<th>1976</th>
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<tr>
<td>Certified Bargaining Units</td>
<td>1</td>
<td>56</td>
<td>63</td>
<td>76</td>
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Note: It is not possible to calculate the percentage of Registered nurses who were within bargaining units. By 1956, the nurses of the major hospitals of the province were certified. The data presented here does not coincide precisely with the data derived from the RNABC Annual Minutes, 1946-76.

1 RNABC Labour Relations Division, Present Certifications, 1981.
with the support of an advisory committee on Employment Relations. This committee later became a standing committee to co-incide with changes in the CNA structure (Capelle, 1956, pp.60-61). In 1964 this committee became a sub-committee of the Committee on Social and Economic Welfare, which was itself a subcommittee of Nursing Service.

The functions of the Nursing Service Committee were to 1) recommend to the Council studies, practices, and projects which will help promote a high standard of nursing, and 2) serve in an advisory capacity to the Council on all matters concerning the social and economic welfare of members. The second clause became the sole responsibility of the Committee on Social and Economic Welfare. This committee's role was defined as: "to recommend to the Council policies which will promote the social and economic welfare of the members, and which will assist the Association to meet personnel problems of members whenever they exist" (October 24, 1964, March 20, 1965). Subcommittees under the committee on Social and Economic Welfare included Personnel Practices (formerly, Employment Relations), Referral and Review (formerly Ethics and Welfare Services for Members (Wadsworth, 1966, pp.57).

Input from the membership in the development of contract demands was a long standing problem for the Association. Earlier attempts to separate Chapter (professional) business and business concerning labour relations had been unsuccessful, and in 1964 it was decided that "bargaining representatives (would be) elected from each regional group of staff because it was agreed (that it was) improper
for a councillor to be involved in the bargaining procedure" (November 21, 1964). The method of developing conditions of employment was revised to establish a Committee on Contract Terms. The members were the Provincial Bargaining Committee, with the addition of staff representatives from public health groups. All staff groups were to submit proposed changes to the contract which the Committee would then present to the Staff Representatives' Conference (February 23, 1968). Thus the Annual Meeting of 1968 was the last year in which Revisions of Recommended Personnel Practices were submitted to the membership of the Association for discussion and approval. This decision was disputed but not revised in 1968 (May 29-31, 1968). Selected date from Recommended Personnel Practices of the RNABC, 1946-1968 is presented in Table 3. The guidelines for the Committee on Employment Relations contains the statement that "remuneration should reflect the value of service to society and therefore salaries for nurses should be commensurate with education, qualifications and past experience" (November 22-23, 1968).

These changes, and the formation of the provincial Committee on Social and Economic Welfare were a direct outcome of changes within the CNA. The national committee, formally established in April 1965, described its terms of reference as:

1. To interpret the philosophy of social and economic welfare for nurses in Canada.

2. To provide guidance, interpretation and moral support to provincial nurses' associations in the development of social and economic welfare programmes.
3. To promote research essential to the advancement of social and economic welfare programmes for nurses (CNA, 1966, pp.7).

and its philosophy as:

The Canadian Nurses' Association believes that one responsibility of the organized profession is to safeguard the welfare of its members. The Association believes that the profession has the right and responsibility to define its functions. It recognizes that basic to the provision of a high quality of nursing care is the adequacy of the nursing staff, conditions of work and an environment conducive to efficiency and individual satisfaction.

The Canadian Nurses' Association approves the principle of collective bargaining for nurses and believes that the bargaining authority for its members should be vested in the professional nurses' association in each province.

The Canadian Nurses' Association recognizes that the relationship of nurses to the public is a major asset in promoting the social and economic welfare of its members. The quality of their work and their interpretation of its character, content and responsibility will serve to build up a genuine understanding of the contribution of nurses in the community.

The acceptance of the principles and responsibilities of collective bargaining for the members of the nursing profession has the full official approval and support of the profession throughout Canada (CNA, 1966, pp.8).

In the preamble to these statements to CNA described the social, economic and political changes taking place in Canada. The growing inability of the individual to function outside of a larger group was emphasized.
The ideological shift.

In 1968 a committee to revise the structure of the RNABC was struck. The rationale for the revision was the increased complexity of the roles and functions of the organization (George, 1969, pp.24-26). The functions of the RNABC were seen to be: 1) administration of the Act, 2) furthering the profession, 3) promotion of employee-employers' relations under which placement and counselling services as well as collective bargaining fell, and 4) "performance of such other lawful things as are incidental or conducive to the welfare of the public and of the nursing and allied professions" (George, 1965 pp.10-15). The implementation of the recommendations resulted in revised objectives, re-structuring the Board, the standing committees and the functioning of the professional staff of the Association. The role and functioning of the President of the Association became an issue. It was suggested that the President be reimbursed for loss of salary resulting from the responsibilities of her office and this was defeated. Later the issue was re-considered in terms of the President's role being a full time paid position. This was defeated because it created leave of absence problems although it was recognized that the President's role demanded a considerable investment of time (February 19, 1972). The role was left as a voluntary, unpaid position. This is consistent with the Association's position that staff nurses or their institution were to be reimbursed for loss of salary only if the nurse was unable to arrange days off to

In view of the structural changes that occurred, and in view also of the evolving attitude of the role of collective bargaining within the Association, a consideration of the Association's statement of objectives between 1950-1971 is useful.

In 1953, the President of the Association stated the objectives as:

(1) to implement and protect standards in nursing education and practice to meet prevailing community needs and

(2) to serve the membership through safeguarding the professional status of nurses and improving their economic security,

to be achieved ......

(1) By setting and safeguarding the standards for nursing education and practice in this province and evaluating and licensing the graduates of B.C. Schools and graduates from other centres according to those standards in the interest of safe nursing care for the public and protection of our professional status.

(2) By providing two registries for private duty nursing in two of the three largest cities in the province and a placement service for other types of nursing positions throughout the province.

While the primary purpose of these resources is to serve our registered members, the public is also served through the placement of nurses, private duty, institutional and public health, where needed, in the communities throughout B.C.

(3) By providing a labour relations programme to obtain and safeguard suitable working conditions and acceptable personnel practices for our members through direct conferences with employees7 (Paulson, 1953 pp.4-5).

7'Employee' was changed to 'employer' by E. Mallory, former owner of the Annual Meeting Minutes, June 5-6, 1953 used for this study.
In 1960, the objectives were stated as:

1. To maintain the honour and status of the nursing profession.
2. To advance the educational standards in nursing.
3. To elevate the standard of nursing practice in order to render efficient service in the interest of the public.
4. To promote and regulate sound employee-employer relations in the nursing profession. (Rossiter, 1960, pp.5)

These were ultimately revised during the late 1960's to read:

The object of the Association is to further the standard of nursing practice in order to ensure efficient service to the people of British Columbia by:

a. effecting the provisions of the Registered Nurses' Act,
b. promoting improvement in nursing education and nursing practice,
c. regulating relations between employers and employees through collective bargaining on behalf of members.
d. engaging in such other activities as are conducive to the health and welfare of the public and the welfare of the nursing and allied professions. (RNABC News, 1971, 7 pp.32).

To change the structure of the Association?

The revision of the Constitution and Bylaws and the re-organization of the structure of the Association did not solve the problem of a single organization representing statutory, professional and economic interests of the membership of the Association. Concern about the role, function and structure of the Association led to the commissioning of the Baumgart study on Nursing Legislation. (November 17, 1972). The purpose of the study was to expand understanding of some of the fundamental issues...(in nursing legislation)
and to provide a basis for discussion and debate" (Baumgart, 1973).

Baumgart identified three roles of the Association, 1) the corporate role delegated by the State concerned with educational and ethical regulation for the protection of the public, 2) the association-or profession-centered role for the influence of the form, range, and quality of services for the public, and 3) the union role for the protection and improvement of the social and economic situation of the membership (Baumgart, 1973 pp.1). Baumgart (1973, pp.8) identified the key issue as how to achieve greater public responsiveness and accountability without sacrificing the values of voluntary professional initiative. Baumgart saw an "inextricable intertwining of interest of the public and the nursing profession....

The belief is that the benefits to the public coming from the harmonizing and integrating of these interests outweigh the potential dangers of conflict. The important organizational consideration is to ensure that checks exist and are applied to prevent sustained departures of a professional association from its declared public purposes.

Particular reference is often made here to the relationship between socio-economic interests - the union role, and conditions for patient care - the public interest role. The great distinction seen between a professional association's negotiating interests and a trade union's is the almost certain preoccupation of professional people with offering an increasingly superior level of service. To have the professional association act as bargaining agent for its memberships is felt to give greater assurance that working conditions secured for nurses will be directly related to public welfare considerations. (Baumgart, 1973, pp.4).

At the same time, the CNA commissioned "A Discussion Paper on the Three Major Roles of Provincial Nurses' Organizations"
Bachard identified three legal entities which may comprise a professional organization: 1) a professional corporation responsible for regulatory and disciplinary functions, 2) a professional association interested in promoting the profession and 3) the professional syndicate or union interested in the socioeconomic welfare of its members. Bachard examined the nursing organizations of the provinces and identified four versions of organizational structures dealing with the three roles. She then presented a model structure in which the three roles were separated but incorporated under a Council of the provincial nurses' association. In the proposed model, the three roles identified were to be performed by separate structures within the Association which was to be governed by a Council formed of representatives of government, the chairman of the professional union sections and representatives elected from the membership. Membership in the Association would be required in order to practice nursing.

External influences on the structure and process of collective bargaining.

In 1973, the Supreme Court of Canada ruled that the Saskatchewan Registered Nurses' Association could not engage in collective bargaining on behalf of its members because of the role management nurses played in the Association. The RNABC recognized the significance of the Supreme Court decision (November 17, 1973). The Labour relations and professional activities of the Association
were (now to be) separated such that the Association shall not be entitled to make or amend anything in the Constitution or Bylaws, the effect of which would give the Association any control over the bargaining functions of the Labour Relations Division" (January 9-10, 1976). This was refined in 1978 to read "the Labour Relations Division shall be governed by a Labour Relations Council to be elected amongst members of bargaining units...(RNABC, Constitution and Bylaws, May 10, 1978). The Professional and Labour Relations Division continued to operate under the umbrella of the RNABC until complete separation was established in 1981.

Unrest in the hospital industry, which included strike votes amongst nurses in 1968 and 1974 led to the government's commissioning of the Blair Report. Its purpose was "to examine the experience of the collective bargaining process in the hospital industry and make recommendations for an improved and a more viable collective bargaining system..." (January 17, 18, 1975). The report recommended the separation

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8 The objectives were revised to read:
The object of the Association is to further the standard of nursing practice in order to ensure efficient service to the people of British Columbia by:
a. effecting the provisions of the Registered Nurses Act;
b. promoting improvement in nursing education and nursing practice;
c. regulating, through a Labour Relations Division, relations between employers and employees through collective bargaining on behalf of nurses for whom the RNABC holds certification and bargaining authority;
d. engaging in such other activities as are conducive to the health and welfare of the public and the welfare of the nursing and allied professions. (RNABC, Constitution and Bylaws, 1978).
of the Health Labour Relations Division as a separate entity from
BCHA but employers' participation in the new Health Labour Relations
Association was conditional on membership in the BCHA (Blair, 1974).
The separation of labour relations activity from the BCHA was analogous
to the separation of labour relations from the RNABC. The RNABC
response to the Blair report and was "positive" (February 14, 1975).

Secondary themes.

The secondary themes for this period are: education, registration, safety to practice, discipline, social security and subsidiary workers.

Two major events in nursing education occurred during this period: 1) the submissions to the Royal Commission on Health services in Canada in 1964 (Hall Commission) and 2) the introduction of 2 year community college programs. CNA and RNABC submission to the Hall Commission stressed the need for increased funding for nursing education, the need to remove nursing schools from hospitals, and the need to increase the availability of university education for nurses.

Provision for flexibility in the structure of nursing education had been made in revisions to the Registered Nurses Act (May 26-27, 1966). Establishment of two year community college programs had started in the Sixties and the consequent closing of hospital schools of nursing began. In 1967 the student nurses'
Association is recorded as requesting that the Association send "letters to Boards of four (of a total of seven) hospital schools of nursing with 44 hour weeks, requesting a 40 hour week and two free days per week for student nurses". The Boards in question "endorsed in principle the intent of the recommendation and (were) hoping to implement a gradual transition to a 40 hour week" (Cunningham, 1967, pp.61). Contract demands for graduate nurses changed from a maximum 40 hour week in 1966 to a maximum 37½ hour week in 1968 (RNABC, proposed..., 1966; RNABC, proposed...1968). Recommended admission requirements and policies for schools of nursing were stated as a 40 hour week one year later (Cunningham, 1968, pp.18).

With the growth of community college programs, concern over the performance of new graduates prompted the Association to study the functioning of new graduates and to "define and validate essential skills required of new graduates" (May 10, 1977).

In the early 1960's continuing education was an issue in determining salary differentials for nurses (May 11, 1963). The need for funds for orientation programs for new staff and for continuing education was presented to the government (May 31, June 1, 2, 1967) (September 19, 20, 1969). The need for additional specialized training for nurses, largely as a result of advanced technology, was also recognized (November 21-22, 1969).

Although a representative from the College of Physicians and Surgeons had been a part of the Examining Board since 1918,
participation had been variable. The role of examiners disappeared with the use of multiple choice exams in the 60's. The College relinquished its examining role in 1969 at its own request (December 12, 1969).

Registration of nurses continued to be a visible issue. A motion "to investigate the question of mandatory registration arose at the 1965 Annual Meeting. There are two aspects to this issue: 1) to protect the quality of nursing care and 2) to protect the employment of nurses. Mandatory registration was studied at length and rejected because "1) mandatory registration would increase the shortage of staff... (and) probably be met by an increase in the utilization of auxiliary nursing personnel, 2) mandatory registration would preclude employment as a graduate nurse: a) preparatory to re-instatement as a registered nurse following disciplinary action, or b) following illness preventing work as a registered nurse, or c) preparatory to reinstatement as a registered nurse when nursing education had been obtained outside the province" (Campbell, 1967, pp.44). This committee recognized that "there is strong incentive in salary schedules to become registered if employed continuously in B.C. (Campbell, 1966, pp.46). Again in 1970, 1974 and 1976, motions for mandatory registration were discussed. In the context of budgetary constraint and the resulting hiring of other than registered nurses, mandatory registration was seen as a means of protecting the public (May 27-29, 1970). In 1976, discussion of mandatory registration was in terms of re-registration on the basis
Concern about safety to practice nursing resulted in a position paper on nursing practice (May 25, 1973), a study on safety to practice (November 13, 14, 1975) and the development of a quality assurance program (September 23-25, 1976).

Disciplinary action is another facet of the registration issue. Until the 70's disciplinary action was an informal procedure within the realm of the Board. A formalized procedure was developed with the stated policy that when "tak(ing) disciplinary action, this.....action should provide the members with the greatest possible opportunity to re-establish professional competence that is consistent with public safety" (November 18-20, 1976). Throughout the minutes there is only occasional discussion of disciplinary matters.

Although the Association was aware of the need for social security for its members from its inception, little concrete action was taken until government plans for unemployment insurance and pension plans become available. Until the introduction of unemployment insurance by the federal government, the BCHA stood alone amongst hospital associations in Canada in support of unemployment insurance for hospital employees and nurses (BCHA, 1940, pp 28-9). The RNABC supported unemployment insurance for nurses as early as 1950 (March 3, 1950), but later revised this decision (November 18, 1967). With the publication of the Federal government paper on unemployment insurance both the CNA and RNABC supported the inclusion of nurses in such a plan (November 13, 1970). Until this time, fears had been expressed that nurses would
receive little benefit from the plan; because of their low unemployment rates.

With the shift of employment of nurses from private duty to publicly funded hospitals and the enactment of the Municipal Superannuation Act, the Association urged BCHIS to provide a superannuation plan for employees of publicly funded hospitals (May 25, 1950). Hospitals, as employers, could participate in 1957 (May 3-4, 1957), but generally did not until the early 1960's. Interest then shifted to the inclusion of medical insurance premiums, income protection plans, and the revision of superannuation plans to end discrimination against dependants and spouses of women (September 19-20, 1969; April 28, 1973).

Subsidiary workers concerned the RNABC in terms of their role, function and proliferation. The Association's concern that practical nurses be used only in an auxiliary capacity was expressed to Directors of Nursing, BCHIS and BCHA (February 24, 1968; May 2-23, 1969). The Association (with the BCHA) rejected Canada Manpower initiatives in developing a program for nurses' aides, (December 12, 1969) and alternately urged that operating room technicians be phased out (April 17, 1971). and expressed concern about insufficient numbers of this group (June 17, 1972). The proliferation of health care workers was studied (April 15, 1972) as was the possibility of bringing together registered nurses, psychiatric and practical nurses under one piece of legislation.
Summary.

The period 1964-76 represents the end of reliance on paternalism. The emphasis of commitment to service in the face of diversity (shortages of nurses, patient need etc.) in which economic needs were put in second place had ended.

In considering the objectives of the Association over this period several points are noteworthy.

1) statements about the professional status of nurses had changed from "safeguarding" and "maintaining" to a statement of nursing as a profession;

2) economic security for nurses is now stated in terms of 'employee-employer" acknowledging the completion of the transition from the major form of employment as private duty nurses to employment as an employee within an institutional structure;

3) acknowledgement of collective bargaining as the mechanism for dealing with economic matters is first stated in the 1972 statement of objectives;

4) the objectives of 1953 have a sense of static steadfastness while a sense of motion or advancement is noted in the objectives of 1960 and 1970; and finally, 5) an acknowledgement of participation in "activities conducive to the health and welfare of the public" is made, although the Association had been active in health policy matters since its inception eg: the practice of midwifery (April 26, 1917; April 21, 1924; April 22, 1935); provincial and
national health policy (January 10, 1919; November 30, 1934; March 25, 1938; December 1, 1942; August 5, 1943 etc.); and women's issues (September 6, 1927; December 3, 1960; October 17, 1970 etc.).

An interesting omission is the lack of expressed interest in the health as well as the welfare of nurses. This is perhaps because the health hazards to nurses were seen only as a consequence of the terms of employment rather than as consequence of the work itself. Alternatively this omission may represent an acceptance of risk or a belief that the 'good' practice of nursing eliminates any risk to health. This had been implied in the discussion of tuberculosis in the Eaton Report (1938, pp.21-23).

On the secondary themes education was the most important. The solution to the problem of hours of work for student nurses was the end of a system based on service in exchange for education. While the Association had exerted pressure for change, the solution came as a result of changes external to the Association. Nursing education became a part of the general education system.

Conclusion: To Protect the Quality of Nursing: 1943-76

Confronted with increased economic and social disparity, reinforced by the strength of a shortage of nurses during and following World War II, nurses in British Columbia voted to support collective bargaining in 1946. This action was seen to be taken 'to protect
the quality of nursing' (May 2, 1951). Restraint on wage demands during the first years of collective bargaining resulted in the eruption of strike votes in 1957 and 1959. The decision by the Supreme Court of Canada in 1973, that the Saskatchewan Registered Nurses' Association could not represent nurses in collective bargaining because of the role of managerial nurses on the Association's board, and concern within the Association's membership about the appropriate role and functioning of the Association led to the separation of professional and labour relations roles and functions in 1976.
CHAPTER 4

Methodology

Introduction

The purpose of this chapter is to present the methodology used to analyze the material presented in Chapters two and three. The methodology chosen was grounded theory (Glaser and Strauss, 1967). This chapter begins with a brief consideration of some of the problems of doing social research and continues with a discussion of the theoretical aspects of grounded theory. A discussion of the application of grounded theory in this study is then presented. A brief discussion of the credibility of grounded theory is presented in the conclusion.

Some Problems of Social Research

This research had two major problems, the selection of 1) the data base, and 2) the methodology. The main source of data, the Board and Annual Minutes of the RNABC, were chosen because these represented the only continuing source of documentary evidence from the inception of the organization to the present. As such, the minutes represented a mass of data organized only by chronology. This data base was supplemented when questions arose or direct reference was made or intuition prompted, by such sources as The Canadian Nurse, The Bulletin of the Registered Nurses' Association of British Columbia, the Annual Minutes of the British Columbia Health Association and selected interviews. Interviews were limited to
persons who were considered to be key personalities, and who were known to be receptive to the study of issues in health care. The interviews were open-ended and, because of the nature of the participants, were reminiscences. No tape recordings were made. Some background understanding was developed in the course of social interaction with people who had lived through some of the issues presented. Their perspectives were found to substantiate the sorting of the data, and their comments were included to enhance the richness of the material. These contributions were spontaneous, and given with enthusiasm and interest in the study.

The question of the method of analysis of the material presented two possibilities - quantitative or qualitative. Cole (1976) has suggested that qualitative research is most applicable for description, formulation of hypotheses, and understanding of the causal process. Cole states that qualitative research risks the distortion of reality, (1976; pp.186) but he points out that this can be countered by 'triangulation', that is, other documentary sources and interviews can be used to see what elements can be agreed or disagreed upon. Alternatively, preceptions of reality can be viewed as interesting, and what 'really' happened as not so important.

Quantitative methodology, "a means of collecting data which can be converted into numbers" (Cole, 1976, pp.77) provides the rationale for a technique of content analysis in which scientific methods are applied to documentary evidence (Holsti 1969 pp.5).
Holsti (1969, pp.14) defines content analysis as "any technique for making references by objectively and systematically identifying characteristics of messages". Alternatively, content analysis can be done as qualitative analysis of documents.

There are several arguments against using quantitative content analysis in this study. 'Scientific method' is a reference to the borrowing and adapting of the methods of natural science to sociology (Filstead, 1970, pp.2-5). As appealing as this may be, Filstead contends that this is not necessarily an appropriate method for the study of behavior. He argues the case for qualitative methodology, "as a legitimate source of either data collection or theory construction," and supports the use of Glaser and Strauss's methodology of grounded theory (Filstead, 1970, pp.5-8).

Advice was sought from two sources. Neither supported the use of quantitative content analysis. It was suggested that the subtlety of the material would be lost (Whittaker, 1980). It was also suggested that quantitative content analysis had proven to be less useful than hoped in the study of the messages of advertising (Pollard, 1980). Thus, the methodology of grounded theory was chosen as the means to study the data. The remainder of this chapter draws heavily on the work of Glaser and Strauss (1965, 1967, 1968).
Grounded theory

Glaser and Strauss (1967, pp.1) define grounded theory as "the discovery of theory systematically obtained and analyzed from the data of social research". Theory is generated by the process of theoretical sampling whereby the researcher jointly collects, codes and analyses data. While the researcher begins with an idea which identifies the basic features of the study, the process of data collection is controlled by the emerging theory directing the researcher to new sources of data. Thus, while Etzioni's (1968) concept of a societal shift from normative to utilitarian behavior suggested the direction this study might take, it did not influence the data collection nor the findings in the data. In this study, a preliminary step of organizing events, processes and trends under thematic headings, by decade (Smith, 1976) was taken to facilitate the organization of the material.

Grounded theory is an inductive method of research which is contrasted with theory generated by deductive methods based on a priori assumptions. Grounded theory is contrasted with research in which empirical examples are chosen to support theoretical formulations. While the research area is entered into with certain ideas or models, 'the development of collective bargaining as a shift in ideology from professionalism to unionism' the methodology of grounded theory represents a shift from the verification of borrowed theory to the preceding step of discovering what concepts and
hypotheses are relevant for the area under study. In the case of this study, the research was an examination of the data, the Board and Annual Minutes of the RNABC and selected material, to establish relevant concepts and emergent hypotheses arising directly out of the data base.

Grounded theory may yield substantive or formal theory. Substantive theory is defined as theory developed from "substantive or empirical areas of sociological inquiry, such as patient care, race relations...". Formal theory is "developed from a formal or conceptual area of social inquiry such as stigma, deviant behavior..." Glaser and Strauss (1967; pp.32). Glaser and Strauss (1967, pp.33) state that substantive and formal theories exist on distinguishable levels of generality," and thus "can shade at points into the other". They state that the researcher should focus clearly on one or other level or on a specific combination because the strategies vary for arriving at each. There was no attempt to develop formal theory from the data studied. In this instance the focus was the substantive area of a provincial nursing organization, with study concentrated on the entry into collective bargaining on behalf of the membership.
The Development of Theory.

The systematic study of multiple comparison groups is used to generate theory. Glaser and Strauss state that the elements of theory that are generated by comparative analysis are 1) conceptual categories and their conceptual properties, and 2) hypotheses or generalized relations among the categories and their properties. Comparative analysis allows the validation of facts, the development of conceptual categories from the facts, the specification of concepts (i.e., the development of the properties of conceptual categories), the generation of theory, and the verification of theory.

Glaser and Strauss recommend researchers immerse themselves in the data and allow concepts and categories to emerge. These concepts and categories are then organized into groups for comparison. This is the process of theoretical sampling. Initially hypotheses are suggested relations amongst categories, not tested relationships. As the data collection continues the researcher is able to generate and verify hypotheses through the comparison of groups. The first hypotheses tend to become integrated to form the basis of the central analytic framework of the research. It is sufficient to generate hypotheses on the basis of suggestion, not on evidence piled up to establish proof. Only if an underlying hypothesis is disproved are the relevant relationships stated in the theory discarded. Out of this activity grounded theory emerges. Grounded theory is presented either as a well codified set of
propositions or as a running theoretical discussion using the conceptual categories and properties generated from the research.

Theoretical sampling.

The role of comparison groups is to promote the comparison of diverse or similar evidence indicating the same conceptual categories and properties. Evidence is not compared for its own sake. The researcher begins with no preplanned set of groups, and no rules for the comparison of groups. The only criterion is that the material be relevant. It is necessary to be clear on the basic types of groups in order to control the effect of the groups on the generality of the population studied and the conceptual level of the theory. The difficulties of selecting groups for study may be decreased by studying only one group or the sub-groups of a selected group during a single research period. The scope of substantive theory can be carefully increased and controlled by the conscious choice of groups. In substantive theory only similar groups are studied. In the development of formal theory the comparison of dissimilar substantive groups of conceptual similarity is used.

Categories and properties are distinguished in order to indicate a systematic relationship between the two elements of theory. A category is a concept about the problem, not its situation. A category stands by itself as a conceptual element of the theory, while a property is a conceptual aspect or element of a category.
The first stage in the development of categories is the identification of themes that have recurred and seem to have some bearing on the problem at hand. These themes are later sorted into categories and properties.

Glaser and Strauss advise against borrowing categories from the literature in order to facilitate the development of new categories and to avoid selecting data that forces a 'fit'. Ignoring established categories allows the emergence of new categories that are most relevant and suited to the data. An attempt is made to aim for diversity in emergent categories. The literature is examined for similarities and convergences only after the analytic core of the categories has been established, and therefore the literature review follows the analysis of the data. Glaser and Strauss (1967, pp.65-69) use the concept of a 'slice of data' to promote the use of different kinds and sources of data in the development of a category and its properties. Theory generated from multiple sources of data promotes a richness and a verification of data, as well as a proportioned view of the evidence.

The systematic analysis of data allows the development of conceptual categories from the data. While specific facts may change, the concept does not, and thus the process of developing a conceptual framework is not dependent on factual events but rather the concepts these events represent.
Categories reach theoretical saturation when no additional data can be found to continue the development of the properties of a category. Saturation is determined by a combination of the empirical limits of the data, the integration and density of the theory, and the researcher's theoretical sensitivity, i.e., the researcher becomes empirically confident that a category is saturated. The adequacy of a theoretical sample is judged on the basis of how widely and diversely the researcher chose the groups for saturation according to the type of theory to be developed. The adequacy of a statistical sample is judged on the basis of techniques of random and stratified sampling used in relation to the social structure of a group or groups sampled. The inadequate theoretical sample is usually thin, poorly integrated and has many obvious unexplained exceptions. The inadequate statistical sample may be accepted uncritically by all those untrained in statistical methods. Glaser and Strauss do not feel theoretical sampling and statistical sampling need be combined. Should it be desirable to express the magnitude of a relationship within a particular group, statistical sampling or a highly systematic observation procedure over time is necessary.

Theoretical sampling is concluded when the researcher judges that saturation has occurred, that is the theory is approaching stable integration and dense development of properties. The concepts that are generated must have two essential features: the capacity to be 1) analytic, that is the general characteristic of the entity should be evident, not the entity itself, and 2) sensitizing,
that is the entity should suggest a meaningful picture to the reader. Glaser and Strauss state that theoretical sensitivity is developed with practice by the researcher and may be a reflection of the researcher's personal and temperamental bent as well as the researcher's ability to have insight or borrow the insight of others.

Once a category or a property is established, only strong evidence, usually from a different substantive area in addition to the creation of a better category, is sufficient to change a category. To avoid forced integration, there is no attempt to apply a model of a formal theory until one is sure it will fit. There will be no attempt to apply a model of a formal theory to this study.

Depth of theoretical sampling refers to the amount of data collected on a group and on a category. Theoretical sampling requires the fullest possible sampling of the group at the beginning of the research when the main categories are emerging. Core theoretical categories need to be as fully saturated as possible. In practice, Glaser and Strauss have found that the researcher saturates all categories until it is clear which are the most important. Throughout this process, systematic, simultaneous collection, coding and analysis take place. As the work progresses, the researcher looks for emergent categories, reformulates categories as new properties emerge and prunes and adds until a theoretical framework emerges understandable to both layman and sociologist.
The Constant Comparative Method of Qualitative Analysis.

The constant comparative method of analysis is concerned with generating and suggesting, but not testing categories, properties and hypotheses about the general problem under study. Glaser and Strauss suggest that the properties may be causes, conditions, consequences, dimensions, types, processes etc. There is no attempt to establish the universality or proof of suggested causes or relationships. Since no proof is needed, it is necessary only to saturate the categories; thus not all data need be considered.

There are four stages in the constant comparative method: 1) comparing incidents applicable to each category, 2) integrating categories and their properties, 3) delimiting the theory and 4) writing the theory. There will be no attempt in this study to delimit or write theory.

In phase one, each incident is coded into as many categories of analysis as possible. Headings were noted on the margin of the field notes. The comparison group in which each incident occurred is recorded. While coding an incident for a category, comparisons are made with previous incidents in the same and different groups coded in the same category. This process generated the theoretical properties of the category. Glaser and Strauss state that the researcher will notice that the concepts abstracted from the substantive situation tend to be labels currently in use for the actual process and behaviors that are being explained: 'the struggle'
for the eight hour day, while the concepts constructed by the researcher tend to be the explanations, 'the attempt to control' the working environment.

The integration of categories and their properties (phase two) occurs as coding develops from the constant comparison of incidents to the comparison of an incident with the properties of the category that resulted from the initial comparison of incidents. The unit of comparison has changed to a more complex level. Ultimately, diverse properties become integrated; the integration of theory occurs.

Delimiting theory occurs at two levels, 1) the theory solidifies, ie. modifications of the theory become fewer, and 2) the original list of categories for coding becomes reduced. This occurs because some categories are shown not to have relevance or because what seemed to be a category became a property of another category. The effect of reduction and theoretical saturation moves the analytic framework to the level of theory.

The final stage of writing theory occurs when the researcher is reasonably convinced that an accurate statement of the subject matter studied can be made. The categories become the major themes of the theory with the coded data and the researcher's notes become the descriptive content behind the categories. Glaser and Strauss state that the presentation of theory can be made in the forms of a discussion which is sufficient for the exploratory stage of theory development or in the form of propositions. This study will be confined to the level of an exploratory statement.
The Application of Grounded Theory to the Data.

The generation of categories and properties began with a review of the minutes of the Association. The minutes are contained in notebooks and bound volumes dating from 1912 to the present. They are hand written from 1912-1923 and typed thereafter. The format, depth and style varies over the 64 years that were reviewed. The minutes include the minutes of the Executive Council, the Council, later called the Board, and the Annual Minutes. Minutes of the Executive Council meetings 1923-27 do not appear to exist. Published annual minutes exist from 1945. Reports of annual meetings appeared both in British Columbia newspapers and in the Canadian Nurse. The minutes of standing or ad hoc committees of the Association were not made available for this research. Contextual depth is a problem on some issues. For example, the transition of the organizational structure and objectives of the Association is unclear and difficult to reconstruct. Supplementary sources such as newspapers, discussion papers, journal articles and interviews were used to try to overcome these difficulties.

Because of the length and complexity of the data base a detailed summary of the minutes, with direct quotes as were felt to be useful, was recorded in field notes totalling 300 pages. In a separate column adjacent to the notes, a heading applicable to the content of the minutes was recorded. These headings were both substantive and theoretical words or phrases. Examples of substantive
headings included the themes presented in the narrative of Chapters Two and Three, and words or phrases used by the participants themselves; thus the chapter heading 'to protect the quality of nursing'.

The headings that appeared in the field notes ultimately numbered 25. A summary of the content related to these headings was made. Themes emerged and this material was grouped under the consolidated headings of registration, education, terms and conditions of employment and the organizational structure of the Association. These themes were considered to be the major themes of the Association. It was recognized that these themes shifted between positions of primary and secondary importance as the interests of the Association shifted. The related themes of the subsidiary worker, health and safety of nurses, social security, terms and conditions of employment of senior nursing staff while important in themselves, are directly related but subsidiary to the major themes. In the narrative, these headings have been presented as dominant themes, that is those themes of primary interest at any given time, or as secondary themes. Suggested relationships amongst the themes and headings were noted in a third column on the field notes, as well as on separate sheets headed with the relevant title. These relationships were repeatedly re-examined as the comparison of groups began.

Early in the research process the comparison of groups presented a problem. It was never the intention to compare nurses in British Columbia with another occupational group that has
similarities with nursing, in, for example, the preponderance of women, and inclusion in the debate over professional status (Etzioni, 1969). Anything other than a comparative study using a similar data base would be theoretically unsound and to repeat the research methodology undertaken for this study was beyond the scope of the researcher's resources. Thus the comparison of groups was limited to groups within the data and the literature.

The comparison of public health, private duty and education nursing groups was considered because these are distinct groups that emerged early in the Association's history. However, the data did not provide adequate information to form comparative groups. As the review of the minutes continued, it became apparent that a comparison of groups could be done on two levels. The first level of comparison is a comparison of the Association's response to the themes which emerged from the data. The second level is a comparison of the original data collected in British Columbia compared with data in the literature. The first level of comparison represents the analysis of the data (Chapter Five) while the second level is the literature review (Chapter Six).

Comparison of the Association's response to the themes which emerged from the data resulted in the emergence of the integrating concept of control. The first indication that control may be the underlying and unifying concept arose from discussions in the minutes on the control of subsidiary workers (March 21, 22, 1969).
Using the concept of control, the categories that emerged are 1) the control of the work force, 2) the control of work practice, and 3) the control of the work environment. The headings of the themes, both major and secondary, represent more than data; they represent responses of the Association which varied over time. Thus the headings or themes are the properties of the categories. Control of the work force represents the attempt of the Association to control the numbers of nurses and the quality of the individual entering the work force. The category of control of the work force has the properties of registration, education, and private duty nurses, student nurses, and subsidiary workers. The category of work practice represents the attempt of the Association to control the quality of the practice of nursing and is closely associated with control of the work force. The category of control of work practice has the properties of education, registration, student nurses, discipline, safety to practice, quality assurance, and the role and function of subsidiary workers. The category of control of the work environment represents the attempt of the Association to control the terms and conditions of employment. The category of control over the work environment represents the attempt of the Association to control the terms and conditions of employment. The category of control over the work environment has the properties of the terms and conditions of employment, education, student nurses, the health and safety of nurses and social security. The major theme of the organizational structure of the Association became a property of each of the
<table>
<thead>
<tr>
<th>Category</th>
<th>Control over the work force</th>
<th>Control over work practice</th>
<th>Control over the work environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property</td>
<td>registration</td>
<td>education</td>
<td>terms and conditions of employment</td>
</tr>
<tr>
<td></td>
<td>education</td>
<td>registration</td>
<td>education</td>
</tr>
<tr>
<td></td>
<td>private duty</td>
<td>student nurses</td>
<td>student nurses</td>
</tr>
<tr>
<td></td>
<td>student nurses</td>
<td>discipline</td>
<td>discipline</td>
</tr>
<tr>
<td></td>
<td>subsidiary workers</td>
<td>safety to practice</td>
<td>health and safety of nurses</td>
</tr>
<tr>
<td></td>
<td>organizational structure</td>
<td>quality assurance</td>
<td>social security</td>
</tr>
<tr>
<td></td>
<td></td>
<td>role and function of subsidiary workers</td>
<td>organizational structure</td>
</tr>
</tbody>
</table>
three categories of control because changes in the organizational structure were a response to efforts to exert control over each of these areas.

The validity of the integrative concept was confirmed by thinking through the themes and their relationships to the suggested categories and properties. The concept of control and the Association's attempt to control the work force, work practice, and the work environment seemed the most complete explanation for what had occurred during the Association's history.

Conclusion.

By way of conclusion, brief consideration will be given to the credibility of grounded theory. Glaser and Strauss point out that qualitative research is often considered 'unsystematic' 'impressionistic', or 'exploratory'. The research is concluded only when the researcher is convinced that a 'reasonably accurate' statement of the subject matter can be made. Thus, what is presented is that which the researcher knows "systematically". The researcher has combined the effect of becoming immersed in the data as well as retaining informed detachment. Glaser and Strauss argue that this represents the conversion of a "normal strategy of reflective persons to a strategy of research" (1967, pp.227). Those, having gone through the experience of doing substantive field work, who do not believe the theory that emerges out of their research are considered to be "tempted toward compulsive scientism" (1967, pp.227).
Glaser and Strauss identify two problems associated with conveying the credibility of the grounded theory. These are 1) conveying the theoretical framework in an understandable fashion and 2) presenting the data in a sufficiently vivid manner as to convey reality while still within the theoretical framework. The first problem is dealt with by presenting the theoretical framework and associated theoretical statements in terms of the emergent concepts of the fieldwork and in terms of the concepts and language of sociology. The second is dealt with by presenting characteristic illustrations (direct quotes, tell-tale phrases, dramatic segments etc.) and by the use of the constant comparative method. Readers will be convinced of the credibility of the researcher if sufficiently caught up in the material as well as by analyzing the research material.

Both the researcher and the reader have responsibilities in the assessment of material. The former for the content and presentation, the latter for critical assessment of the material presented.
CHAPTER 5

Analysis and Discussion

Introduction

An analysis and discussion of the narrative presented in Chapters Two and Three is found in this Chapter. On the basis of theoretical sampling conducted according to the tenets of grounded theory and a comparison of groups within the data (Glaser and Strauss, 1967) categories and properties emerged from the data. The integrating concept of control emerged to form the categories of control of the work force, control of work practice, and control of the work environment. From these categories of control, three pastures of control assumed by the Association are identified. These are 1) compromised control, 2) co-ordinated control, and 3) bargained control. These postures of control were assumed in response to the need to achieve what was possible in negotiation with forces external to the Association. External forces include the political processes inherent in negotiation with the government, hospital administrations, the Hospitals' Association, the medical profession and consumers. According to the Association's negotiating power, the strategy was one of lobbying, moral suasion, or bargaining. Negotiation also took place amongst groups within the Association. These groups include private duty, public health, education and hospital nurses as well as the Associations' elected
leaders, professional staff and grassroots membership. There is no clear pattern of negotiation in this setting but the emergence of 'cosmopolitan' and 'local' groups is identified and recognized as influencing the pattern of negotiation with external forces.

This chapter begins with a brief discussion of the concept of control as it is used in this study and is followed by a discussion of negotiation within and external to the Association. Following this, examples of compromised control, co-ordinated control and bargained control are discussed.

The Concept of Control

Control is defined as "the power of directing and restraining the course of action" (Pocket Oxford Dictionary, 1959). The concept of control used in this study is thus the power of directing and restraining the course of action of the members (individuals) and the membership (the whole) in the practice of nursing. Thus, the categories of control which emerged are 1) control of the work force, 2) control of work practice, and 3) control of the work environment. A comparison of the categories of control led to the identification of three postures of control assumed by the Association in its negotiation with external forces. These are compromised control, coordinated control and bargained control. Compromised control is characterized by taking a "middle or mixed course" (Pocket Oxford Dictionary, 1959),
These postures of control existed both sequentially and simultaneously. Thus compromised control predominated (1912-43), coordinated control, 1944-57, and bargained control from 1957 to the present date. Elements of each type of control can be found in other time periods. For example, an episode of bargained control existed when the Association directed its legislative sponsor to withdraw the amended registration Bill of 1916. Compromised control has persisted on the issue of registration. The Association has never been prepared to restrict the care of the sick to registered nurses. The Association has responded to the need to care for the sick by the expansion or contraction of the work force according to need largely defined by external forces. Compromised control of education and working conditions of student nurses existed until the education of student nurses was removed from the delivery setting hospitals. The most prevalent pattern has been compromised control.

Table 5.1

Postures of Control Assumed by the RNABC: 1912-76

<table>
<thead>
<tr>
<th>Postures</th>
<th>1912</th>
<th>1928</th>
<th>1943</th>
<th>1959</th>
<th>1976</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compromised control</td>
<td>Control of the work force</td>
<td>Control of work practice</td>
<td>Control of the work environment</td>
<td>Control of work environment</td>
<td>Control of work practice</td>
</tr>
<tr>
<td>Coordinated control</td>
<td>Control of work environment</td>
<td>Control of work practice</td>
<td>Control of the work environment</td>
<td>Control of work practice</td>
<td></td>
</tr>
<tr>
<td>Bargained control</td>
<td>Control of the work environment</td>
<td>Control of work practice</td>
<td>Control of the work environment</td>
<td>Control of work practice</td>
<td></td>
</tr>
</tbody>
</table>
Negotiation with Internal Forces: 'Cosmopolitans and Locals'

The nurses who initiated the struggle for registration in British Columbia may be seen as setting out to establish nursing as an organized professional group in an effort to supersede other types of nursing available. Out of the struggle for registration emerged a group of leaders who were to become the leaders of nursing in British Columbia, and indeed who were part of the cosmopolitan nursing guild of Canada and the International Congress of Nurses. Merton (1957, pp.392-402) uses the distinction between "orientation toward local and larger social structures" in which the 'local' is parochial in interest and the cosmopolitan is orientated to the world, or is ecumenical in interest" (pp.392-93). Helen Randal, Ethel Johns, Grace Fairley, Alice Wright, Esther Paulson and others aptly qualify as cosmopolitans.

By the nature of cosmopolitans and locals, and by the nature of the Association, the locals rarely appear in the minutes as individuals, but their concerns, especially between 1942-68 appear. These concerns are expressed as issues in the terms and conditions of employment, and the struggle by private duty nurses to maintain a registry within the Association. Occasionally individuals appealed the refusal of registration, usually because of inadequate secondary school education. The separation of cosmopolitans and locals is most graphically illustrated by the events of the strike, in 1939, by the Comox nurses, and the Association's response.

1 See Appendix B for biographical note
Several factors reinforced the formation of a cosmopolitan group. These are 1) the difficulty of participating in Association affairs due to the long hours of work, 2) the development of a hierarchy amongst nurses, 3) the impact of short term career commitment, 4) an organizational structure that did not facilitate communication within the Association, and 5) the absence of participation in Association affairs by student nurses until 1946.

The long hours of work by nurses have been discussed at length in earlier chapters. Nonetheless a group of nurses participated actively in Association affairs with considerable commitment, effort and with a major loss of their leisure time. Executive Council and Council meetings were held after the normal working day, usually Friday evenings, and later, all day Saturday. Attendance at provincial, national or international meetings was often done on holiday time (Paulson, 1981). The minutes of the Association record repeated requests to the BCHA and hospital boards to allow nurses time to participate in Association affairs. There was nonetheless the feeling amongst cosmopolitans that more nurses could have participated if they had wished (Paulson, 1981).

The development of a hierarchy amongst nurses, was the result of a shift in employment pattern from the independent practice of private duty nurses to institutional employment. This was reinforced by the shortage of nurses during World War II in which practical nurses became a substantial part of the work force and a
heirarchy of supervision developed. Eaton has made clear that
directors of nursing were in a position of conflict between getting
the job of caring for the sick done and improving working conditions.
This conflict separated nurses. The leaders by employment were also
the leaders of the Association (Eaton, 1938, pp.61). This means that
until a hierarchical structure of institutional nursing had developed
by the mid 1940's, most nurses were peers of one another and as such
there was less conflict of interest amongst nurses in the 1920's and
1930's than developed later.

The attrition of nurses to marriage compounded the problems
of the difficulty of participation, although there were mechanisms
within the Association to allow non-active nurses to participate
in Association affairs. The outcome of limited participation by the
general membership contributes to a general unawareness of Association
affairs amongst the membership. Recognition of this led to the formation
of Chapters and Districts within the Association on the basis of the
proposals of 1938. Student nurses who formed 50% of the registered
nursing work force until the early 1940's were excluded from participating
in Association activities until 1946 when a Student Nurses' Association within the RNABC was formed.

This background provides an explanation for the ascendancy
of a cosmopolitan group within the Association and some explanation
of the 'need to educate' nurses on what the Association could offer
when control of the work environment become a dominant theme of the
Association's activities. Also explained is the potential for conflict of interest over the means of getting the job of caring for the sick done, and the potential ability of the leaders of the Association to control the extent of social and economic demands of the locals once collective bargaining had been legitimized.

The minutes of the Association provide little data on negotiation amongst occupational interest groups within the Association. Private duty, public health and education interest groups were the first groups formed within the Association. The private duty registry as a separate entity within the Association ceased to exist in the late 1960's after protracted negotiation within the Association. The end of Association support for this group represents the ascendancy of the institutionally employed nurse, and is part of the Association's attempt to control the workforce. With the exception of the elimination of support for the private duty registry, changes in the structure of the Association affecting occupational groups were usually in response to changes in structure of the CNA, and consequently do not seem to have been negotiated within the Association.

On the basis of this discussion it would appear that the Association's leaders were in a position to represent nursing's best interests as defined by the cosmopolitans until 1957. The strongest evidence supporting this view is the lengthy discussion at the executive council level on registration, the formulation of a policy on the Association's role in collective bargaining, and the
Association's response to the strike vote of 1957. (Rossiter, 1957, pp.799) This is not to say that the membership was without strength. The membership effectively forced the Association executive to take a strong stand with the government in the negotiations of 1959.

It would also appear that the relatively low visibility of the process of negotiation of the terms and conditions of employment when the postures of compromised control and coordinated control dominated, reinforced the separation between the cosmopolitans and the locals and decreased the power base of the Association in external relationships. The visible struggle to improve working conditions prior to 1946 was left to the CCF, the nurses themselves (the Comox strike) and a political mediator, Mrs. Eaton. When visibility increased (strike votes of 1957, 1959) the results improved. In the period of coordinated control (1943-1957) the balance of power was not necessarily favourable to the leadership who took on negotiation with employers on behalf of the nurses. Esther Paulson, as a member of the executive of the RNABC, while employed by the Provincial Government presented the economic concerns of nurses employed in Provincial Government hospitals. She described negative repercussions in her own work and economic security (Paulson, 1981). The reliance on moral suasion and the trust in paternalism evident in this period provides an explanation for failing to predict this outcome.
After 1959, there is insufficient data to assess the balance of power between the cosmopolitans and locals. The lack of data dealing with labour relations activities in the Association minutes after 1959 is a reflection of the growth of this activity as a separate function of the Association. The formation of a Nursing Administrators' Association in the late 1960's suggests a loss of power by the cosmopolitans in their capacity to respond to the pressures exerted by the locals within the Association and in the work setting and is a statement of appreciation of their increased vulnerability.

Negotiation with External Forces

Hospitals in British Columbia were established by religious orders, charitable groups, enterprises, whether medical, nursing or private interests and in the case of mental disease and tuberculosis, the provincial government. Administrators of these hospitals organized themselves to form the British Columbia Hospital Association in 1918. Nursing administrators participated through the nursing section or as invited guests.

It is apparent from the minutes of the BCHA annual meetings that inadequate funding of hospitals was identified as an issue of major concern as early as 1919. Revenue for hospitals was generated from patients' fees, charitable sources and municipal and provincial revenue in proportions of approximately 1/3 until 1949 when the provincial government took over the funding of hospitals. This event
had the effect of transforming an amorphous body responsible for hospital funding into a concrete entity. However, collective bargaining by nurses remained at the local hospital level until the mid 1950's. Since then, the BCHA and later the HLRA has buffered the government from direct negotiations with nurses on the issue of the terms and conditions of employment. Nonetheless, the creation of a single funding source has created a single body ultimately responsible for the funding of hospitals. However, the funding of hospitals and the terms and conditions of employment of nurses are not the first or the only issues about which the Association has negotiated. The issues involved in control of the work force, work practice and work environment are interwined such that one negotiation affected another over the course of the Association's history. The realization of these interrelationship has influenced the strategies the Association has chosen. The strategies chosen were lobbying, moral suasion and bargaining. These reflect the balance of power and the nature of the relative stakes involved.

Lobbying is defined as "the frequenting of parliament ... to solicit votes" (Pocket Oxford Dictionary, 1959), moral suasion as "reasoning or advice as incentive" (Pocket Oxford Dictionary, 1959), and bargaining as "haggl(ing) or dispute" (Pocket Oxford Dictionary, 1959). Overt lobbying occurred only during the struggle for registration - there was nothing to lose, the Association had no power to influence the course of nursing practice without registration.
Moral suasion was used between 1919 and 1957. In the face of an abundance of nurses (1919 - 39), the poor financial position of hospitals and a decline in number of private patients during the depression, the Association had no effective power to negotiate the terms and conditions of employment, but was able to promote the closing of substandard schools and indirectly promote the employment, if not improve the terms and conditions, of nurses. The curriculum of students was the direct responsibility of the Association under the Registered Nurses Act, but working, classroom, and living conditions were not. Thus the strategy of moral suasion in an attempt to improve the lot of students. The shortage of nurses during and after World War II changed the dynamics of the balance of power, and thus the strategies in the negotiation process. Bargaining as a strategy began only when the balance of power was favourable to the membership at large. The membership had to be prepared to play for high stakes (strike) before the full exercise of the Association's power could be tested. Because of the vulnerability of the Association's leadership in their own employment, the leadership had a stake in containing the memberships' demands to what was thought to be acceptable to the BCHA and the government.
Table 5.2
Strategies for External Negotiation of Specific Issues
Used by the RNABC: 1912-76

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In every instance of negotiation the options were limited because of the underlying commitment to providing care for the sick and because of the interrelatedness of the issues. Negotiations on one issue had the potential of affecting negotiations on other issues. Mandatory registration was not sought because, while there was a desire to protect the public, there was no desire to prevent anyone from nursing, but only from "claiming to be a registered nurse" (October, 11, 1913). It has been made clear that all the issues surrounding the education of student nurses were compromised by the need to provide service to patients in hospital, and that this compromise ended only after the education of nurses was established outside of hospitals. Bargaining over the terms and conditions of employment occurred only after the membership was prepared to strike. The strategies of negotiation were chosen to achieve what was
thought to be possible.

Postures of Control.

Compromised Control.

Compromised control is defined as a "middle or mixed course" (Pocket Oxford Dictionary, 1959). The Association's attempt to control the work force and work practice has been dominated by the issues of registration and education.

In the struggle for registration, the fledgling Association acted in apparent unity to establish a new order of nursing. But registration was not achieved without compromise with the external arena. The Association recognized the Provincial Legislature's resistance to mandatory registration, and the need of the public for various levels of nursing care. It would appear that in exchange for voluntary registration, midwifery was not recognized. This had the support of the medical profession who could now count on a more reliable workforce and control over maternal care. The major outcome of this compromise was that the total nursing work force has never been under the control of the Association. Consequently, over the years, the forces of supply and demand have forced the Association to modify its position on role and function of student nurses, private duty married nurses, and subsidiary workers. The Association has never been able to control the volume of the work force or to influence the
patterns of demand for nursing care, as for example has the medical profession (Cooper, 1973, pp.93; Evans, 1973, pp.162). Thus a posture of compromise has dominated the Association's attempt to control the work force and consequently work practice. Discussions of mandatory registration have occurred throughout the history of the Association, but have remained internal to the Association.

Another example of compromised control was the position of the Association vis à vis educational standards and the living, studying and working conditions of student nurses. Educational standards were improved indirectly by increasing the educational entrance requirements in the 1930's. Helen Randal, representing the Association, used moral suasion as a strategy to close substandard schools of nursing and in an attempt to improve conditions for student nurses in the 1920s and 1930s. Substandard schools of nursing were closed due to the efforts of Helen Randal and due to the adoption of the belief by the Hospital Association and hospital boards, that graduate nurses could be hired more cheaply than students could be trained. This was especially true during the Depression when unemployment amongst nurses was very high, and nurses, especially those from the prairies, could be hired very cheaply (Randal, 1938; Eaton, 1938, pp.11).

The Association had the power (by statute) to approve schools of nursing but could not actually force the closure of schools. The graduates of non-approved schools were denied registration as a
means of exerting pressure upon non-approved schools of nursing. Conditions improved for students because of the Association's efforts and possibly, also because of the impact of the Hospital Construction Act of 1949 providing financing for hospital construction which included nurses' residences and classrooms. This is not certain because Esther Paulson recalls that one school received a new residence and classrooms in the early 1950's only because of the private donation of funds (Paulson, 1981).

Although the government had the regulatory power to control the working conditions of student nurses from the early 1940's no action was taken, and the Association had no power to force action.

The improvement of working conditions of students and graduate nurses was compromised by the position of the leaders of the Association, who were also the directors of nursing of the hospitals and schools, which were the subject of concern, and by the desire of the Association to improve the education of nurses before the issue of the working conditions was addressed (Eaton, 1938, pp.60-62). The fact that the Association's leaders were themselves compromised well before collective bargaining began, lends credence to the viewing of directors of nursing as vulnerable. This vulnerability ultimately led to the formation of a nursing administrators' group which separated from the Association in the mid 1970s. This also illustrates the importance of the roles played by Helen Randal, as Registrar (1918-1941) and Alice Wright as Registrar, and later as
Coordinated Control.

Coordinated control represents a state in which the parties are "equal in status" (Pocket Oxford Dictionary, 1959). With the Second World War came a shortage of nurses, a hierarchical structure of the nursing work force, improved salaries and working conditions for the general population, the growth of unionization and, postwar, rapid inflation. Nurses were characterized as "restless".

It is difficult to assess the extent of the restlessness of nurses. British Columbia was a province whose work force was actively engaged in unionization (Jamieson, 1968). Nurses must have been aware of the economic gains achieved by unionized workers. Since registration was not mandatory for practice, the Association could have lost a portion of its membership if action were not taken. This was recognized when the Association discussed the potential relationship between the Association and trades unions (January 5, 1944; March 1, 1944). This is an example of compromised control of forces within the Association and serves to explain the effort to educate nurses about the gains the Association had made in improving the terms and conditions of employment. However, there was still the problem of the 'locals' who did not participate in Association activities and thus would not hear the message, and the fact that those
who were informed may not have seen the efforts of the Association as sufficient. The option of joining a union was thus appealing. However, the fact that it took two votes, 1944 and 1946, to endorse the role of the Association in collective bargaining speaks to the general confusion of the membership. The formation of chapters and districts of the Association in the early 1940's may have contributed to increased communication between the cosmopolitans and locals.

In 1942 a committee under the Placement Service had begun a survey of working conditions and salaries. Alice Wright, arriving as the new Registrar of the Association, recognized the seriousness of the restlessness of nurses, and under her leadership, began a fresh attempt to exercise some control on the work environment. Out of the work of this committee a base-line of Recommended Personnel Practices was developed by Alice Wright and Elizabeth Braund, and was revised, usually annually. Negotiation with BCHA took place; both parties were in effect selling their agreement to the Recommended Personnel Practices to their respective constituencies. This occurred before collective bargaining was approved nationally or provincially. To the extent that both parties met voluntarily and contracted to 'sell an agreement to their constituencies' a state of co-ordinated control existed. Undoubtedly the BCHA had a vested interest in a quiet labour scene, especially during the period of the war years when pressure on hospitals was very great. The shortage of nurses, which persisted until the mid-late 1950's
strengthened the position of the Association. Once the 'glamour of the war' had worn off, both parties could afford more latitude in their tactics. By 1950, Harvey Agnew of the Canadian Hospitals Association was writing in support of better salaries and working conditions for nurses even if it meant a higher bill for patients (Agnew, 1950, pp.27-28). The practice of co-ordinated control exercised by the RNABC and BCHA continued after nurses became certified and engaged in collective bargaining for the benefit of non-unionized nurses. The Association continues to this day to represent the interests of non-unionized nurses to employers, on the nurses' request.

An element of co-ordinated control is present in the current system of education of student nurses. While the pattern of approval of schools based on the curriculum continues as an internal mechanism, the existence, funding and operation of schools is now a matter for universities, community colleges and the Ministry of Education. The use of hospitals and public health districts for practical experience is negotiated by nurse educators with the Association playing a facilitating role but not actually influencing the construction or use of clinical units. This pattern developed in the mid 1960's with the beginning of the closure of hospital schools of nursing.
Bargained Control.

The period of bargained control, characterized by 'haggling' and 'dispute' (Pocket Oxford Dictionary, 1959) was initiated by the Association's support of strike action in 1957. To the extent that Recommended Personnel Practices were prepared by the officers of the Association, with input from staff representatives of employee groups, and approved by the Executive Council before being presented to the general membership for debate at the annual meetings until 1968, the Association was able to influence the demands of the membership and the power of bargained control was mitigated. As the labour relations function of the Association grew to dominate the Association's activities, the power of those associated with this aspect of the Association's activities grew.

Coincident with this, the process of bargaining became rationalized and the government, who had become the sole funder of hospitals, was forced to become more responsive to the demands of nurses because strike votes were exercised as leverage.

As salaries and social security measures for nurses improved, the Association turned inwardly to re-examine its role and function. The discussion papers Baumgart (1973) and Bachard (1973) can be seen as attempts to evaluate and re-establish the alignment of the nursing associations' roles. The separation of labour relations functions from the Association, although precipitated by an external force (the ruling by the Supreme Court of Canada, 1973, in
which the Saskatchewan Registered Nurses Association lost its right to engage in collective bargaining for nurses because of the role of management nurses in the Association) forced this realignment. Bargained control of the work environment will no longer be mitigated by the internal resolution of professional and labour interests.

Conclusion

This chapter has presented an analysis of the data based on the Association's attempt to control the work force, work practice and work environment. Comparison of these categories led to the identification of three postures of control assumed by the Association: Compromised control, co-ordinated control and bargained control. A consideration of negotiation within the Association led to the identification of 'cosmopolitan' and 'local' constituencies. Negotiation with external forces was considered. The strategies used were identified as lobbying, moral suasion and bargaining.

The changing postures of control were identified as a response to internal and external forces and the need to achieve what was possible. For terms and conditions of employment the 'possible' was defined by the cosmopolitans until 1959, and thereafter by the locals. The shift from compromised control to coordinated control of the work force was reflected by the introduction of the negotiation of Recommended Personnel Practices with the BCHA, and by the introduction of collective bargaining in individual hospitals as the locals
demanded. The push to coordinated control was the result of the recognition of the increased economic and social disparity of nurses, and the fear of a loss of membership to unions organizing hospital workers reinforced by a profound shortage of nurses. The bargained control of the work environment began in 1959 with the Association's support of the nurses strike votes for economic gain. The Association's shift to accept the postures of bargained control of the work environment is a reflection of the Association's attempt to retain control of the work force.

While it has not been the intention to examine the relative economic gains made during the evolution of the Association's activities, it is nonetheless argued that only after nurses were prepared to strike could compromised and coordinated control be exchanged for bargained control on the issue of the terms and conditions of employment.
CHAPTER 6

Literature Review

Introduction

Glaser and Strauss (1967, pp.37) suggest that the purpose of the literature review in grounded theory is to compare the analytic core of the categories which emerged from the data with the similarities and convergences with the literature. In this study, the literature review has the additional function of providing comparative groups for the groups which emerged from the data. Glaser and Strauss (1967, pp.37) suggest that the literature review be done after the emergence of these categories in order to avoid contaminating the development of the analytic core. Thus the literature review follows the presentation of the narrative, a discussion of the methodology, and the presentation and discussion of the analytic core.

The comparison groups which emerged from the data were 1) 'cosmopolitans and locals' who were functioning within the RNABC, and 2) the Association's responses to the themes found in the data.

The major themes which emerged from the data were registration, education and the terms and conditions of employment. Secondary themes included student nurses, private duty nurses,
health and safety of nurses, subsidiary workers and social security. Repeated review of these themes resulted in the emergence of the integrating concept of control. Using the concept of control, the categories that emerged are 1) control of the work force, 2) control of work practice and 3) control of the work environment. The literature will be reviewed under these headings, using the properties of the categories, or what were the major and secondary themes of the narrative as is appropriate. A discussion of the groups comparable to cosmopolitans and locals is integrated under these headings.

The literature review is limited to literature analyzing the history and activities of nurses and nursing associations in Canada, England and United States. Little of the literature reviewed had the focus of this study, and thus it was necessary to review selected portions of individual pieces of literature.

Control of the Work Force

Registration.

The control of the work force has been defined in this study as the attempt of the nursing association to control the numbers of nurses and the quality of the individuals entering the nursing work force. Registration has become the common standard by which to distinguish levels of nurses (trained and untrained). Registration as a goal of nursing associations originated in
England before the turn of the century (Abel-Smith, 1960).

In England, the battle for the registration of nurses was bitter, split the ranks of nurses and generated controversy in the Houses of Parliament, but was ultimately passed by a Minister's bill, in December, 1919 (Abel-Smith, 1966, pp.61-98). Midwives had achieved registration in 1902 (Abel-Smith, 1960, pp.77). Abel-Smith (1960) and Bellaby and Oribar (1980) consider the movement for the registration of trained nurses as the outcome of the reformist zeal of the second generation of Nightingale's nurses. Bellaby and Oribar see these nurses as part of a social and technical elite who were responding to the threat" that untrained and voluntary labor posed to its hegemony over nursing" (pp.298). As well, Bellaby and Oribar see registration as an attempt to wrest from hospital and state authorities the recognition of the "distinct" and "unsubstituable skills of untrained hospital nurses" (pp.298).

Bellaby and Oribar (1980, pp.298) argue that although registration was a prize the reformers won, it was a compromise because it granted the new General Nursing Council jurisdiction over the standards of nurse training (and indirectly over practice) but did not grant nurses legal control over entry to the profession. The 'dominance of medicine" was not challenged, and the recruitment of labour for hospital work could continue without reference to the GNC (pp.298).
White (1976, pp.209-217) suggests that registration in Great Britain was delayed until 1919 not only because there was 1) lack of agreement in the profession over the details of registration, 2) disagreement over the principle of registration and 3) the practical problems of defining a nurse, but 4) because the Government feared the system of educating nurses which provided "the least expensive means of obtaining and employing nurses" (pp.216) would break down.

In the United States the struggle for registration was conducted on a state by state basis. The earliest bill for registration was passed in North Carolina in January, 1903 (Kalisch and Kalisch, 1977, pp.259). Krause (1977, pp.46) points out that in the United States, nurses are the only subsidiary work force in health care that has achieved registration without dominance and control by physicians.

In Canada, the struggle for registration is described by Gibbon and Mathewson (1947, pp.352-358). There were three unsuccessful attempts to secure Dominion registration for nurses prior to 1909. All the provinces within Confederation had achieved voluntary or mandatory registration by 1922. Coburn (1974, pp.152) points out that in the struggle for registration in Canada, "nurses were arguing from a powerless position for protection against "practical" nurses who were forced to accept even lower pay and the broadest range of domestic duties in order to survive. Unfortunately,
as was the case with many unions, nurses did not combat the problem by including these unorganized women within a registration scheme which could have recognized different levels of nursing. As it was, the exploitation of this cheap source of labour continued to plague the nursing associations into the 1940's and even later" (pp.152).

Summary.

The goal of registration, and the role of a nursing elite, as well as the outcomes described by Bellaby and Oribar are consistent with events in British Columbia and the analysis in the preceding chapter. While the elite were split in England over the issue of registration. (Abel-Smith, 1960, pp.65-80) there is no discussion of this occurring in Canada or the United States. There is no discussion of the response to registration by grassroots or 'lesser trained nurses'. In the literature on American nursing, an elite and proleteriat have been identified as arising from the transition of private duty nursing to institutionally employed nursing (Wagner, 1980, pp.271-290). Ashby (1976) describes a split in American nursing leaders over eight hour laws, and the role of education and service of students. It is evident that, as Coburn (1974) suggests, the failure to include the ranks of lesser trained nurses, or to close the ranks of nursing by mandatory registration or, as Bellaby and Oribar (1980) suggest, the failure to grant nursing associations the legal
control over the entry to nursing has resulted in an inability of nursing associations to control the work force. This led to the continued exploitation of student and graduate nurses as was described in the narrative.

Thus, the presence of the category of control of the work force with the property of registration is confirmed in the literature as is a split in the ranks between the leaders of the nursing associations and the grassroots. The recognition and registration of midwives and their subsequent role in the delivery of health care in England is at odds with events in Canada and the United States. This would make an interesting comparative study, since there was support for the practice of midwifery by Local Councils of Women in British Columbia, but none in the ranks of nurses and doctors.

Control of Work Practice

In this study, control of work practice represents the attempt of the provincial nursing association to control the quality of the practice of nursing by means of controlling the education of student nurses. In the context of the narrative of this study, control of the practice of nursing has been considered as nursing was known and practiced during the 20th century. The context of this is lost without recalling that women were once considered the healers of western society. Ehrenreich and English describe the persecution
of wise women as witches, suppression of the knowledge of healing, the banning of midwifery and the subsequent dominance of the medical profession and the subservience of women in health care. The appearance of Nightingale's vision of nursing in the 19th century can be seen as an attempt to re-establish control over the care of the sick in the context of Victorian times. In the 20th century registration and education as a means to professionalize have been the main strategies to gain control over the practice of nursing.

In Canada, Coburn (1974) and in the United States Ashley (1976), Strauss (1966), and Wagner (1980) describe the rapid proliferation of nursing schools designed largely to provide cheap labour. As late as 1958 Saskatchewan hospitals with teaching programs reported a direct profit to the hospital as a consequence of the value of the labour of the students (Royal Commission on Health Services, 1, 1964 pp.274 cited by Allentuck, 1978, pp.45). In England, White (1977) describes the critical role which poor law nurses, who were well established before the advent of Nightingale, played in forming "an alternative group of nurses who cared for the poor, the long-term sick and the aged-infirm" (pp.23), these patients represented 75% of the hospitalized sick of the country, consequently nurses trained in the tradition of Nightingale in the voluntary hospitals cared only for a small portion of institutionalized patients.
In the United States the response to the dilution of the practice of nursing, as defined by the leaders of the nursing profession, was the development of an ideology of reform by specially trained nursing educators (Strauss, 1966, pp.72-81). Because of the close alliance of American and Canadian nursing leaders originally established through the Nurses' Associated Alumnae Associations of the United States and Canada (1896-1907) (Gibbon and Mathewson, 1947, pp.356) this ideology is evident in Canada. Thus, the importance of the Goldmark report of 1923 studying nursing education in the United States, and the Weir Report of 1932 in Canada is explained. Also explained is the importance of the tradition of Columbia Teachers College in nursing education (Strauss, 1966, pp.72-81), as is the importance of the establishment of the first university school of nursing in Canada at the University of British Columbia.

In England Nightingalism, a tradition of reform with an ideology of vocationalism, a commitment to sacrifice and subservience to male doctors in the care of the sick (Williams, 1974), and an ideology of sanitation (Davies cited by Carpenter, 1977, pp.166), had been adopted as a response to poor law nursing and was part of the first wave of reform which led to the formation of nursing associations and the struggle for registration. This ideology seems to have persisted until the Platt report (1964) because the education
of nurses in Great Britain was considered by the Royal College of Nurses in 1943 "as to (be to) a certain extent an apprenticeship" and later, in 1964, (the Platt Report) as "an education rather than an apprenticeship" (Davies, 1978). Thus the ideologies of reform in North America and Great Britain differed. This was due in part to the role of education in North American society where education is seen as a means of achieving class mobility.

**The Push to Professionalize.**

The importance of the educational ideology in North America is that it is part of the struggle to control work practice by professionalizing nursing. Nurses' struggle to be acknowledged as a professional occupational group represents the struggle to achieve status and recognition in the context of society, and thus the control of work practice.

The literature on occupations has devoted much energy to the study of those occupations referred to as 'professions'. Vollmer and Mills (1966) distinguished between the concepts of profession and professionalization. The term profession has been used to describe abstract models of occupational characteristics while the concept of professionalization refers to "a dynamic process whereby many occupations can be observed to change crucial characteristics in the direction of 'profession'" (pp.vii, viii).
The question of whether or not nursing is a profession has been debated at length. The establishment of a professional organization, registration, a code of ethics, the shift to university education and the attempt to control work practice all represent the attempt by nurses to achieve the criteria of professional status (Wilensky, 1964).

Katz (1969) views nurses as a semi-profession because nurses are predominantly women, employed by organizations in which close supervision is an inherent feature, and because their careers are interspersed with other commitments. He rejects the idea that nurses have a discreet knowledge base. The lack of differentiation in the ranges of tasks and responsibilities amongst grades of nurses clouds the degree to which nursing is a full time specialized task. Krause (1977) and Wilensky (1964) see the shift of nursing education to a university setting as one of the key strategies in the process of professionalization. While a university education provides status, Krause considers the move to universities a failure, because nursing does not control the means of nursing work. Nonetheless Wilensky's (1964) sequence of professionalization defining work as a full time specialized task, establishing a training school preferably at a university, the establishment of a licensing mechanism, and creating a code of ethics based on purity and service has been achieved with varying degrees of success.
Krause (1977, pp. 52-55) takes the analysis of the attempt to professionalize a step further by arguing that this has been one of a series of strategies in an attempt to gain autonomy in the workplace. He describes the sequence as the "shift to university training," and "take-over of physicians' dirty work," the "adoption of a managerial ideology," "the "outside mover approach," the "size the technology strategy" and "unionization" for greater control over work as well as for higher wage levels. Basing nursing education in a university setting is seen as an attempt to gain upward occupational mobility. This has failed because nursing does not control the setting of health care delivery. The takeover of physicians' dirty work is seen as an attempt to gain authority in the work setting but is diluted by the physicians' claim of legal responsibility and ultimate responsibility. Public health was seen in the 1900's as an avenue for greater occupational autonomy. This failed due to the legal subservience of nurses to physicians. The seize the technology strategy has failed because other occupational groups have moved in more quickly than nurses, and because ultimately the technology is controlled by physicians. The use of collective bargaining has failed, in Krause's view, because increased wages have been used as a bribe by employers to divert attention from the demands of nurses to control their work.

Nurses and nursing associations, by emphasizing registration and improved standards of education, have vested importance in
professionalizing by the achieving of the attributes of professionalism. As Strauss (1966) points out, nurses have succeeded in convincing the public of their professional status. This has created a dilemma, since efforts to improve the terms and conditions of employment by professional means failed, the alternative was collective bargaining, considered until recently a non-professional strategy. Changes in the organization of nursing work and the entry of government into health care changed these dynamics.

Summary.

The literature recognizes that nurses used a variety of strategies in an attempt to control work practice. The primary efforts were directed to the establishment of registration and the control of the education of students. The role of students as cheap labour impeded educational reform in Canada, the United States and England. In the literature these efforts to bring about reform have been characterized as professionalizing strategies, and are viewed as a failure in the attempt to gain professional status and as a consequence, to control work practice. The literature does not assist in supporting or rejecting the postures or the strategies of control suggested in the analysis of this study. Although the approach and the definitions vary, the literature supports the category of control of work practice with the properties of registration and education.
Control of the work environment

In this study the control of the work environment represents the nursing association's attempt to control the terms and conditions of employment. The literature identifies 1) the development of scientific medicine, 2) changes in the organization of the work, 3) the development of a hierarchy within nursing and 4) the socio-economic concerns of nurses as factors in the development of collective bargaining by nurses in Canada, England and United States. Depending on the ideological stance the emphasis on these factors varies.

Concurrent with the urbanization and industrialization of Europe, Eastern United States and Canada was the development of scientifically based medical practice. The development of scientific medicine and the increased use of technology in the care of the sick meant that by the 1930's it was no longer possible to be ill and receive good care at home. The age of technology in hospitals had arrived. Hospitals were no longer reserved for the sick poor (Somers, 1971).

With changes in the technology of health care, the organization of nursing work changed. Wagner (1980, pp.278-284) Bullough and Bullough,(1965, pp.84-85) describe the pressures exerted on private duty nurses in the United States to become institutional employees and their vigorous protest. There is no Canadian or
English literature describing this phenomenon. Abel-Smith (1960) describes private duty nurses as fully employed until the Depression, but as not necessarily, in the eyes of the College of Nursing, giving satisfactory services. The literature does acknowledge the development of a hierarchy within nursing service and its consequences. Baumgart (1980) describes the entry of the graduate nurse into institutional employment in Canada as entering a "social system that had been designed and for many years had operated according to the social norm of the native, submissive student who was subjected to closer control and discipline in her work" (pp 3). Baumgart states that nurses were forced to transfer their responsibilities from the emphasis on the care of patients and the healing act to balancing loyalties among the institution, the physician and the patient. White (1977, pp.24) illustrates that a hierarchy was well established in poor law nursing in England in the 19th century.

Carpenter (1977) describes the rise of a managerial class of nurses in Great Britain and ascribes the development of collective bargaining to this division within the profession. Carpenter argues that this occurred because of "profound changes in job content" (pp.174). He identifies three areas of change 1) the increase in numbers of clinical responsibilities being delegated to nurses from doctors as a result of the growth of scientific medicine;
2) the increased importance of the nurse as coordinator of activities at the ward level due to the emergence of paramedical occupations who have intermittent contact with patients, and 3) the increased number of chronically ill patients who require long term care. Carpenter argues that as the proportion of chronically sick patients increased, "job satisfaction in carrying out basic nursing tasks declined. The nursing elite began to look more towards clinical and managerial aspects of their work" (pp.174). Dirty work or routine work was delegated, and this meant an increased abandonment of traditional nursing values. Katz (1966), Krause (1977), Mauksch (1966) and Williams (1974) support this general argument, but Williams (1974) describes the issue not as a loss in job satisfaction but as a shift in ideology from vocationalism to professionalism. Vocationalism is the expression of traditional nursing values in which the sanctity of both the nurse and patient are preserved. Professionalism is an ideology in which prestige and reward to nurses is associated with clinical tasks delegated by medicine and managerial activities.

This literature pays little attention to socio-economic concerns of nurses. Badgley (1975, pp.9-17) writing from a Canadian experience, identifies growing unionization and wage discrepancies triggered by monetary inflation as resulting in labour unrest and strikes by health workers. The consequence has been the
gradual erosion of professional autonomy, the emergence of social pressures stemming from job status inconsistencies, and the increased importance of relative income levels. In Badgley's view professional autonomy has been challenged when national health insurance plans have been introduced. Badgley sees the resemblance of professional associations to trade unions and argues that collective bargaining will result in more direct social responsibility on the part of these occupations than was previously evident.

With specific reference to nurses, Badgley suggests that status symbolism, especially visible in nursing, has been stressed in lieu of job remuneration or job benefits. He views this middle level work force as having a short term career commitment and a high job turnover which has limited the growth of strong associations and constrained the sense of militancy among workers. A slow build up of job frustration filled by an awareness of women's rights, the impact of inflation, and by disenchantment with traditional prestige symbols has resulted in an awareness of income levels equaled or exceeded by workers with less formal training and in a sense of job alienation. Badgley predicts sharper conflict in the future if the health system remains rigid and authoritarian in the face of current social forces. As an example, Badgley points out that sanctions against striking doctors have not occurred, but professional hospital employees
and nurses have been subject to sanctions Badgley identifies the moral issue to be solved as whether conflict will be "anticipated and structurally channelled to increase the satisfaction of health workers and in turn achieve the target of good health for the public" (pp.16).

Issues in collective bargaining by nurses in England, United States and Canada.

England.

Regardless of the emphasis on the factors precipitating collective bargaining by nurses, the literature supports the position that the nursing work force entered collective bargaining as a response to the failure of nursing associations to control the work environment.

In England the first union activity amongst health care workers is traced to the Asylum Workers' Union formed in 1896 as a response to the exclusion of asylum nurses and attendants from registration. The first strike occurred in 1918, when a 60 hour week was sought (Green, 1975, Ross, 1979). Lewis (1976) describes the relationship between nurses, trade unions, professional organizations and the government since the formation of the National Health Service in 1948. The representatives of the professional bodies are viewed as being drawn from a select group
from the ruling class and their allies who are controlling the social order of nursing in Britain. The organizations representing nurses are argued to have failed to enable nurses to keep pace with the cost of living and achieve a wage increase of any note. This has resulted in work to rule, demonstrations and strikes by nurses. McKay (1974) has described the allegiances and attitudes of British hospital nurses in response to this strain.

Bellaby and Oribar (1980, pp.291-309) in a Marxist analysis of strategies adopted by British hospital nurses do not believe that developments in medical technology are the prime explanation for all the changes in the mode of control and delivery of health care.

The dominance of medicine over health care workers, the influence of technology and its suppliers, and government intervention are seen as promoting the erosion of nurses' control over the means of treatment. Consequently nurses have responded by equivocating between the strategies of professionalism and unionism.

The issue of the right to strike and the dilemma of professionalism and union activity in British nursing is debated by Clark (1979), Ferguson (1976) and Williams (1979). The North American model of professional associations engaging in collective bargaining with the right to strike is not suggested in the British literature. The models suggested are, a professional
organization with a commitment to no strike action or, affiliation with a union with an interest in patient care and links with trade unions or the Labour party (Ferguson, 1976).

**United States**

Collective bargaining by nurses in the United States is important in this study for two reasons: 1) because of the generally acknowledged influence of American union activity on the Canadian scene (Woods, 1973, pp.65-94) and 2) because Alice Wright was aware of and supported the activities of the California Nurses' Association before she returned to British Columbia in 1943.

Swanberg (1970, pp.54-56) identifies three phases of activity amongst hospital workers in the United States: 1) 1896 to the entry of the US into World War II, characterized by inactivity and passiveness, 2) World War II to 1965, characterized by growing awareness and organization, 3) 1965, characterized by intense action and militancy. In 1935 the Wagner Act permitted hospital employees to engage in collective bargaining, but attempts to organize were largely unsuccessful. This act was amended in 1947 (Taft-Hartley) and hospital workers in nonprofit hospitals were exempted collective bargaining rights. In 1962 employees of federal health care institutions were permitted to engage in collective bargaining. In 1967 Catholic hospitals in the
United States were influenced by the Vatican II "Pastoral Constitution on the church in the Modern World" which stated "among the basic rights of the human person...(is) the right of freely founding labour unions" (Brown, 1967, pp.57-60) Miller and Shortell (1969) show that unionization in non-federal hospitals doubled between 1961-69. In 1974 an amendment to the Taft-Hartly Act extended collective bargaining to non-profit hospitals. This was opposed by the American Hospitals' Association (Rasaco, 1974, pp.79-80).

The first union activity in hospitals in the U.S. occurred in San Francisco in 1919. The principal demands were shorter hours and better working conditions. There was relatively little activity until 1936 when the American Federation of Labour organized the engineers and institutional workers of three large San Francisco hospitals. The Toledo Plan of 1956 occurred after an extended hospital workers' strike in that city and resulted in an agreement that unions would not bargain collectively or strike; and that hospitals would not discriminate against union members (Bruner, 1959). A bitter strike in New York City, was preceeded by the establishment of a union at Montefiore hospital (Cruickshank, 1959). The administration of this particular hospital supported the entry of the union (Cherkasky, 1959). Increased union activity of hospital workers in the US is seen as associated with the Civil Rights movement because of the
composition of the hospital work force (Davis and Foner, 1975).

Bullough (1971, pp.276-278) describes the growth of militancy amongst nurses in California during World War II as due to an intense recruitment for workers in a booming economy in which "nursing's economics did not benefit" (pp.277). The American Nurses' Association did not establish a committee on economic affairs until 1946. The efforts of Shirley Titus, then executive director of the California Nurses' Association, persuaded the ANA to study employment conditions of nurses in 1945. Bullough describes Titus as "an enthusiastic supporter of collective bargaining" (1971, pp.278). The ANA approved the role of state nursing associations in collective bargaining in 1946. The ANA lifted a ban on strikes by nurses in 1968 (Miller, 1975).

Titus, writing in The Modern Hospital, 1944 (pp.71-74) in an article called "Economic Security is not too much to ask" attributed the "awakening of nurses... to a full appreciation of their economic position" to 1) the development of a system of general staff nursing in which there was a marked increase in the number of general staff nurses subjected to hospital exploitation, 2) a sharp reduction of nurses salaries and prerequisites (laundry services) during the depression, which for many nurses had never returned to their pre-depression level, 3) the advancement of medicine and scientific knowledge... which has elevated the status
of nursing from a craft to a profession, and the lack of professional status, 4) the passing of the Social Security Act in which workers, but few nurses, received protection against old age, illness and lack of employment opportunities, 5) inflation which increased the cost of living but not nurses' salaries. Titus recognized the desire of staff nurses to organize, and the pressure staff nurses and private duty nurses were prepared to exert on their leaders "to do something about salaries" (pp.73). She argued that bargaining freely and independently relative to the conditions of employment was a democratic right, and that professional status offered no protection to employed persons. This article is important not only for its timing, and legitimizing of collective bargaining but also because reference is made to this article in the Executive minutes of the RNABC (December, 1943) to "acquire copies".

The literature on collective bargaining and nurses in the American nursing journals concentrates on 1) whether or not collective bargaining is appropriate for professionals (Conta, 1972; Erickson, 1971; Gillingham, 1950; Hopping, 1976; Mahony and Conlan, 1966); 2) the effect of collective bargaining on the structure and functioning of professionalism (Bloom, 1979; 1980; Cleland, 1974; Conta, 1972; Copp, 1973; Denton, 1976; Hott, 1976; Schutt, 1973; Zimmerman, 1971); 3) the ambiguous role of the director of nursing: is she to ally herself with the nursing staff, management, or act as a go-between (American Nurses' Association, 1970; Driscoll, 1974;
Hospitals, 1974; Rosasco, 1974); 4) the role of middle nursing management, especially in labour disputes (Bloom, 1980; Cleland, 1974); 5) the role of collective bargaining in defining patient care (Jacox, 1971; Kravit, 1973); 6) the right of nurses to strike (Mauksch, 1971; Miller, 1975; Schutt, 1968). Jacox (1971) has suggested that the emphasis on the "professional behavior" of nurses was used by hospitals and nursing administrators as a means of social control because of their vested interests in a quiescent workforce.

The issues are not resolved. Grand (1971, pp.289-299) describes the conflict as reflecting three distinct ideological positions of nurses. Nightingalism is an ideology of service which is interpreted as precluding concern with economic and working conditions. Employeeism represents a set of beliefs that lead nurses, as employees, to believe that their employer had their best interests at heart. Grand argues that the employeeism is reciprocal of paternalism and that the Depression contributed to the growth of employeeism. Professional collectivism is based on the assumption that working conditions are inherently and positively related to the quality of nursing care. Grand argues that the service ideology and the reality of the low economic status of nurses were reconciled by viewing the quality of care given by nurses as dependent upon satisfactory economic status and working conditions. While the narrative clearly illustrates
that both grassroots nurses and the leaders of the RNABC recognized the problems of the terms and conditions of employment from the earliest days of the Association, this position was not enunciated until the middle of late 1940's. Nightingalism in a pure form as described by Grand did not exist amongst nurses in British Columbia. Given the charitable nature of hospitals, and the limited public funding of hospitals until 1949 in British Columbia the use of moral suasion from the formation of the Association until the first strike votes of 1957 and 1959, employeeism may best describe the dominant ideology of nurses in British Columbia until 1957.

Two critics outside of nursing have examined the role of the ANA and state nursing associations (Dolan, 1980; Levi, 1980). Dolan argues that the professional nursing association serves the elite and because of the failure of collective bargaining by nursing associations to make significant economic gains unionization outside of professional associations will occur (Dolan, 1980). Levi (1980) argues that nursing associations have been unable to control the nursing labour supply and have failed to monopolize a distinct set of tasks and thus are unable to achieve upward social and economic mobility on behalf of nurses. While acknowledging an oversupply of beds and the availability of unemployed nurses, Levi suggests that the Seattle nurses strike of 1976 was broken by the hospitals because of the failure of the professional
association 1) to control nurses willing to work as scab labour
2) the absence of "powerful allies" or "clout" 3) the failure
of nurses to secure a monopoly over any set of "socially signi-
ficant, or even insignificant, roles" (pp.347). What Levi does
not address is the integrationist role of middle nursing management
(Jones, N. and Jones, W., 1979) who were prohibited from striking
in this situation and the amount of medical care given in hospital
which is may or not be an essential service (Hall, 1967).

In Canada two review articles consider the issue of
collective action by nurses to improve their salaries and working
conditions. A federal study for the Women's Bureau, Department of
Labour (Beckett, 1964) identified the public and professional
view that collective action on the part of nurses to improve their
working conditions was unethical. Low salaries and unsatisfactory
working conditions are identified as contributing to an insufficient
supply of nurses and a high rate of wastage. Because the majority
of nurses in Canada were not covered by labour relations legis-
lation collective bargaining was a voluntary act without the
protection of labour legislation. The evolution of recommended
minimum standards for personnel policies for nurses by a committee
on employment relations within the professional association to
collective bargaining by professional associations is described
province by province. The 'situation in B.C.'was as described in
the narrative except that no evidence of the formation of a Labour
Relations Committee formed in 1942 was found in the minutes of the Association. Beckett concludes that the growth of collective bargaining by nurses depends on 1) the amount of public support given, 2) the importance of health services in the community and the demand for health personnel, 3) the awareness by nurses that dedication to service does not obviate the right to salaries and working conditions consistent with the importance of their contribution to the community, and 4) the activity of trades unions amongst non-professional employees of hospitals as a spur to nurses. Beckett remarks that "except in the province of Quebec, the labour movement in Canada has not been active in recruiting nurses to its ranks" (pp.12). Beckett has overlooked the effect of the Hospital Employees Union to unionize the nurses of VGH on the activities of the RNABC.

Cormick (1969, pp.667-682) views nurses as professionals who are part of the public sector because the government is the ultimate employer and because "the essential nature of their task decrees that their employment is a matter of public concern" (pp.667). Cormick recognizes that the conflict between professionalism and unionism within nursing, legislative impediments and the lack of skilled bargainers within nursing associations have impeded progress towards collective bargaining by nurses. Health care, because of the high cost, and undesirability of duplication and its non-profit status, is considered to be a monopoly situation
with the nursing profession controlling entrance to the profession through registration procedures. Cormick does not acknowledge the proliferation of health care workers including the establishment of a subsidiary nursing work force, evident in the late 1960's, and the consequent difficulty in identifying work unique to nurses, nor the effect of subsidiary and parallel workers diluting nurses' monopoly (Krause, 1977; Levi, 1980).

Cormick suggests that hospital administrators have been opposed to collective bargaining by nurses because "wage increases would have to be passed on to consumers who are in no position to fight the rising costs of an essential service: (Hawley cited by Cormick pp.679). This view has been noted to be prevalent in the American literature, and indeed was the crux of debate in revision of laws prohibiting employees of non-profit hospitals from entering into collective bargaining in the US (Match, Goldstein and Light, 1975, pp.27-36) but is not generally consistent with the Canadian position. As early as 1950, Harvey Agnew, long time Executive Director of the Canadian Hospitals' Association supported the entry of Ontario nurses into collective bargaining by arguing that "the public cannot expect to get hospital care at prices which can only be maintained by holding salaries and wages at less than current levels" (Agnew, 1950, pp.27-28). This view is supported by J.D. Bradford (1981) former executive director of the BCHA and Steeves (1960, pp.100-101).
On the basis of available data, Cormick suggests that it is difficult to establish a clear relationship between bargaining strength and salary or salary gains but suggests that provincial associations with "high" bargaining strength (e.g., B.C.) do better on basic salary rates and salary gains. He also identifies a "relationship between general per capita income rank and nursing salary rank... which suggests that the general economic environment is an important factor" (pp. 681-682). Cormick predicts that organizing for collective bargaining will increase the general strength of nursing associations in areas where they are able to act as bargaining agents and that nursing associations will be able to exert increased influence over training standards and methods, even though the basic avenue of change will still be through the legislative process.

Foucher (1980), in addressing the Canadian Nurses Association Biennial, discusses the question of nurses and their membership in professional associations and trade unions. He suggests that a change in values of nurses has come about due to increased government intervention in health care, resulting in administration based on bureaucratic values. He argues that "whereas formerly it was reasonable to expect open discussion and free ratification of agreements between professional associations and hospital administration which shared certain values, the use of such a process of establishing nurses' working conditions became less satisfactory when
administrative values began to change" (pp.2). While nurses have sought "protection from management decisions by means of bureaucratically - oriented rather than professionally-oriented contract positions..." (pp.2) nurses have expressed ideological conflict by a reluctance to strike.

In the case of British Columbia, working conditions of nurses did not improve a great deal or uniformly as a reflection of the 'sharing of certain values' but rather as a result of 1) the shortage of nurses beginning in 1939-40, 2) the beginning of collective bargaining by non-professional hospital workers, and 3) the beginning of collective action by nurses in 1946. Rather it would seem that bureaucratic administration has reinforced the pressure nurses feel to maintain active unionism. Foucher discusses nurses' claim to be professional and suggests that the problem nurses have belonging to a professional organization will increase in proportion to the lack of clarity in the way they perceive the act of nursing. The role the professional association takes in clarifying and promoting the act of nursing will affect the commitment to the association. In considering trade unions, Foucher uses Torraine's (1965) typology to describe three types. Unions may be based on 1) class, and "dominated by the struggle against class power", 2) negotiation, with the aim to improve member's working conditions", or 3) integration, with the aim "to contribute to the smooth operation of society and its structures" (pp.6-7). The objective of unionism based on negotiation may be utilitarianism, control or co-management. It its purpose is utilitarian, the union is
committed to the defence of workers' interests and their collective privileges, without challenging the employer or attempting to involve itself in the management process. If its purpose is control, the union endeavours to take on management rights and to influence decision-making. It may adopt a cooperative or an adversary stance within the existing institutional framework. If its purpose is co-management, the union wishes a share of the power and to use that power to its own advantage". (Durand, 1971 cited by Foucher, pp.6-7).

On the basis of the narrative presented in Chapters 2 and 3, the objective of collective bargaining activity of the RNABC could be characterized as utilitarian between 1943-76. Foucher points out that the interests and demands of nursing unions and professional associations overlap or are interrelated and that the organizations can elect to adopt opposing or joint strategies for dealing with these demands. Failing this, unions and professional associations may integrate, with one or the other losing membership if membership is voluntary, or losing power. In the case of the RNABC, with voluntary membership in law, but mandatory membership enforced by hiring institutions, the professional association may lose out to the union.

To ensure the maintenance and development of professional association, Foucher suggests that these organizations should
1) "display an interest in member's concerns... and provide through open structures the opportunity for membership input" 2) "put forward professional models in the field of nursing...(and) "if warranted for the practice of nursing, a bachelor's degree as a requirement for admission into the profession." 3) "call for more forceful persuasive strategies in the institutional framework" (pp.9-10). In this last respect the RNABC's activities during the 1976 crisis at VGH were supportive to the membership.

An interesting omission from Foucher's paper is any discussion on the role of nursing management in the professional association and the nursing union or the need for a separate union for middle management nurses. With the separation of the professional and union structures in Canada, the question of managerial nurses participating in the professional association is less acute than in the United States. In due course the B.C. nursing administrators group may come back under the wing of the professional association see p.31 and union a specific issues does not challenge, but rather supports this group. With increasing budgetary constraint in health care, and the inherent tension between hospital administration and the nursing department, because of the large consumption of the total budget by the nursing department, the director of nursing is in an increasingly tenuous position, and challenges to the system by the professional association and/or
the union may not be interpreted as supportive.

Baumgart (1980) in Professional Obligations, Employment Responsibilities and Collective Bargaining: A New Agenda for the 1980's in an address given to the RNABC Labour Relations Division, 4th Annual Convention argues for the coexistence of the professional association and union. She states that both have specific and complementary roles. Baumgart predicts the "emergence of collective bargaining as a means of harmonizing professional interests and responsibilities with employment obligations" (pp.1) Baumgart expresses the concern that because of the lack of value attached to nurses' work, and the inhibition of the development of specialization amongst nurses, both to the advantage of hospital administration, nurses will have difficulty gaining greater autonomy and control over their work.

Summary.

The literature reviewed supports the category of the control of the work environment with the major properties of the terms and conditions of employment, although, clearly registration and education played important roles. The literature acknowledges that collective bargaining is a well established response in Canada, England and United States.

The strategies of nurses were seen to equivocate between
professionalism and unionism. The form of union activity and its
effect on the professional organization was discussed by several
authors. The issues remain unresolved. As with control of work
practice, the literature does not assist in supporting or negating
the postures or strategies of control suggested in the analysis of
this study.

Conclusion

This chapter has presented a review of selected literature
relevant to this study. The purpose of the literature review was to
compare the analytic core of the categories which emerged from the
data with the similarities and convergences of the literature. In
addition this literature review had the function of providing
comparisons for the groups which emerged from the data of this
study.

Collective bargaining as a response to the terms and
conditions of employment of nurses is well established in Canada,
England and United States. Collective bargaining as a strategy was
contrasted with the failure of so called professional strategies.
The role of cosmopolitans and locals, or elite and proleteriat
was confirmed by several authors. The concepts of control of the
work force, control of work practice and control of work environment
were also confirmed in the literature. Strategies of nurses were
seen as equivocating between professionalism and unionism.
No literature studied showed nurses or nursing associations using the strategy of lobbying and moral suasion to emerge, although the pattern of bargaining emerged. Similarly the postures of the RNABC, compromised control, co-ordinated control and bargained control could not be found in the literature. This is more likely due to the characteristics of the data base of this study rather than to the lack of similarity of the RNABC with other nursing associations.
CHAPTER 7

Explanations: Negotiations with External Forces

Introduction

The purpose of this chapter is to consider selected paradigms from the literature on social policy and from the literature of sociology in an attempt to explain the events, processes and trends (Smith, 1976) of the negotiation process.

Alford's (1972), "A Case of Dynamics without Change" can be used to explain the failure of the reformers, 1918-43. Similarities between the current American scene and the scene in British Columbia 1912-43 are described. From the English literature a paradigm of legitimacy, feasibility and support (Hall, Land, Parker and Webb, 1975) can explain the failure of the issue of the terms and conditions of nurses to be recognized and acted upon.

A brief discussion of the relationship of control contexts, social order and negotiation and the professions is presented by considering Johnson's typology of professions. The chapter concludes with brief comments on Etzioni's (1968) concept of societal processes and the entry of nurses in British Columbia to collective bargaining.
Alford (1972, pp.127-64) proposes a paradigm for examining the debate on the reform of the American health care system and the lack of change over the past 40 years. Using the concepts and discarding the detail applicable to the American scene, this paradigm becomes a useful tool for analyzing issues in the British Columbia health care scene that are related to the terms and conditions of employment of nurses. The American health care system which is controlled by private enterprise is analogous to the health care system in British Columbia prior to the introduction by the provincial government, of hospital insurance in 1949, and medical insurance in 1968. Alford proposes that there are two groups of reformers, market reformers and bureaucratic reformers, and three interest groups, corporate rationalizers, professional monopolists and the community. Market reformers "would expand the diversity of facilities available, the number of physicians, the competition between health facilities, and the quantity and quality of private insurance" (pp.128). Market reformers are those who believe that hospitals should serve as the organizational framework for health care delivery, and that problems of access should be resolved by increasing the numbers of physicians and facilities, and providing public insurance only for the poor.

Bureaucratic reformers "stress the importance of the hospital ... and wish to put individual doctors under the control of hospital medical boards and administrators"(pp.129). Bureaucratic
reformers are concerned primarily with coordinating fragmented services and instituting planning and public funding while keeping the hospital as the centre of a network of health services. The community population is seen as an external constituency of health providers to be organized to represent its interest for the maintenance of the system. The reforms concerning the role and organization of the professions are instigated by bureaucratic reformers. Alford describes corporate rationalizers as being composed of hospital administrators, medical school directors and government health officials, with an ideology of rational, efficient, cost conscious coordinated health care delivery. The professional monopolists are seen as supporting those bureaucratic reforms which protect their own interests. In Alford's paradigm they accuse the corporate rationalizers of not being concerned with personalized care. In turn professional monopolists are accused of setting up a screen of legitimacy to protect their own interests. Community interests are characterized as a group of people who are not part of a network of health institutions and thus are free to demand more and better health care. However, Alford points out that this group does not have the necessary information to lobby effectively, nor does it know the levers of power, the interests at stake or the actual nature of the (health care delivery) institution and thus its members are either coopted into the system or excluded from successful lobbying due to ignorance. Alford argues that the strategies of reform based on either 'market' or bureaucratic reform are unlikely to work because each type of reform stresses certain
core functions of the health system and regards the others as secondary. Government is not seen as an independent power standing above and beyond the competing interest groups because the major characteristics of the health system are due to private control. Alford concludes by arguing that "change is not likely without the presence of a social and political movement which rejects the legitimacy of the economic and social base of pluralist politics" (pp.164).

In applying this paradigm to British Columbia of the late 1920's and 1930's, George Pearson and George Weir can be characterized as bureaucratic reformers. Pearson chaired the hearings on Health Insurance in 1932 and was responsible for the 1936 Health Insurance legislation which was passed but never proclaimed. Had this legislation been proclaimed the unemployment and economic situation of nurses might have improved incrementally. Hospital would have ceased to be charitable institutions and thus nurses would have been freed from that particular ideological burden. As an academic George Weir prepared the survey of Nursing, 1932, and made specific recommendation to socialize medical and nursing care and to take nursing education out of the hospitals (Weir, 1932). On entry into politics he became Provincial Secretary and as such was responsible for the mental and tuberculosis hospitals of the province and for the province's support of charitable hospitals. When the question of the working conditions of nurses became political fodder (Steeves, pp. 100-101) the response was to initiate the Eaton survey or working conditions in hospitals in 1938. Steeves description of these events
suggests that Weir "had waited so long he could wait a bit longer", while the Premier is described as "waiting for the Report of the Rowell-Sirois Commission on dominion - provincial relations to see whether something hopeful would come out of it" (pp.121). The dynamics of party and federal-provincial politics stagnated the impetus for change. If the broad base of support for health insurance given by the plebiscite of 1937, was insufficient to prompt the government to act, little could be expected for nurses. When hospital insurance did come to the province in 1949, working conditions for nurses improved only gradually, and through the efforts of nurses, not those responsible for the health care system. The work week for graduate nurses was reduced from 48 to 40 hours by 1955. Student nurses continued to work longer hours. With the support of the Association, there was restraint in demand for improvement in salaries, until increased pressure from the grassroots supported by strike threats in 1957 and 1959 resulted in wage adjustments.

Of the interest groups, the corporate rationalizers represented by the hospital administrators and government officials could do nothing but gain by holding fast on the terms and conditions of employment of nurses. The debate on the "Amendments to Hospital Act and Hospital Regulations" at the BCHA annual meeting of 1938 (pp.20-21; 50-59; 76-77) is illustrative of this group acknowledging a need for improvement in working conditions but finding reasons, largely financial, not to implement change. The doctors as professional
monopolists supported voluntary registration for nurses. They were assured some control over the Association by participating in the annual examination of graduating students. The doctors lost interest in this activity and relinquished their role voluntarily, but exercised a more pervasive control in the work setting.

In this study, the community interests are the public at large and the Women's Institute of British Columbia and the Local Councils of Women. Eaton described the general community as being very concerned about the working conditions of nurses (1938, pp.30), but clearly no organized support, other than that offered by the CCF in the legislature, existed. The W.I.B.C. is described by Zacharias (1980, pp.69) as being instrumental in working with the BC Department of Health to establish health centres throughout the province. "By 1930, 132 public health nurses had been appointed as a result of women's representation" (Douglas, cited by Zacharias 1980, pp.69). The role of the W.I.B.C. in supporting public health is acknowledged in the 1921 Report of the Provincial Health Department. What the community interests, as represented by the Local Council of Women, could not influence was the medical monopoly over maternal care. The LCW lobbied to register midwives and later to permit the practice of midwifery "in scattered districts of Canada" (April 26, 1917). It is an interesting question whether the growth of public health nursing was a bureaucratic response to protect the medical dominance of maternal care. The nursing Association first opposed and later supported "advanced obstetrical training under medical
supervision" (April 22, 1935). The nursing profession supported medical dominance of this activity either because of a lack of confidence in nurses' training and knowledge, under the influence of the medicalization of natural processes or because of a lack of training and knowledge due to medical dominance. The issue of midwifery is an example of the dominance of professional monopolists at the expense of improving maternal and infant mortality rates. The issue of medical dominance arose again as technology expanded and the role of the nurse was questioned (January 5, 1950; November 14, 1953).

Summary.

In Alford's terms the nursing Association represented a weak professional monopolist because it could not control the work force giving nursing care and because it could not define work practice independently of the medical profession. Despite the presence of influential leaders, such as Grace Fairly, on the Health Insurance Committee of 1932, there is no evidence that the profession's opinion influenced the course of events until a strike vote was a reality.

Negotiation: The Importance of Legitimacy

Alford's paradigm is about the system, which if altered might have had a redistributory effect (Marchak, 1975) for nurses. This paradigm leaves unanswered the question of why the issue of the terms and conditions of employment of nurses was not dealt with directly as a
single issue, or as part of legislation regulating general working conditions.

An alternative approach for examining the lack of change in the terms and conditions of employment of nurses in British Columbia Hall, Land, Parker and Webb's model (1975) of legitimacy, feasibility and support. Hall et al. suggest there are three general criteria against which the claims of an issue may be measured. Legitimacy is determined by asking if it is an issue with which the government considers it should be concerned. Those issues which are considered legitimate may or may not be given priority. Feasibility is considered important because the possibility of taking steps to deal with a problem may determine its chances of gaining attention. Feasibility is determined by 1) the prevailing structure and distribution of theoretical and technical knowledge, 2) who (bearing in mind their ideologies, interests, prejudices and information) does the judging, and 3) the outcome of (government) testing for feasibility in relation to the use of resources, collaboration, and administrative feasibility. Support for an issue is recognized to be difficult to measure. In the short term what is thought to be public opinion is more important than an empirical evaluation.

This paradigm is most useful in explaining negotiation with external forces, but in passing it should be noted that negotiation within the Association on the means to deal with the issue of the terms and conditions of employment of nurses also took place within the framework of legitimacy, feasibility and support. Collective bargaining was a legitimate and feasible method of dealing with the
new registrar, Alice Wright (Wright, 1981). The legitimacy granted collective bargaining by the CNA in 1944 was probably influential in legitimizing collective bargaining for the general membership. Support for collective bargaining was denied by the general membership in 1944 but granted in 1946. The entry of the HEU into the scene may be viewed as forcing the legitimacy of collective bargaining for some of the membership. The interim period of negotiating recommended Personnel Practices with the BCHA may be seen as a version of collective bargaining viewed as feasible by the leadership. This is also true of the limited contract demands made until 1969. Some locals were dissatisfied with the leadership given during this period (Crawford, 1981).

In the case of external negotiations, the responsibility for the delivery of hospital care largely through charitable institutions until 1949, buffered the government from direct responsibility for the working conditions in hospitals. In the governments' view the issue of the terms and conditions of nurses did not have legitimacy. The feasibility of improving the terms and conditions of employment of nurses was largely a dollars and cents issue. The government rejected the possibility of granting increased funds for the salaries of nurses during the 1930's (Steeves, 1960, pp.100-102; 120-121). Percy Ward, as hospital inspector for the government, submitted a report on "economic Aspects" to the Eaton Report (1938, pp. 82-104). He was unable to predict the expected increased costs of granting nurses in government aided hospitals a basic salary of $60.00 per month with room and board because of varied administrative procedures in the
hospitals surveyed (pp.80-90). Thus the technical knowledge was too limited to produce concrete data to promote action.

There is also the case of the working conditions of student nurses, for whom the government had the regulatory power of control following the release of the Eaton Report in 1939. The argument that the effect of the Depression on the province and on Vancouver, the political chaos of the Liberal party, and its defeat (including George Weir) in 1941 as well as World War II (Ormsby, 1968, pp.469-479) was to place the problems of the nurses' too low on the agenda for the attainment of the political support necessary for change can be made. However, a minimum Wage Act which did not affect nurses, but did affect other hospital workers had passed in 1938. It would appear that the lack of legitimacy, at the political level and the lack of support at the bureaucratic level, exacerbated by a view of nurses as "form(ing) a group which absorbs economics made necessary by other demands and that the very fact that they can be depended upon to render service without protest and without drastic action has kept them working hours of such length that their health suffers and normal, essential social activities are denied to them" (Eaton, 1938, pp.12-13). Connelly (1978), Eichler (1973) and Smith (1973), discuss women at work in Canada which supports this general position. The struggle by women to achieve a 'legitimate' role in British Columbia is described in "In Her Own Right' (Latham and Kess, 1980).
Summary.

The terms and conditions of employment of nurses failed to gain the attention and action of the government because the issue failed to have the legitimacy, feasibility and support of the political and bureaucratic powers of government. Post-war, gains were made in the hours of work, and modestly, in salaries. The confrontation with the government expressed in the strike votes of 1957 and 1959, illustrate that the legitimacy, feasibility and support to improve the terms and conditions of employment of nurses did not alter until nurses forced the issue by calling a strike vote. Conditions for students improved incrementally on the wake of improvements for graduates. Marked improvement of conditions for students improved only when nursing education was removed from hospital schools.

Control Contexts, Negotiation and Social Order

With the comparison of the responses of the Association to attempt to control the work force, work practice, and work environment, three postures of control contexts were identified. These were compromised control, coordinated control and bargained control.

The concept of the exercise of control is about negotiation as a means of maintaining social order (Strauss, 1977, pp. 4-7; 234-239). The study of social order has been described as the central problem of sociology, Watkins (1975) writes that "the classical formation of the problem was provided by Thomas Hobbes, the 17th century
philosopher. The essence of it is given in the question. How, if human beings are fundamentally egotistical and self-seeking, is society possible? How is the individual to be restrained from simply grabbing all he can for himself without consideration for his fellows? How are individuals to be obliged to live together in reasonable harmony?" (1975, pp.2-3). There are however, two social orders in this study; an internal social order within the membership of the Association, and an external social order in the relationship of nurses as individuals, and as an Association in society.

Johnson (1972) suggests a model for studying occupational groups which rejects the usual approach of traits and functionalism to suggest that "various social mechanisms have arisen to 'manage' areas of social tension which present problems of social control" (pp.44). "Those occupations which are associated with peculiarly acute tensions ... have given rise to a number of institutionalised forms of control, 'professionalism' being one. Professionalism, then, becomes redefined as a peculiar type of occupational control rather than an expression of the inherent nature of occupations" (pp.45).

Johnsons' typology of profession is

1) collegiate control, in which the "producer defines the needs of the consumer and the manner in which these needs are catered for" (pp.45). Law and medicine exemplify this pattern.

2) patronage in which the "consumer defines his own needs and the manner in which they are to be met" (pp.46), and is
expressed as oligarchic or corporate forms of patronage. Communal control expressed as consumer politics is also present.

3) mediative in which "a third party mediates the relationship between the producer and consumer, defining both the needs and manner in which the needs are met" (pp.46). Capitalists and state mediative types are identified. In the state mediative type the state mediates between the producer and consumer. Thus this typology suggests three different ways in which professionals become bureaucratized, each "having varying consequences for occupational practice" and each being "the product of different institutionalized forms of control" (pp.85).

In the case of nurses, doctors mediate the relationship of the nurse with the patient (Bellaby and Oribar, 1980) by controlling the entry of the patient into the system (Watkins, 1975) while the state mediates the organization distribution and funding of the means of care. The entry into collective bargaining with the acceptance of the possibility of strike action represents the participation of the nursing association into this mechanism of social control. The 'first round' has been the negotiation of the terms and conditions of employment but the 'second round' is likely to deal with "the needs and the manner in which needs are met" as the disputes at Vancouver General Hospital and the role of the health Ministry exemplify (Bellyache at VGH, 1978). The state's entry into the mediative process in health care represents the state's concern for the "provision of social services in a general rather than a
personal service orientation of professionalism (pp.84). It may be that the
disruptions at VGH represents the ideological response of the personal
service orientation of nurses.

Summary

The concept of professions and the state as agents of
social control has been suggested. Collective bargaining by
nurses has been proposed as a response to the state mediation of
health care.

Negotiation and Societal Processes

This study began with an awareness of Etzioni's concept of the
shift in relationships within society from normativism to utilitarianism.
During the research process there was no attempt to look for data
which would confirm or disprove this concept. It would seem
appropriate, at the end of this study, to examine Etzioni's concept
in light of the findings of this study.

Etzioni (1968 pp.104) suggests that both individual and
organizational relationships within society may be characterized as
normative, utilitarian or coercive.

"A normative relationship entails shared values
and norms; the relating actors treat each other as
goals and their mutual commitments are non-rational.
Utilitarian relations entail a complementary interest;
the actors treat each other as means and commitments
are rational. Coercion entails the use or the
threatened use, of means of violence by one actor
against one or more other actors. Actors treat each other as objects, and the commitment may be either rational or non-rational. Concrete relations are frequently a mixture of the three kinds. However, one tends to dominate.... each of the three basic relationships serves as a base of both integration and cleavage, and that the very act of binding is also an act of setting a boundary." (pp.96).

He writes that cooperation is more likely to occur within the first, contained conflict within the second, and uncontained conflict within the third." (pp.96)

Within this concept of relationships Etzioni (pp.357) identifies three levels of power: persuasive power (eg. propaganda) is associated with normative relationships, utilitarian power is power expressed in economic terms and in terms of control over technical and administrative capabilities. Finally, coercive power is expressed with the use of weapons, and military force etc.

Professionalism represents the normative relationship between the nurse and the patient which developed as a natural extension of the vocationalism of nursing in the 19th c. (Williams, 1974). Williams notes that this vocationalism elevated the status of both the nurse and the patient. The sanctity of caring for a helpless adult human being established the meaning of the work of nursing in the social context in which it was performed. In this setting power was expressed in symbolic fashion by persuasion. The integrity of the nurse and patient remained intact.
Efforts to professionalize nursing began late in the 19th C (Abel-Smith, 1960) and in British Columbia resulted in the passing of the Registered Nurses' Act of 1918. Because nursing is seen to have achieved many of the characteristics associated with professionalization (Wilensky, 1964) and because nurses are seen to have a strong commitment to the service ideal ie: patient care, the RNABC is characterized as having a commitment to professionalism. Thus, the term 'professionalism' as it was interpreted in the first three quarters of the twentieth century, will be used to represent the normative stance of both the individual nurse and the association.

While normative relationships continued to dominate, a number of forces moved nursing towards utilitarianism. With the end of the First World War there was concerted effort to standardize and improve the education of student nurses, and improve the working conditions of graduate nurses. The end of private nursing duty as a major employment group in nursing changed the status of the majority of nurses from relatively independent practitioners to employees of institutions. This change in employment status and the rise of technology and the subsequent necessity for hospitalization institutionalized the relationships involved in the care of the sick. During this period, the value of nursing and the "proper conduct" of nurses and of the nursing society were dominant themes of the professional belief system (Jacox, 1971).
As nursing struggled to become complementary to the physician, took on increasingly sophisticated technical tasks and delegated direct human care to the assistant to the professional nurse, nursing attempted to declare itself an autonomous profession (Katz, 1969). Patients became both the means of work and the meaning of work. The helpless adult had become a clinical categorization, both nurse and the patient had lost their sanctity (Williams, 1974). In British Columbia, utilitarianism amongst nurses has been expressed as unionism since the early 1940's (Registered Nurses Association of British Columbia, Labour Relations Division, 1977). While unionism in nursing has continued to espouse a commitment to high standards of patient care, the dominant value is a "rational commitment" (Etzioni 1968, pp.96) to the institution of employment. This rational commitment was initially negotiated in economic terms and more recently in demands for direct participation in the decisions affecting the working environment. The recent demands (Unhappy VGH nurses, 1978) for increased participation in the decisions affecting the work environment may be part of the rational commitment to the institution of employment, or it may be a 'last fling' at negotiating normative relationships in patient care.

Summary.

This study would appear to confirm Etzioni's contention that relationships within society are moving from the normative to utilitarian. The price, for nurses, in this shift has been the loss of
sanctity for both the patient and the nurse. Collective bargaining by nurses in British Columbia has represented the move to utilitarianism. But collective bargaining has also represented an attempt to regain lost sanctity, firstly by establishing a competitive economic status and secondly by attempting to negotiate the context of the nurse-patient relationship.

Conclusion

This chapter has considered selected paradigms from the literature on social policy and the literature of sociology in an attempt to explain the failure of the terms and conditions of employment of nurses to improve, and the subsequent entry of nurses in British Columbia into collective bargaining.
CHAPTER 8

Ideological Shift: The Attempt To Resolve Chronic Strain

Introduction

This study began with the notion that the minutes of the Registered Nurses' Association of British Columbia would provide an explanation for the early development of collective bargaining by nurses in British Columbia. On one level the explanation can be reduced to the understanding that nurses in British Columbia were no longer willing to tolerate their perceived economic and social disparity. On another level, the data is a study of a shift in ideology of a specific group within society.

As was noted earlier, Blishen has written of the ideological response of doctors in Canada to social change, in particular to changes in the financing of health care. Similarly, this study is about the response of nurses in British Columbia, as reflected by the data in their Association's minutes, to changes in society. This chapter examines the ideological shift of nurses beginning with a discussion of the role of ideology and continuing with a discussion of the origins and evolution of nursing's ideological stance. This chapter concludes with some comment on the implications to the health care system of the shift of ideology of nurses.

The Role of Ideology

The role of ideology in the study of society has a long history (Geertz 1964, pp.47-52). Geertz writes that "there are
Currently two main approaches to the study of the social determinants of ideology: interest theory and strain theory (pp. 52).

Interest theory is considered to be rooted in the 'cultural idea systems' of social systems. Ideological statements are seen "against the background of a universal struggle for advantage, (pp. 52). While strain theory takes cognizance of social systems and personality systems, strain theory differs from interest theory in the acceptance of the idea that no social structure is completely successful in coping with conflicting values. Thus strain theory adopts the notion of the "chronic malintegration of society" (pp. 54).

Interest theory's concentration on individual or group quest for advantage is considered to be too simple an explanation. Thus Geertz quotes Sutton's definition of ideology as "a patterned reaction to the patterned strains of social role" (pp. 52).

The concept of strain is not viewed so much as "an explanation of ideological patterns but (as) a generalized label for the kinds of factors to look for in working out an explanation" (Sutton quoted by Geertz pp. 54). Geertz has identified four main classes of explanation for the use of ideology. These are 1) "the cathartic explanation" that is, "the safety-valve" or scapegoat theory... 2) "the morale explanation" that is, "the ability of ideology to sustain individuals (or groups) in the face of chronic strain... 3) the solidarity explanation... the power of ideology to knit a social group or class together..." and 4) the advocacy explanation "in which the ideologists state the problems for the larger society..." (pp. 55). Geertz
acknowledges the limitations of the concept of ideology and points out that the role of the symbolic outlet is more easily understood than the complex process of the symbolic formulation of ideology.

The Origins and Evolution of Nursing's Ideological Stance

To understand the origins and evolution of nursing's ideological stance, it is necessary to examine nursing's commitment to the care of the sick. The origins of the vocationalism of nursing, a calling which "involved the total submission and eradication of self" (Williams, 1974) is found in the portrait of nursing heroines and practitioners.

In the eyes of nursing historians, Fabiola, an early Christian saint, characterized the work of nursing sisters of both Roman Catholic and Protestant orders through whom nursing is said to have survived. (Goodnow, 1916) Florence Nightingale represented the 19th century expression of this calling.

Williams (1974) writes of the ideological resolution of the 'calling' to nursing and the reality of the social status and economic position of women of the 19th and 20th century, in relationship to the care of the helpless adult. The status of nurses was low, they had no legal right to wealth or property, except through men's dispensation, and male control was further sustained through the value of 'obedience'. "The relationship between doctors and nurses reflected the same structural and moral conditions of male dominance."
Then, as now, doctors have a monopoly of the knowledge relating to disease and its treatment, and nurses' work is regarded as being in service to this knowledge...". Obedience became the ideological resolution to the reality of social status and job situation of the 19th century nurse. Embodied in an ideology of vocationalism, "the servile role of nursing and the submission that it required of its incumbents, was consolidated and adjusted to psychologically. For, being called, a nurse could see her servility, not as her rightful place and her rightful work, but as her total sacrifice". This ideological stance was consistent with 19th century values, (religious, social and economic) and with Nightingale's effort to disabuse nursing of its image of Sairey Gamp. The performance of nursing acts for the sick adult were thus part of a sacrifical performance regarded by the nurse as her privilege and through which she found her satisfaction and fulfillment. Defining the care of the sick as a sacrificial performance elevated both the patient and nurse and conferred a sense of dignity on both (Williams, 1974).

Florence Nightingale adopted this spirit of vocationalism from Kaiserwerth (Goodnow, 1916, pp.49) and promoted it in England by establishing St. Thomas's school for lady pupils in 1860. The graduates were sought by North American schools of nursing (Gibbon and Mathewson, 1947, pp.146; Kalisch and Kalisch, 1978, pp.88-91) in an effort to reform lay nursing practice. The early nursing leaders did not envisage registration. Because of open recruitment and the spread of schools of nursing of varying quality, registration
represented a means of institutionalizing the reform of nursing. Nightingale did not support registration (Abel-Smith, 1960, pp.65) but the flexibility of the Nightingale legend (Whittaker and Olesen, 1967, pp.30-46) allowed early reformers to ignore this, although Abel-Smith (1960, pp.65) suggests that, in Britain, her views on registration may have been ignored for other reasons. Strauss (1966, pp.65-84) describes the adoption of the Nightingale model by nursing leaders in the United States. This model failed because of the proliferation of schools of poor quality. Subsequently an educational ideology (Strauss, 1966, pp.72) of reform through university education was adopted. It was the intention of those programs to change nursing by providing better qualified teachers who would teach nursing students better, and who would work towards decreasing students working hours and improving standards of care.

Nursing leaders in Canada and the United States have been closely associated since the first attempts to organize professional nursing associations in North America. The Nurses' Associated Alumnae Association of the United States and Canada was founded in 1896. The objects of the Association were to "establish and maintain a code of ethics, to elevate the standard of nursing education, to promote the usefulness and honor, the financial and other interests of the nursing profession". This Association later became the American Nurses' Association while the Canadian branch ultimately became the Canadian Nurses' Association in 1930 (Gibbon and Mathewson, 1947, pp.356-358). The influence of the educational models crossed the
49th parallel. British Columbia's nursing leaders participated in this process, initiating the opening of the first Canadian university school of nursing in 1920.

The outcome of this activity was to reinforce the idea of nursing as a profession in the minds of nurses and the public (Strauss, 1966, pp.71-72). This too was accomplished in British Columbia. During the legislative debates on registration, nursing was referred to as "an honourable and useful profession" (The nursing profession, 1916). Strauss points out that during this period a concept of a 'profession' had hardly been developed in North America. Flexner's report on medical education had enunciated the characteristics of a profession and the reform of medical education began. Although Canada was never faced with the diploma mills of the United States medical schools, Flexner did have an impact on Canadian medical education (MacNabb, 1970, pp.33). Because of the relationship between nurses and doctors, nurses looked up to physicians, and leaders such as Isabell Hampton-Robb reinforced this: "Medicine has made us a profession: now we must live up to it". (Robb. 1907), cited by Strauss, 1966, pp.72). From the points of view of sociologists, it was considered that, by 1933, nursing in England was becoming professionalized (Carr-Saunders and Wilson, 1933, pp.117-121). In North America, the debate has been lengthy with many considering nursing a semi-profession. Katz (1969) typifies this position.
Professionalism, as an ideology was adopted by nurses and became a source of conflict with the ideology of vocationalism. The value system of medicine and nursing shifted to a respect for the expert use of hospital based technology. The task of nursing shifted from intimate tasks 'performed sacrificially' such that the task, the nurse and the patient were 'sanctified and consecrated', to actions and judgements which were based on...mainly clinical definitions of illness and helplessness... . An ideology of vocation becomes dysfunctional or obsolete where skilled tasks require independent judgement rather than obedience, and since the acquisition of skills has to be paid for, the task to which they relate cannot then be regarded by society, doctors or nurses as menial. Since they are not seen as menial then they do not require a sacrifice of self, but seen as skilled they require, rather, an assertion of self in creative and innovative action.

These newer attributes of nursing are embodied in the ideology of Profession. When analysed in a specific context of usage it is seen as a claim for equality between nurses and doctors, and here the relation between men and women of the culture is again reflected. It asserts that nursing is a profession, and that as such 'it is not ancillary to medicine, but complementary to it. The claim to be a profession thus importantly involves the break of the traditional relationship between doctors and nurses, and we have seen that this relationship is one dimension of the image of the bedside nurse...

'Professional' imagery attends the bedside nurse performing tasks that are highly skilled. This is in contrast to the traditional bedside nurse whose work we have seen centred importantly on helplessness and was performed through notions of humanitarian service and newly constituted routines that preserved the person and adult-hood of the sick. Where a 'professional' nurse's work focuses on clinical procedures and observations, then helplessness as a condition of an adult human being may become categorised, and even lose itself as a human condition, through the emphasised use of clinical terms and clinically oriented judgements and behaviours of the nurse. (Williams, 1974).
As Williams states, the rise of a professional ideology resulted in a claim by nurses to control their own work. But before this claim was made, a comparison of the economic reward of the work of nurses to reward for the work of other workers was made by nurses. Canadian nurses were voicing a sense of economic disparity in the first issues of the Canadian Nurse (Canadian Nurse 1907; 1908). Early advocates such as Helen Randal, thinking change would come with improved education of nurses and with the education of society to the needs of nurses, used moral suasion to achieve the closure of numerous substandard schools in the Province. But improved education did not bring a change in working conditions, and a succession of advocates challenged the system. Thus Weir can be identified as an external advocate who made a very clear statement of the problems of nursing. The promise of health insurance sustained nurses for a period of time but not indefinitely. The CCF played an advocacy role in the late 1930's as did Mrs. Eaton. Internal advocates include the nurses who struck at Comox in 1939 and Alice Wright. While Alice Wright was hired by the Association because of her expertise in nursing education, with the expectation of acting as an educational consultant and managing the Association, she was confronted with 'restlessness amongst the nurses'. Alice Wright's successors in collective bargaining, Evelyn Hood and Nora Patton played roles that, although new, had been legitimized by the RNABC and CNA membership. Alice Wright would then, in Watkins' (1975) terms, have played a critical legitimizing role by virtue of her position in the social structure of nursing in British Columbia.
Underlying the ideologies of vocationalism, professionalism and reform through registration and improved education is a commitment to the care of the sick. The most clearly stated example of this commitment in this study is found in the interviews with practicing nurses quoted by the Eaton Report. The nurses are quoted as "believing that the very fact that they can be depended upon to render service without protest and without drastic action has kept them working hours of such length that their health suffers and normal essential social activities are denied to them" (Eaton 1938, pp.12-13). The commitment to this ideology, by both the leaders and the grassroots nurses insured the performance of roles "that otherwise might have been abandoned in despair or apathy" (Geertz, 1964, pp.55) Geertz has called this the 'morale explanation' of ideology, that is 'the ability of ideology to sustain individuals or groups in the face of chronic strain" (Geertz, 1964, pp.55). The commitment to the care of the sick also represents Geertz's solidarity explanation of ideology: that is, the power of ideology to bind a social group or class together. But as the narrative has shown, the ideological commitment of nurses, while never giving up a commitment to patient care, shifted in expression. This is the advocacy explanation of ideology (pp.55).

The chronic strain of nurses.

The chronic strain of nurses has three readily identifiable sources, 1) the nature of the work itself, 2) the terms and conditions under which the work is undertaken, and 3) the relationship of the
work and its rewards to the work and rewards of others. Thus far, in this study little attention has been given to the nature of the work itself. The work of nursing has been influenced by the development of technology in the care of the sick and the proliferation of allied health workers. As a consequence of the development of technology, medicine has passed to nursing its 'dirty work' (Hughes, 1958, pp.49-52) and a subsidiary work force has been introduced into nursing which allows nurses to delegate their own dirty work. In addition to Hughes' concept of dirty work, there is the dirty work that arises out of the care of patients that is not delegated. Williams (1974) has defined bedside nursing as "a complex compound of actions and tasks performed in a context of social relations, the evaluation of these tasks ... entails an evaluation of persons (specifically ... doctors, nurses and sick people) and their status relative to one another". Henderson has defined the function of the nurse as "assist(ing) the individual sick or well, in the performance of those activities contributing to health or its recovery (or a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible" (Henderson, 1964, pp.63). Thus far two types of dirty work have been identified, 1) those tasks delegated by medicine to nursing, and 2) those tasks related to the intimate care of patients. But there is a third type of dirty work not usually acknowledged beyond allusions to bedpans.
Esther Paulson describes how she, as the only nurse on a tuberculosis ward at the Royal Columbian Hospital in 1929 had to clean all the linen of blood and excreta before it went to the laundry in order to protect the laundry staff from possible infection. Helen Shore describes a similar activity as a student at VGH in the 1940's. While nurses are no longer required to prepare linen for the laundry, and hospitals are staffed with personnel assigned to clean the hospital premises nurses do continue to participate in modern versions of this type of work. But more importantly, technological advances have resulted in the possibility of salvaging patients devastated by trauma or surgical procedure, thus intensifying the nature of the intimate care of patients. Consequently nurses perform the tasks of the first two types of dirty work which may be profoundly distasteful. While these tasks have been accepted and performed as a part of nursing care, the reality of the second and third is often forgotten or ignored and thus it is important to recall them to establish the reality of nursing work. The difference between the performance of 'dirty work' with an ideology of vocationalism and the current ideology is that the loss of dignity and sanctity of both the patient and the nurse is intensified.

The fact that nurses continue to care for the sick illustrates Geertz's solidarity explanation of ideology, that is the power of ideology to bind a social group or class together. Greenwood (1966) has identified the existence of a professional culture as a characteristic of professional groups. Watkins (1976, pp.111-113)
takes this notion, and discusses it in terms of "something that may be meaningful and significant because certain individuals or groups have come to adopt it". He notes also that "the extent of their adoption of the 'ideal', the degree to which this in practice effects their behaviour, what they regard as circumstances which relieve them of various of the self-imposed obligations, are all matters of empirical fact and have to be discovered by investigation. It is also useful to recognize the existence of certain 'positions' in the social structure where persons may be located in an important 'controlling' way. In the case of the nurses in British Columbia, the obligations which developed out of the vocationalism of 19th century nursing and which were seen as the normative relationship between nurses and society changed over time. The change occurred because of changes in the technology of health care, changes in the practice of nursing and because of changes in the values and norms of society. These changes created a discrepancy which could not longer be accommodated. Advocates, within and external to nursing, attempted to accommodate the conflicting forces of the old ideologies and the new pressures. Geertz defines the advocacy explanation "of ideologies (and ideologists) as articulating, however partially and indistinctly, the strains that impel them, thus forcing them into the public notice. Ideologists state the problems for the larger society, take sides on the issues involved and 'present them in the court' of the ideological market place" (White, cited by Geertz). Although ideological advocates (not altogether unlike their legal counterparts) tend as much to
obscure as to clarify the true nature of the problems involved, they at least call attention to their existence and, by polarizing issues, make continued neglect more difficult" (pp. 55).

Conclusion: Omens for the Future

The move towards acceptance of collective bargaining by nurses was influenced by the shift from an ideology of vocationalism to professionalism. The failure of these ideologies to relieve the chronic strain of nurses, exacerbated by the recognition of the discrepancy in economic value between the nurse and subsidiary health workers and others in society, resulted in the adoption of collective bargaining. A factor in the development of militancy was that hospitals had ceased to be charitable institutions. While Provincial funding of hospitals (in 1948) did not relieve hospitals of economic pressures, nurses no longer had to view themselves as part of a charitable system. The demand for increased wages by nurses was restrained between 1948-56 but the rejection of the conciliation report by the hospitals in 1957 precipitated a new militancy. In 1959 a strike vote was taken to support increased wage settlements. The support of these actions by the Association represented an escalated level of militancy.

While nurses in British Columbia have been in the forefront of collective bargaining by Canadian nurses, there has been increased use of collective bargaining by employed professionals generally (Goldenberg, 1975) and this has, no doubt, been an important
legitimizing factor for nurses. Only in 1976 was strike action taken by nurses in British Columbia. (since the 1939 strike of the nurses of St. Joseph's Hospital, Comox) In other provinces, both nurses and doctors, had established precedents, (St. Justine's nurses strike, 1963; doctors' strikes in Saskatchewan, 1962, and in Quebec, 1967 and 1970). These strikes have been called to "protect the public interest" (Goldenberg, 1975, pp.286-288). Hall's prediction of conflict because of a "gross inequality in distribution of benefits" (Hall, 1967, pp.5) had materialized. However, negotiations on behavioural issues (Etzioni, 1968) have proved more difficult to solve for all professional groups (Goldenberg, 1975, pp.288).

The entry of the Association into collective bargaining has alleviated but not relieved nurses of their sense of economic disparity. Twenty years after nurses entered collective bargaining in British Columbia, Noel Hall, addressing the 50th Annual Conference of the BCHA in 1967, spoke of the value system of society which endorsed these disparities by virtue of the wage structure. He predicted, with particular reference to nursing, that conflict would result from a situation in which education, training and skill were valued but not rewarded.

The conflict has been defined only in economic terms until recently. The dispute at VGH in which several nursing administrators were summarily fired because of their attempts to deal with the lack
of grassroots nursing participation in the decisions that affect nurses work (Bellyache at VGH, September 2, 1978) represents an extension of the conflict in which education, training and skill are valued but not rewarded. Indeed, in Williams' terms, "the assertion of self in creative and innovative action" so valued in the professional nurse is thwarted.

Negotiation on the issue of the participation of nurses in the decisions that affect their work, that is, the terms and conditions under which employment for the practice of nursing is undertaken, is likely to be the next phase in the attempts by nurses to relieve their chronic strain. Because the underlying commitment to patient care seems to co-exist with Williams' concept of nurses' professional ideology, nurses will attempt to regain the dignity and sanctity of their work by bargaining on normative issues. Improved salaries cannot forestall this indefinitely (Krauss, 1977). This will challenge the present structure and organization of health at all levels of the delivery system. Since there are strong vested interests in the status quo the challenge will be met with active resistance. Turbulence more complex than that generated by the demand for improved salaries can be anticipated.


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APPENDIX A

CORRESPONDENCE CONCERNING
ACCESS TO THE BOARD AND
ANNUAL MINUTES OF THE
REGISTERED NURSES ASSOCIATION
OF BRITISH COLUMBIA