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Office: 313-577-1750 Fax: 313-577-8159

aaupaft@wayne.edu

www.aaup-aft.wayne.edu

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Nurses Seek Voice To Correct Understaffing at DMC

CEO Duggan Balks at "Fair Election Agreement" to Determine Union Status

By Steve Babson, Information Coordinator

You might think that in a professional work environment, particularly in a university-affiliated hospital, discussion of opposing views concerning staffing and union representation would be free of intimidation and bullying. Unfortunately, this has not been the case at the Detroit Medical Center (DMC).

From the moment last fall that nurses began to seek negotiations over chronic understaffing, President and CEO Michael Duggan has refused to support a "Fair Election Agreement" that would democratically determine whether or not the Michigan Nurses Association (MNA) will represent DMC nurses.

Instead, President Duggan has alternated between, on the one hand, public pronouncements of concern for nurses and the occasional concession to their needs, and, on the other hand, a campaign of intimidation aimed at nurse activists who call for change in DMC policies. Charges of illegal harassment of MNA supporters are currently before the National Labor Relations Board.

Many of our faculty and academic staff in the School of Medicine and College of Nursing interact on a daily basis with the approximately 2,000 registered nurses who work in the DMC's seven hospitals and allied clinics. For AAUP-AFT members and for

the surrounding community that relies so heavily on the DMC for medical care the issues raised in this dispute are vitally important.

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Understaffing and Patient Care

The single most important issue for DMC nurses is understaffing and its negative impact on patient care and the morale of direct-care staff.

The appropriate ratio of bedside nurses to patients varies by hospital and department, but for the largest number of patients in medical-surgical units, a 1-5 ratio is often cited as the minimum staffing level for adequate care. California mandates such a ratio in medical-surgical departments and a 1-2 ratio in acute care.

At DMC, nurses report that staffing ratios in medical-surgical units are commonly at a ratio of 1-8: that is, only one direct-care nurse to every eight patients. Too often, that ratio ranges upwards to 1-10 and higher. In acute care, a 1-4 ratio is reportedly common in many units.

There is ample evidence that this level of understaffing has a negative impact on patient care. As reported in the *Journal of the American Medical Association*, nurse researchers at the University of

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Pennsylvania found that “the odds of patient mortality increased by 7% for every additional patient in the average nurse’s workload” (Aikens et al, v. 288 no. 16). Citing a confidence interval of 95% for its findings, the Penn researchers concluded that a 1-8 ratio of nurses to patients would increase the odds of patient mortality by 31% compared to a 1-4 ratio.

They also found that at the 1-8 level of understaffing nurses are twice as likely to experience burnout and job dissatisfaction. Based on survey returns from more than 10,000 nurses, 43% of those reporting high levels of emotional exhaustion and job dissatisfaction planned to leave their current job in the next 12 months.

The experience of DMC nurses supports this conclusion. While many senior nurses struggle to continue working in a community they love, a high proportion of younger nurses leave the DMC within a few years to take jobs in suburban hospitals where the stress levels are lower— or they leave the profession altogether, contributing to the well documented shortage of nurses.

“Doctor Quality” or Collective Voice?

DMC management insists that there are already adequate means for individual nurses to report problems with staffing levels, and that collective bargaining is disruptive and unnecessary. Nurses can email President Duggan directly or submit individual complaints concerning mismanagement on a special electronic form called “Doctor Quality.”

It should be no surprise that most nurses regard “Doctor Quality” with a high degree of skepticism. A complaint from a single nurse is easily ignored or dismissed as unwarranted carping. When individual complaints aren’t addressed, the reporting system loses credibility. For less experi-

enced nurses, there is also an understandable reluctance to invite the disapproval of superiors by drawing attention to management policies that compromise patient care.

Individual nurses are left to bear the brunt of the consequent understaffing. Twelve-hour shifts stretch to 14 and 16 hours to cover for shortfalls, and nurses are routinely called in on their days off by colleagues pleading for help. When a nurse’s attention is spread over too many patients with too little support, it is the nurse (not the responsible managers) whose license is at risk when a medical emergency eludes timely detection.

It is for this reason— above all others— that the majority of nurses at the DMC main campus signed up with the Michigan Nurses Association last fall to seek a collective voice at work. Among their key priorities is to negotiate procedures that legally obligate management to provide adequate staffing for the bed-side care of DMC patients.

Double Standard

The double standard that President Duggan has promoted in response to these nurses is hard to square with principles of fair debate. Guided by anti-union consultants, DMC supervisors have repeatedly attacked the organizing efforts of the nurses, distributed anti-union leaflets and verbally disparaged collective bargaining.

This negative campaign would not be so objectionable if nurses were also permitted to state the positive case for collective bargaining. There is little tolerance, however, for nurses who try to communicate this side of the story. They have been subjected instead to a variety of bullying tactics designed to intimidate and silence those who object to severe understaffing:

- * Nurses who distribute leaflets that counter management’s claims have been threatened with discipline and written up if they persist. Members of the nurses’ “Organizing Committee for Change” have been singled out for harassment and threats.

- * Nurse advocates have been berated for even talking

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about organizing while they are at the same nursing stations where supervisors, in contrast, have openly denounced the MNA as “a cult” that has “hood-winked” the nurses.

* Activists have been called into interrogations by supervisors who state bluntly that support for the Michigan Nurses Association is seen by management as disloyalty. Newer nurses with little job security are especially vulnerable to this kind of intimidation, and some have been threatened into silence.

* As a group, nurses have been forced to sit through “captive audience” meetings where supervisors coached by IRI Consultants present a one-sided attack on the idea of collective bargaining. Supporters of the Michigan Nurses Association are not allowed to present the opposing view. Indeed, MNA representatives are barred from the premises.

A Call for Fair Elections

Supporters of the Michigan Nurses Association are confident they can win a fair election to determine whether or not a majority of nurses favor collective bargaining. There are, however, two obstacles that stand in the way of such a democratic process.

The first is the National Labor Relations Board (NLRB), the federal agency which conducts workplace elections to determine the level of employee support for collective bargaining. The NLRB is currently dominated by the Bush Administration’s pro-employer majority, led by Chairman Robert Battista, a corporate lawyer from Detroit who previously served Fortune 500 companies.

NLRB regulations have always been weak when it comes to preventing the intimidation tactics used by some employers. Chairman Battista has made matters worse in private-sector hospitals like the DMC with a 2006 decision re-defining “charge nurses” as members of management. As such, they are ineligible to vote in an NLRB-conducted election.

Most labor experts expect this decision to be overturned once Battista’s anti-union majority is removed from office. Many nurses rotate through the routine business of being a “charge nurse,” meaning they draw up the assignments determining which nurses cover which patients. Charge nurses are work leaders who continue to care for patients themselves and have no control over hiring, firing, or discipline—the traditional measures of management status.

Because this NLRB decision would artificially eliminate half the union supporters at the DMC, the Michigan Nurses Association has asked President Duggan to endorse an alternative set of rules, a “Fair Election Agreement,” that would allow a mutually acceptable determination of eligibility for voting. It would also ensure equal access to communication and debate within the hospital and promote a “mutually respectful” relationship between management and union representatives.

The NLRB permits alternative rule making when the two sides can agree on the terms of such an arrangement. Other hospital organizations have agreed to these terms, including Kaiser-Permanente, Healthcare Corporation of America, and Catholic Healthcare West. Dozens of Detroit’s community and religious leaders have urged President Duggan to do the same.

Duggan, however, has become the second obstacle to a fair election. Discussions between his office and the Michigan Nurses Association have been hot and cold for many months, with Duggan agreeing to some provisions of a fair election process and rejecting others. At the same time, he has insisted that an entirely unrelated group of over 300 “specialty nurses” and “Certified Registered Nurse Anesthetists” be included in the vote.

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Enter the Consultants

If President Duggan's goal is to delay a vote through endless (and futile) NLRB hearings or to prolong the process through continued stonewalling on a Fair Election Agreement, he is taking his cue straight from the script of anti-union consultants.

Justice delayed is, indeed, justice denied, and the rule of thumb among consultants is that the longer you stretch out the process, the more likely that union supporters quit or become demoralized, reverting to a silent cynicism.

This is very likely the counsel Duggan is receiving from IRI Consultants, the firm he has hired to coach DMC supervisors and guide management's campaign to fend off collective bargaining. IRI is well practiced in using the carrot, the stick, and (above all) procedural delay to neutralize union support without violating the NLRB's permissive standards on employer misconduct.

Their advice apparently does not come cheap. In a recent case where Yale-New Haven Hospital in Connecticut hired IRI Consultants to manage an anti-union campaign, a neutral arbitrator ruled last fall that

the tactics promoted by IRI were so abusive that the hospital had to pay \$4.5 million in fines to both the union and the workers. During the course of the arbitrator's investigation it was confirmed that IRI had charged the hospital \$2.2 million over nine months for its questionable advice. (*Arbitration Proceeding Before Margaret Kern, Yale-New Haven Hospital v New England Health Care Employees, District 1199, SEIU, 10/23/07*)

Since President Duggan has apparently made a similar commitment of funds, it is pertinent to ask who is paying the tab. Representatives of the Michigan Nurses Association have raised this question in recent hearings in Lansing, where the House Labor Committee is considering legislation (H.B. 4443) to prohibit the use of taxpayer monies to propagandize against union organization.

The DMC is the largest recipient of public healthcare funding in the state. The refusal of President Duggan to abide by a Fair Election Agreement is shameful enough. That we are very probably being taxed to pay for these undemocratic practices is worse yet. It's time to let the nurses decide through a free and fair election.

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