THE UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

AN ECONOMIC STUDY OF EMPLOYMENT CONDITIONS FOR REGISTERED PROFESSIONAL NURSES IN OKLAHOMA

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

DOCTOR OF PHILOSOPHY

BY

JACK W. NICKSON, JR.

Norman, Oklahoma

1963

AN ECONOMIC STUDY OF EMPLOYMENT CONDITIONS FOR

REGISTERED PROFESSIONAL NURSES IN OKLAHOMA

APPROVED BY

DISSERTATION COMMITTEE

ACKNOWLEDGMENTS

This acknowledgment is a token of my gratitude to the Oklahoma State Nurses Association for a grant which made this study possible. Special thanks should be extended to the membership of that association, and especially to Bernice Slater, their Executive Secretary, and to Juanita Proctor, who had the often tedious task of extracting the more salient points from the study for the members of the association.

Paul A. Brinker was the chairman of my Dissertation Committee, and without his constant surveillance I am certain this study could not have been completed. He, along with the other members of my Committee, were most generous with their time and their knowledge.

Above all, my appreciation goes to my wife, who, perhaps more than any other individual, contributed to the completion of this undertaking. Her patience and understanding were the most important part of my motivation.

To all of these I offer my most sincere gratitude for the contributions which they have made.

TABLE OF CONTENTS

Appendices Page

AN ECONOMIC STUDY OF EMPLOYMENT CONDITIONS FOR REGISTERED PROFESSIONAL NURSES IN OKLAHOMA

CHAPTER I

OBJECTIVES AND METHODOLOGY

The purpose of this study is to examine the economic status of registered professional nurses in the state of Oklahoma and to determine the role that should be adopted by the Oklahoma State Nurses Association in representing the state's professional nurses. Although similar studies have been, and are being, conducted in many parts of the United States, none have been carried out in Oklahoma.[1] Some preliminary research has been done for the state, but such work has been too narrow in scope to serve as an indication of the economic status of the state's nurses.[2]

---

[1]The following states and cities are among those which have already conducted studies similar to this one: Alabama, Arkansas, California, Georgia, Kansas, Minnesota, Missouri, New Hampshire, New York, North Carolina, Washington, Boston, Washington, D. C., and other regional, state, and national studies.

[2]Some of the more significant preliminary research regarding standards in the state of Oklahoma includes: William E. Rogers, Employment Practices With Respect to Nurses of Oklahoma, Studies in Business and Economics Number Ten (Norman, Oklahoma: Bureau of Business Research, College of Business Administration, The University of Oklahoma, October, 1953); Oklahoma State Hospital Advisory Council, Survey of Health Facilities and Needs--Oklahoma County, Oklahoma (Oklahoma City: Oklahoma State Hospital

Investigation of the available preliminary research indicated that more intensive study would be desirable.

Several further objectives were found to be necessary in order to achieve the purpose of this study. Determination of the economic status of nurses is dependent upon the measurement of certain indicators of standards of living and working conditions within the profession. Therefore, one further objective is to gather statistical data useful in the determination of the nurses' economic status. This involved not only the gathering of existing data, but the collection of new data which had not previously been available in a usable form. These accumulated data may have a secondary value in that they may prove useful in subsequent research.

A second objective implied by the general purpose of the study is an evaluation of the economic status of professional nurses. Such an evaluation presupposes the existence of some criteria. The criteria used in evaluating these data are developed and applied in the testing of these data.

Third, in order to determine the role that should be played by the Oklahoma State Nurses Association it is necessary to evaluate the past effectiveness of both the Oklahoma State Nurses Association (OSNA) and the American Nurses Association (ANA) regarding their influence upon the level of economic welfare

---

Advisory Council, December, 1959); and Division of Nursing Resources, Survey of Nursing Needs and Resources in Oklahoma--1956 (Oklahoma City: Federal Security Agency, Public Health Service, Division of Nursing Resources, April, 1951).

of the state's professional nurses. The procedures used by the ANA and OSNA to maintain and advance the economic status of nurses in Oklahoma are explored and assessed with a view to determining their strength and weaknesses.

A fourth aim of the study is to arouse interest in this area so that others will subsequently engage in additional research. It is hoped that the delineation of problems requiring additional research will serve as a stimulus to others.

The methodological approach employed in the study consists of a statistical survey of professional nurses in Oklahoma.[3] The survey of working conditions, job attitudes, and other indicators was conducted by means of a mail questionnaire sent to a representative group of nurses throughout the state. Five hundred nurses were sent questionnaires. Of these, 260, representing 52 per cent, returned usable replies. Those who filled out and returned usable questionnaires represented about 13 per cent of the estimated total of 1,888 currently registered nurses in Oklahoma.

It was felt that the mail questionnaire had several advantages over other possible means of collecting the desired information. A mail questionnaire is a less expensive method of collecting data than personal interviews, so that a larger sample can be taken with the same amount of funds. In addition, the

---

[3] A copy of the questionnaire used can be found in Appendix VI.

mail questionnaire allows the respondent to fill out the form at his own convenience. Lastly, inasmuch as the questionnaire asked for information which is often reluctantly given, it was felt that the mail questionnaire would make the obtaining of this confidential information somewhat easier than alternative possibilities.

The mail questionnaire, of course, has certain possible disadvantages. There is the possibility that the reply will be too small to be useful. It is also possible that the informant may not understand the questions, or that expensive, time-consuming follow-up work will be necessary. However, none of these problems assumed serious proportions in this study.

The survey was limited to those who have fulfilled the requirements for practice as a registered professional nurse. All branches of nurses were included. Because the nursing population in the state is somewhat heterogeneous, it was considered desirable to segregate the population into homogeneous subgroups on the basis of duties performed. Names were then selected from each subgroup at random. It was felt that this stratified random sampling technique would assure a satisfactory degree of representativeness.

The persons to be sent questionnaires were selected from the membership reports of the Oklahoma State Nurses Association, and approximately one out of every four names on the lists was selected.

The number of responses varied from one question to another, and answers falling into each category were expressed as percentages

of the total usable number of replies to the questionnaire. No attempt was made to exclude from the survey those questionnaires that did not provide answers to all questions.

The questionnaires were mailed during the second week in February, 1961. Respondents were given until the first week of July to return the questionnaires, after which time any returned questionnaires were not considered.

This survey produced data on salaries, working conditions, fringe benefits, attitudes, and so forth in the nursing profession. The results of the survey were then compared with data on the national level, with other geographical regions, and with comparable data in similar professions. In this way it was possible not only to establish factual data regarding salaries and other indicators of economic welfare, but also to state the position of Oklahoma nurses relative to nurses across the nation.

A second approach to the study involved an examination of existing literature in the nursing profession, including similar past studies in other states, historical sketches, professional periodicals, and publications of the ANA and the OSNA. An examination of this material was necessary to gain insight into the philosophy of the ANA and the OSNA, and to enable the study to take a fruitful path.

Several excellent sources of information were used to gain many of the needed ideas in this study. Of great importance were the records of the ANA and OSNA. Another valuable source

was Twenty Thousand Nurses Tell Their Story,[4] a book based upon more than thirty studies sponsored by the ANA, the American Nurses Foundation, and others. Various U. S. Department of Labor publications were also utilized to aid in the analysis and comparisons of professions. Other sources which were significant, though not as valuable as those mentioned here, appear in the bibliography. The data obtained from the statistical survey represent the most original and useful material in the study.

Chapter II, "Employment Analysis of the Nursing Profession," contains information on the economic status of nurses nationally and in certain regions. Here a comparison is made between the nursing profession and somewhat similar professions in an effort to weigh the advantages and disadvantages which exist in the nursing profession. To accomplish these objectives, selected statistics are presented on average starting salaries and the average number of hours worked per week by nurses in the United States. Similar data are also examined for nurses in selected cities and regions of the nation in order to provide a geographical basis for comparison. Selected data are also presented which make possible the comparison of the nursing profession with other occupations in which women generally seek employment.

The major part of the statistical data for Oklahoma is presented in Chapter III. It is here that the statistical analysis

---

[4]Everett C. Hughes, Helen MacGill Hughes, and Irwin Deutscher, Twenty Thousand Nurses Tell Their Story (Philadelphia and Montreal: J. B. Lippincott Company, 1958).

is presented as a result of the aforementioned survey. Such data as wage statistics, hours worked, fringe benefits, and cost of living data are carefully examined to determine important problems faced by Oklahoma nurses. Significant data are computed and compared to better define and delimit these problems.

Chapter IV, "Policy Implications of the Employment Analysis of Registered Professional Nurses in Oklahoma," contains a more complete examination of the problem areas uncovered by the statistical data in the previous chapter.

Next, in Chapter V, "Nurses and Collective Bargaining," an evaluation is made of collective bargaining as a technique for improving the economic problems of the state's registered professional nurses. Because the economic security program of the American Nurses Association would be likely to serve as the vehicle through which collective bargaining would take place at the state level, the role of that economic security program is examined in Chapter V.

Chapter VI, "Nurses and Legislation," contains an examination of various types of federal and state legislation which is pertinent to state nurses associations, and an examination of the legislation as it applies to the Oklahoma State Nurses Association.

Finally, Chapter VII presents the conclusions of the study.

CHAPTER II

SUMMARY OF NATIONAL, REGIONAL AND OCCUPATIONAL ASPECTS OF NURSING

Because a knowledge of economic conditions within a profession is essential to the alleviation of adverse conditions in that profession, selected national statistics for the nursing profession are examined in this chapter. The purpose of this and the following chapter is to discover the economic conditions of the nursing profession in order to determine its relatively favorable or adverse aspects.

In this chapter data are provided on salaries and working conditions. Data are also presented which suggest economic differences between various occupations from which the woman worker may choose employment. Not only is it relevant to note salary conditions of nurses across the country and to examine salary differences among various regions of the nation, it is also significant to note how women in nursing fare when compared with women in other fields such as social administration, library work, diatetics, secretarial work, medical technology, or stenography. In some of these fields the educational requirements are similar to those in professional nursing and this makes useful

comparisons possible.

This examination of national and regional data serves to give a basis for comparison, and is, therefore, useful to the analysis. Further, these data take on added significance when compared with employment statistics for the nursing profession in Oklahoma. The Oklahoma data, from a sample obtained by the writer, comprise the greater part of the following chapter.

The data of Table 1 serve as a point of departure, showing the average starting salaries of general duty nurses in

TABLE 1

AVERAGE STARTING SALARIES OF GENERAL DUTY NURSES IN THE UNITED STATES, SELECTED YEARS, 1945-1959

Year	Average Gross Monthly Starting Salary	Average Hours Scheduled Per Week
1959	$294	41
1958	286	41
1956	262	41
1955	253	41
1953	242	42
1951	224	44
1949	213	45
1945	155	48

Source: Women's Bureau, U. S. Department of Labor, 1960 Handbook on Women Workers, Bulletin 275 (Washington, D. C.: U. S. Government Printing Office, 1960), p. 78, citing American Hospital Association, "Hospital Salary Survey."

the United States for selected years. It can be seen that salaries of general duty nurses almost doubled between the years of 1945 and 1959, climbing from $155 a month in 1945 to $294 by 1959. Thus, the salary increase in this fourteen-year period was almost 90 per cent. Yet the external personal and professional qualifications necessary to become a nurse, as shown in Appendix VI, lead to the implication that even after this large increase, the salary scale of the general duty nurse is not at a level commensurate with her educational and professional background. In a comparison of working men and women with four years of college, the U. S. Department of Commerce showed that the median income for women in 1958 was approximately two-fifths of men's income--about $242 per month for women.[1] For comparison, the range of nurses' salaries is between $300 and $425 per month--still only 49 to 71 per cent of the income of men with equivalent levels of education.[2]

In Table 2 both starting and current median monthly salaries are presented for the general duty nurse, the head nurse, the supervisor of nursing, and the director of nursing service. It can be seen in this table that the highest starting salary in 1959 was $385. General duty nurses are seen to have

---

[1] U. S. Department of Commerce, Bureau of the Census, "Current Population Reports," P-60, No. 33 (Washington: U. S. Government Printing Office, 1960), p. 5.

[2] See Table 2 of this study.

had the lowest starting salary, with the top salary going to the director of nursing service. Still, the highest median salary reported was $385 per month. Current median monthly salaries, also given in Table 2, varied from a low of $300 a month to a high salary of $425 a month for the director of nursing service.

TABLE 2

MEDIAN MONTHLY SALARIES OF NURSES IN NON-FEDERAL GENERAL HOSPITALS IN THE UNITED STATES, CLASSIFIED BY TYPE OF DUTY PERFORMED, FEBRUARY, 1959

Classification	Median Monthly Salary[a]	
	Current Salary	Starting Salary
Director of nursing service	$425	$385
Supervisor of nursing	360	340
Head Nurse	326	310
General Duty Nurse	300	286

[a]Living out, or living in with cost of maintenance deducted from salary.

Source: Women's Bureau, U. S. Department of Labor, 1960 Handbook on Women Workers, Bulletin 275 (Washington, D. C.: U. S. Government Printing Office, 1960), p. 78, citing American Nurses' Association, Spot Check of Current Hospital Nursing Employment Conditions, February, 1959.

A detailed presentation of monthly salaries before deductions of Oklahoma nurses is given in Table 3. When all

TABLE 3

REPORTED MONTHLY SALARIES BEFORE DEDUCTIONS OF OKLAHOMA NURSES, CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961

Monthly Salary Bracket	Type of Duty Performed									
	School Nurses		Head Nurses		General Duty Nurses		Private Duty Nurses		Occupational Health Nurses	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Less than $150	0	0.0	2	5.1	3	7.7	0	0.0	0	0.0
$151 - 200	0	0.0	2	5.1	0	0.0	2	10.0	0	0.0
201 - 250	0	0.0	0	0.0	2	5.1	0	0.0	0	0.0
251 - 300	1	9.1	6	15.4	9	23.1	3	15.0	0	0.0
$301 - 350	4	36.4	15	38.5	14	35.9	2	10.0	0	0.0
351 - 400	4	36.4	6	15.4	3	7.7	5	25.0	1	33.3
401 - 450	1	9.1	2	5.1	3	7.7	4	20.0	1	33.3
451 - 500	0	0.0	2	5.1	3	7.7	3	15.0	0	0.0
$501 - 550	1	9.1	2	5.1	2	5.1	1	5.0	1	33.3
551 - 600	0	0.0	1	2.6	0	0.0	0	0.0	0	0.0
601 - 650	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Over $650	0	0.0	1	2.6	0	0.0	0	0.0	0	0.0
Sub-total[a]	11	100.0	39	100.0	39	100.0	20	100.0	3	100.0
Unusable Replies	0		3		6		28		8	
Grand total	11		42		45		48		11	

TABLE 3--Continued

Type of Duty Performed										Total	
Public Health Nurses		Office Nurses		Institutional Nurses		Educational Administrators and Teachers		Other			
Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
0	0.0	2	14.3	1	4.2	0	0.0	0	0.0	8	4.0
0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	4	2.0
1	4.0	2	14.3	0	0.0	0	0.0	1	12.5	6	3.0
5	20.0	1	7.1	2	8.3	2	11.1	1	12.5	30	14.9
11	44.0	4	28.6	5	20.8	2	11.1	3	37.5	60	29.8
3	12.0	3	21.4	7	29.2	4	22.2	2	25.0	35	17.4
3	12.0	1	7.1	6	25.0	6	33.3	0	0.0	27	13.4
1	4.0	0	0.0	0	0.0	1	5.5	0	0.0	10	5.0
0	0.0	1	7.1	0	0.0	2	11.1	0	0.0	10	5.0
1	4.0	0	0.0	1	4.2	0	0.0	1	12.5	4	2.0
0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
0	0.0	0	0.0	2	8.3	1	5.5	0	0.0	4	2.0
25	100.0	14	100.0	24	100.0	18	100.0	8	100.0	201	100.0
3		0		9		0		2		59	
28		14		33		18		10		260	

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

categories of nurses are taken as a group, almost 30 per cent of those nurses reported that their monthly salary fell between $301 and $350 per month. This group represented almost twice the number in the next largest category. And well over half of all Oklahoma nurses are seen to fall into a salary range of between $251 and $450, while 23.9 per cent receive less than $301 per month.

The mean salary for all categories of Oklahoma nurses was $348. The average monthly salaries computed by the writer from the questionnaire data for the specific classifications are given below in descending order:

Occupational health nurses	$488
Educational administrators and teachers	415
Institutional nurses[3]	398
School nurses	366
Private duty nurses	361
ALL NURSES	361
Public health nurses	345
Head nurses	343
General duty nurses	323
Office nurses	310

Thus, the highest paid group of nurses in Oklahoma is seen to be the occupational health nurses, with office nurses receiving

---

[3]The category of institutional nurses includes the director of nursing service and supervisors. While figures were not obtained for these two categories separately, if national ratios are applied to appropriate data on the state level the average salary for the director of nursing service in Oklahoma would be approximately $460 per month; the average salary for supervisors would be about $388. If these two categories had been excluded from the institutional nurses, the average salary for the group would be slightly less than that shown above.

the lowest monthly salary. Occupational health nurses, educational administrators and teachers, institutional nurses, and school nurses receive higher average salaries than the average for all nurses, while public health nurses, head nurses, general duty nurses, and office nurses receive a salary lower than that for all nurses. The average salary for private duty nurses is the same as that for all nurses in the state.[4]

The absence of extreme values in the survey data makes these figures (arithmetic means) representative of the salary status of each category. However, the median figures are given below for the same categories. This is done to provide a comparison with median figures given earlier in the chapter for the nation and on a regional basis. The median figures, when compared with other median figures for the region and the nation, will provide a useful means of comparison of salary data.

---

[4]In contrast to the salary picture of registered professional nurses in Oklahoma, that of social welfare workers for the nation as a whole provides a beneficial comparison. About 71 per cent of the social welfare workers employed by state and local governments hold a bachelor's degree. Thus a large per cent do not. In this respect, the social welfare worker is somewhat comparable to the professional nurse. Yet, the average annual salary in all positions of local and state agencies in mid-1960 was $5,210. And the median annual salary of all social welfare workers employed in federal government agencies in 1960 was $6,480. Executives without a bachelor's degree, employed by state or local governments, earned approximately $5,000 a year. Supervisors in the same category earned slightly more, while direct-service workers earned slightly less.

These salary figures for social welfare workers indicate a rather large discrepancy between their salaries and the salaries of registered professional nurses in Oklahoma--a discrepancy which may lend support to the notion that registered professional nurses in the state are underpaid on the basis of what they might earn in

The following median monthly salaries were found to exist for each category of professional nurses in Oklahoma:

Occupational health nurses	$450
Educational administrators and teachers	408
Private duty nurses	380
School nurses	356
ALL NURSES	345
Institutional nurses	340
Public health nurses	333
Head nurses	331
Office nurses	328
General duty nurses	319

Turning to a geographical comparison of nurses' salaries, Table 4 contains data for four categories of professional nurses in several regions. Oklahoma is included within the Southwest region. It can be seen that salaries in the Southwest region are among the lowest for all four categories of nurses.

Table 5 contains additional data on a geographical basis. Industrial nursing represents the highest paid category among professional nurses. The average weekly salaries of this group of nurses is shown in Table 5 by various regions. In view of the data in Table 2 it may be assumed that the salaries of industrial nurses in the various metropolitan areas are the highest salaries paid to any group of professional nurses in their respective regions.

While no data are available for a metropolitan area in Oklahoma, salaries in the Dallas, Fort Worth, and Kansas City areas

---

similar occupations. (The data presented in this footnote are derived from data presented by Toivo P. Kanninen, et. al., op. cit., pp. 862-68 and pp. 379-87, respectively.)

TABLE 4

MEDIAN MONTHLY CURRENT SALARIES[a] OF FULL-TIME PROFESSIONAL REGISTERED NURSES, IN NONFEDERAL GENERAL HOSPITALS, BY POSITION AND REGION, FEBRUARY, 1959

Region[b]	Director of nursing service	Supervisor	Head nurses	General duty nurses
United States	$425	$360	$326	$300
New England	c	335	325	295
Middle Atlantic	458	370	326	287
Border States	c	356	310	285
Southeast	400	320	290	260
Great Lakes	435	380	355	320
Middle West	375	350	310	290
Southwest	400	325	320	284
Mountain	c	350	310	294
Pacific	500	395	370	330

[a]Salaries are basic gross cash salaries, before deductions, for nurses who live out or who live in and have cost of maintenance deducted from salary.

[b]The states included in each region are: New England--Connecticut; Middle Atlantic--New Jersey, New York, and Pennsylvania; Border States--Delaware, District of Columbia, Kentucky, Maryland, Virginia, and West Virginia; Southeast--Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee; Great Lakes--Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin; Middle West--Iowa, Kansas, Missouri, Nebraska, North Dakota, and South Dakota; Southwest--Arkansas, Louisiana, Oklahoma, and Texas; Mountain--Arizona, Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming; Pacific--Alaska, California, Nevada, Oregon, and Washington.

[c]Insufficient number to compute median.

Source: American Nurses Association, Facts About Nursing (Research and Statistics Unit, American Nurses Association, New York, 1960), p. 121.

TABLE 5

AVERAGE WEEKLY SALARIES OF INDUSTRIAL NURSES IN SELECTED METROPOLITAN AREAS OF THE UNITED STATES, 1960

Area	Number of Women	Average Weekly Salary
Baltimore	151	$ 93.50
Boston	249	84.50
Buffalo	180	95.50
Canton (Ohio)	66	93.50
Cleveland	271	97.00
Dallas	79	86.00
Dayton	81	93.00
Denver	39	85.00
Des Moines	20	88.50
Detroit	497	102.00
Fort Worth	33	103.00
Indianapolis	102	96.00
Kansas City (Mo.-Kans.)	103	91.50
Memphis	29	83.50
Miami	32	78.50
Minneapolis-St. Paul	102	88.00
Newark-Jersey City	313	91.50
New Orleans	43	90.50
Philadelphia	299	89.50
Pittsburgh	323	98.50
Portland (Me.)	9	77.00
Providence	92	73.00
Richmond (Va.)	52	95.00
St. Louis (Mo.-Ill.)	204	89.00
San Bernardino-Riverside-Ontario (Calif.)	29	96.50
San Francisco-Oakland	143	96.50
Seattle	78	98.50
York (Pa.)	17	78.00
Washington, D. C.	57	86.00

Source: Women's Bureau, U. S. Department of Labor, 1960 Handbook on Women Workers, Bulletin 275 (Washington, D. C.; U. S. Government Printing Office, 1960), p. 80, citing U. S. Department of Labor, Bureau of Labor Statistics, "Occupational Wage Surveys."

can perhaps be considered somewhat comparable to salaries in Oklahoma metropolitan areas, at least for the purpose of geographical comparisons. The arithmetic average of these three areas is a weekly salary of $93.50, which is greater than the average weekly salaries in fifteen of the metropolitan areas examined, but is less than the average weekly salaries in two metropolitan areas. The average weekly salary for all metropolitan areas examined is $90.29, as compared to the $93.50 for the areas of Dallas, Fort Worth, and Kansas City.

This comparison is, of course, somewhat arbitrary when applied to the situation existing in Oklahoma. A more meaningful picture of the Oklahoma situation is found in the following chapter, where data descriptive of the economic status of nurses in Oklahoma are presented.

Although data on the starting and current salaries within the nursing profession are relevant, it is necessary to compare salaries of the nursing profession with those of other professions before reaching conclusions regarding the economic status of registered professional nurses.[5] Data which are helpful in making this

---

[5]While consideration at this juncture might also be given to the notion of the relative elasticity of the supply of nurses with respect to the salary scale (i.e., whether or not higher pay would increase the supply), the more meaningful area of analysis appears to lie in comparing the nursing profession with alternative occupations available to the nurse. For while the professional nurse may not be economically free to choose between working and being idle, she is nevertheless relatively mobile in comparison with women of other occupations requiring similar training and a comparable level of formal education.

type of comparison are presented in Table 6. Here, average annual salaries can be compared for various occupations in which women commonly seek employment and which can be considered somewhat comparable to the nursing profession. However, it must be remembered that any comparison among various occupations is somewhat arbitrary since no two occupations are entirely statistically comparable. Nevertheless, the occupations given in Table 6 represent occupations requiring similar levels of education. These data can, therefore, be used to gain a rough approximation of the relative economic status of nurses as compared to that of other occupations. These data are classified by region also, in order to provide for further geographical comparisons.

From Table 6 it can be seen that for the United States as a whole five of the selected occupations receive a higher average annual salary than do nurses. These occupations include chemists, mathematicians and statisticians, home economists, research workers, and therapists. However, when examining the South (which includes Oklahoma), biological technicians also out-rank the nursing profession in terms of average annual salary. Of the occupations represented, nurses in the South receive higher annual salaries than do teachers, social and welfare workers, dietitians, secretaries and stenographers, and typists.

A more complete analysis of occupations is afforded by Table 7, though on a national level only, and only for women in selected occupations in Federal service for the year 1954. Out of 23 selected occupations, the public health nurse ranks tenth in

TABLE 6

STARTING SALARIES OF JUNE 1957 WOMEN COLLEGE GRADUATES, CLASSIFIED BY TYPE OF DUTY PERFORMED AND GEOGRAPHICAL REGION, IN THE UNITED STATES

Occupation	Number of Graduates	Average Annual Salary				
		United States	Northeast	North Central	South	West
Total Graduates represented	63,945[a]	$3,739	$3,764	$3,860	$3,381	$4,050
Chemists	569	4,847	4,847	-----	-----	-----
Mathematicians, statisticians	627	4,675	4,608	-----	-----	-----
Home economists	808	4,040	3,965	-----	4,011	-----
Research workers	626	3,971	3,955	-----	-----	-----
Therapists	701	3,947	-----	3,957	-----	-----
NURSES	4,302	3,875	3,845	4,167	3,673	3,814
Technicians, biological	1,586	3,854	3,595	3,987	3,897	4,000
Teachers	39,320	3,799	3,840	3,925	3,348	4,185
Social and welfare workers	1,266	3,792	3,752	3,791	3,553	4,131
Dietitians	401	3,576	3,624	-----	-----	-----
Secretaries and stenographers	4,089	3,295	3,437	3,403	3,069	3,372
Typists	449	3,104	-----	-----	3,222	-----

[a]Includes some graduates whose occupations are not shown separately or who did not report their occupation, as well as a few graduates working outside continental United States.

Source: Women's Bureau, U. S. Department of Labor, 1960 Handbook on Women Workers, Bulletin 275 (Washington, D. C.: U. S. Government Printing Office, 1960), p. 81, citing Women's Bureau Bulletin No. 268, "First Jobs of College Women: Report on Women Graduates, Class of 1957."

TABLE 7

WOMEN'S AVERAGE SALARIES IN SELECTED OCCUPATIONS IN FEDERAL SERVICE, 1954

Civil Service Commission occupational series	Number of women employees	Average annual salary
Medical officer	267	$8,144
Social administration	166	7,430
Attorney-advisor	172	6,905
Business economics	85	5,908
Statistics	416	5,693
Adjudicating	370	5,552
Position-classification	663	5,543
Physics	112	5,541
Bacteriology	227	5,348
PUBLIC HEALTH NURSE	186	5,168
Budget administration	610	5,110
Chemistry	559	5,067
Mathematics	450	4,937
Library	2,889	4,799
Dietitian	1,069	4,785
NURSE	19,128	4,450
Information and editorial	2,862	4,277
Secretary	22,783	3,741
Medical technician	1,265	3,729
Clerk-stenographer	46,349	3,296
Clerk-typist	77,368	3,115
Nursing assistant	8,208	2,973
Sorting-machine operation	155	2,823

Source: Adapted from Women's Bureau, U. S. Department of Labor, 1960 Handbook on Women Workers, Bulletin 275 (Washington, D. C.: U. S. Government Printing Office, 1960), p. 83, citing the U. S. Civil Service Commission.

average annual salaries received, and the nurse (all categories) ranks sixteenth. The only occupations receiving a lower annual salary than the nurse are informational and editorial, secretary, medical technician, clerk-stenographer, clerk-typise, nursing assistant, and sorting-machine operation--all requiring less formal preparation than the field of nursing.

While the data presented here are not adequate for as many comparisons as would be desirable between nursing and other professions, they nevertheless provide some insight into the nursing profession and yield a basis for some significant comparisons. It seems fair to conclude, after an examination of these tables, that salaries in the nursing profession are considerably lower than salaries in comparable occupations requiring similar educational and professional backgrounds. And in Table 6 it has been seen that the situation for the professional nurse in the South is somewhat worse than that of nurses in other geographical regions.

But the real test of the economic status of registered professional nurses in Oklahoma must be the examination of economic data applicable to nurses in Oklahoma alone. Only then can adequate comparisons be made and significant conclusions reached. And it is to this end that attention is now directed. When examining the data in Chapter III, educational criteria, the national salary picture, and other similar information already alluded to or contained in the appendix should be carefully considered.

CHAPTER III

EMPLOYMENT STATISTICS FOR THE NURSING PROFESSION IN OKLAHOMA

In order to determine employment conditions for the state's professional nurses it is necessary to compile certain types of economic data concerning salaries and working conditions. The compilation of such data was made possible through the use of a mail survey of a sample of registered professional nurses in Oklahoma.[1] The survey enabled the writer to present data which give some indication of the employment conditions facing a portion of the state's nurses, even though the data may not be representative of the whole of Oklahoma nurses. Replies to the questionnaire represented 13 per cent of the state's estimated 1,888 registered professional nurses. Most of the information contained in this chapter results from that survey.

Information was obtained on employment status, tenure, income, length of the work week, on-call duty, salary supplements, overtime payments, other types of compensation, sick leave, work schedules, insurance and retirement coverage, policy determina-

---

[1]The nature of this survey is explained more fully in Chapter I and Appendix V.

tion, and job satisfaction. An analysis of each of these categories is presented below.

Full-time vs. Part-time Job Status

An analysis of nurses according to whether their work is of a full-time or a part-time nature is presented in Table 8. It can be seen that almost 87 per cent of the respondents to the questionnaire reported that they were employed full-time. Of the various groups of nurses, 100 per cent of those in four categories reported that they worked full-time. These categories were: educational administrators and teachers, public health nurses, occupational health nurses, and school nurses.

At the other extreme less than half of the private duty nurses questioned reported that their employment was full-time. This low figure for private duty nurses is understandable, of course, because of the nature of their work, which involves working on individual cases as they are needed. Between 82 and 87 per cent of the office nurses, general duty nurses, and head nurses in Oklahoma work full time, with 12 to 18 per cent of jobs in those classifications being filled by part-time workers.

Tenure in Nursing

The data in Table 9 show, quite surprisingly, that almost one out of six (17.8 per cent) of the total number of nurses questioned reported that she had been a professional nurse for over 30 years, a remarkably high degree of job tenure. A second high category of tenure was between 11 and 20 years, with over

TABLE 8

NUMBER AND PER CENT OF OKLAHOMA NURSES REPORTING FULL- AND PART-TIME EMPLOYMENT CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961[a]

Classification	Total Employed		Employed Full-Time		Employed Part-Time		Unusable Returns
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number
Educational Administrators and Teachers	18	100.0	18	100.0	0	0.0	0
Institutional Nurses	24	100.0	23	95.8	1	4.2	9
Office Nurses	14	100.0	12	85.7	2	14.3	0
Public Health Nurses	23	100.0	23	100.0	0	0.0	5
Occupational Health Nurses	4	100.0	4	100.0	0	0.0	7
Private Duty Nurses	21	100.0	10	47.6	11	52.4	27
General Duty Nurses	39	100.0	34	87.2	5	12.8	6
Head Nurses	39	100.0	32	82.0	7	18.0	3
School Nurses	11	100.0	11	100.0	0	0.0	0
Others	10	100.0	9	90.0	1	10.0	0
Totals	203	100.0	176	86.7	27	13.3	57

[a]With respect to this table and Tables 9 through 35, which follow, the returned questionnaires were received from February 10 through July 1, 1961.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 9

LENGTH OF TIME AS A PROFESSIONAL NURSE, AS REPORTED BY OKLAHOMA NURSES, CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961

CLASSIFICATION	0-10 Years		11-20 Years	
	Number	Per Cent	Number	Per Cent
Educational Administrators and Teachers	6	33.4	5	27.8
Institutional Nurses	6	25.0	5	20.8
Office Nurses	3	21.4	6	42.9
Public Health Nurses	3	12.0	5	20.0
Occupational Health Nurses	0	0.0	2	50.0
Private Duty Nurses	1	4.3	9	39.1
General Duty Nurses	9	23.1	15	38.5
Head Nurses	6	15.0	16	40.0
School Nurses	1	9.1	3	27.3
Others	3	30.0	2	20.0
Totals	38	18.3	68	32.7

TABLE 9--Continued

21-30 Years		Over 30 Years		Total Usable Replies[a]		Unusable Replies
Number	Per Cent	Number	Per Cent	Number	Per Cent	Number
5	27.8	2	11.1	18	100.0	0
8	33.3	5	20.8	24	100.0	9
3	21.4	2	14.3	14	100.0	0
14	56.0	3	12.0	25	100.0	3
2	50.0	0	0.0	4	100.0	7
6	26.1	7	30.4	23	100.0	25
6	15.4	9	23.1	39	100.0	6
14	35.0	4	10.0	40	100.0	2
3	27.3	4	36.4	11	100.0	0
4	40.0	1	10.0	10	100.0	0
65	31.2	37	17.8	208	100.0	52

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

32 per cent of those questioned falling into this category.

The majority of educational administrators and teachers are shown to have been professional nurses between 11 and 30 years (over 55 per cent). About one-third of the institutional nurses reported having been professional nurses from 21 to 30 years. The highest number of private duty, general duty, and school nurses reported that they had been professional nurses between 11 and 20 years.[2]

Occupational health nurses showed the greatest spread in their length of time as professional nurses, with the few nurses in this category in the sample being evenly distributed between 11 and 30 years of service.[3] Head nurses were concentrated in the 11-20 year bracket. Most office nurses reported 11-20 years of service, and over half of the public health nurses reported 21-30 years of service.

Bases for Salary Increases

Also important to the professional nurse is the basis upon which she can expect to be granted salary increases. That is, are salary increases granted simply on the basis of length of service in her present position, on the basis of merit, on

---

[2]It is possible that these figures reflect something not readily apparent. The OSNA expresses concern because new graduates do not join the association for a number of years after entering the nursing profession. Hence, these figures may have an upward bias.

[3]However, the small number of usable replies obtained for occupational health nurses was small; therefore, the length of service suggested by those replies should not be interpreted as necessarily being representative of the majority of occupational health nurses.

the basis of some combination of length of service and merit, or on some other basis?

Table 10 contains the bases for salary increases for professional nurses in the state of Oklahoma, as reported by the nurses themselves. The largest number of responding nurses in Oklahoma receive salary increases on the basis of length of service and merit combined. The number reporting this basis for salary increases represented over 45 per cent of those questioned. Almost 30 per cent of those reporting said that salary increases were based on length of service, and were automatic. Almost 14 per cent of Oklahoma nurses receive salary increases purely on the basis of merit.

It is also shown in Table 10 that over 10 per cent of those questioned reported some other basis for granting salary increases. By far the most common reason given by this group was "at the discretion of the employer" or "whenever employer's income is sufficient." In these cases nurses can see no set pattern for salary increases.

It is interesting to note that 70 per cent of the school nurses questioned reported that salary increases were based on length of service and were automatic. The remaining school nurses reported length of service and merit as a basis for increases. None reported merit alone as a basis for salary increases.

TABLE 10

REPORTED BASES UPON WHICH SALARY INCREASES ARE GRANTED TO OKLAHOMA NURSES, CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961

Classification	Basis for Salary Increases			
	Length of Service (Automatic)		Merit	
	Number	Per Cent	Number	Per Cent
Educational Administrators and Teachers	1	6.7	1	6.7
Institutional Nurses	6	46.2	6	46.2
Office Nurses	3	25.0	3	25.0
Public Health Nurses	6	24.0	5	20.0
Occupational Health Nurses	0	0.0	1	25.0
Private Duty Nurses	0	0.0	2	50.0
General Duty Nurses	17	50.0	0	0.0
Head Nurses	8	26.7	2	6.7
School Nurses	7	70.0	0	0.0
Others	2	20.0	3	30.0
Total[a]	50	29.9	23	13.8

TABLE 10--Continued

Basis for Salary Increases						
Length of Service and Merit		Other		Total		Unusable Replies
Number	Per Cent	Number	Per Cent	Number	Per Cent	Number
12	80.0	1	6.7	15	100.0	3
8	61.5	3	23.1	13	100.0	10
4	33.3	2	16.7	12	100.0	2
11	44.0	3	12.0	25	100.0	3
3	75.0	0	0.0	4	100.0	7
0	0.0	2	50.0	4	100.0	44
14	41.2	3	8.8	34	100.0	11
17	56.7	3	10.0	30	100.0	12
3	30.0	0	0.0	10	100.0	1
4	40.0	1	10.0	10	100.0	0
76	45.5	18	10.8	167	100.0	93

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

Length of the Work Week

Tables 11, 12, and 13, which follow, contain information regarding the number of days worked per week by professional Oklahoma nurses, the number of weekly hours those nurses are on call, and compensation received for on-call duty, if any. The number of nurses who receive extra compensation for professional expenses is indicated in Table 14.

An examination of these tables shows that almost 80 per cent of the professional nurses in Oklahoma reported working five days a week. This is considered by many as a normal working week. However, the table also contains data showing that over 11 per cent of the nurses in the state work six days a week. While this 11 per cent represents only slightly more than one out of ten professional nurses in the state, the figure is nevertheless significant. Moreover, more than 15 per cent of the state's professional nurses work six or seven days a week. And, as will be pointed out later, many of these work without the benefit of overtime compensation.

On-Call Duty

While around 80 per cent of the nurses questioned worked only five days a week (Table 11), many of those nurses not actually working overtime were on call. Table 12 contains these data. Significantly, almost 48 per cent of those reporting indicated that they were on call more than 100 hours per week. They are subject to be called to duty if the need arises. This, of course,

TABLE 11

REPORTED NUMBER OF DAYS WORKED PER WEEK
BY OKLAHOMA NURSES, EARLY 1961

Number of Days Worked	Number of Nurses	Per Cent of Total Nurses
One Day	1	0.5
Two Days	6	2.8
Three Days	3	1.4
Four Days	2	0.9
Five Days	168	79.2
Six Days	24	11.3
Seven Days	8	3.8
Sub-total[a]	212	100.0
Unusable Replies	48	
Grand Total	260	

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 12

REPORTED NUMBER OF WEEKLY HOURS OF ON-CALL DUTY FOR OKLAHOMA NURSES ACTUALLY ON CALL, EARLY 1961

Number of Hours on Call	Number Reporting	Per Cent of Total Nurses
1- 25 hours per week	10	22.7
26- 50 hours per week	8	18.2
51- 75 hours per week	3	6.8
76-100 hours per week	2	4.5
More than 100 hours per week	21	47.7
Totals[a]	44	100.0

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 13

REPORTED NUMBER AND PER CENT OF OKLAHOMA NURSES RECEIVING COMPENSATION FOR ON-CALL TIME NOT WORKED, BY TYPE OF COMPENSATION, EARLY 1961

Type of Compensation	Number Reporting	Per Cent of Total
Compensatory time off	11	25.0
Half-time pay	0	0.0
Time-and-one-half pay	0	0.0
No compensation	27	61.4
Other compensation	6	13.6
Totals	44	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

limits the nurses' activities during non-working hours. It is significant too that none of the nurses questioned considered that they were never on call. Most indicated that on-call duty was to be considered part of their job. In addition, over four per cent of the nurses pointed out that they spend as much as 76 to 100 hours per week on call.

Yet, in Table 13 it can be seen that over 61 per cent of the state's nurses receive no compensation whatsoever for on-call time not actually worked. About 25 per cent receive compensatory time off, and over 13 per cent receive some other form of compensation. But none reported receiving pecuniary compensation for their on-call duty.

Compensation for Professional Expenses

Another possible source of income to Oklahoma nurses is examined in Table 14, which shows the number of nurses receiving compensation for professional expenses. It can be seen in this table that over 77 per cent of the nurses in Oklahoma receive no compensation for professional expenses. Of the approximately 22 per cent who do receive compensation, slightly less than half receive variable travel expenses, and most of these are public health nurses. By "variable travel expenses" is meant that mileage and meals are paid when traveling to conventions and/or professional meetings. The remaining nurses who do receive compensation for professional expenses receive between $1 and slightly over $20 per month. Thus, compensation for professional expenses

TABLE 14

REPORTED NUMBER AND PER CENT OF OKLAHOMA NURSES RECEIVING COMPENSATION FOR PROFESSIONAL EXPENSES, BY AMOUNT RECEIVED, EARLY 1961

	Number	Per Cent
Number Receiving Compensation:	45	22.3
Amount of Compensation:		
1) Travel expenses (variable)	20	44.4
2) $1-10 per month	4	8.9
3) 11-20 per month	2	4.4
4) 21-30 per month	2	4.4
5) Over $20 per month	7	15.6
Number Not Receiving Compensation:	157	77.7
Sub-total	202	100.0
Unusable Replies	58	
Grand Total	260	

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

can be seen to be a relatively minor source of gross income for the professional nurses in Oklahoma.

Salary Supplements

Maintenance in addition to salary could also be an important source of income for professional nurses; and this possibility is examined in Table 15. This table contains the percentage of Oklahoma nurses "living in" and "living out" by classification. The type of maintenance, if any, received by these two groups of nurses is presented in Tables 16 and 17.

About eight per cent of the nurses responding reported that they live in, while over 92 per cent live out. Thus, any maintenance received by nurses living in appears relatively insignificant in obtaining the over-all picture of maintenance. Of those living in and receiving maintenance, most reported that the maintenance received was in the form of free laundering of uniforms or the provision of uniforms. The next most common type of maintenance for nurses living in is the provision of a room. About 20 per cent of those living in and receiving maintenance reported that they were provided with a room. Only six of the 40 nurses receiving maintenance received either one, two, or three meals. Further, many of those reporting meals as a type of additional maintenance receive discounts on meals instead of free meals.

Of those living in, educational administrators and teachers, institutional nurses, and school nurses appear to receive the most maintenance. Of the educational administrators and

TABLE 15

REPORTED NUMBER AND PER CENT OF OKLAHOMA NURSES LIVING IN AND LIVING OUT, CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961

Classification	Total		Living In		Living Out		Unusable Replies
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number
Educational Administrators and Teachers	18	100.0	2	11.1	16	88.9	0
Institutional Nurses	24	100.0	3	12.5	21	87.5	9
Office Nurses	14	100.0	0	0.0	14	100.0	0
Public Health Nurses	24	100.0	1	4.2	23	95.8	4
Occupational Health Nurses	4	100.0	0	0.0	4	100.0	7
Private Duty Nurses	23	100.0	1	4.3	22	95.7	25
General Duty Nurses	39	100.0	2	5.1	37	94.9	6
Head Nurses	39	100.0	2	5.1	37	94.9	3
School Nurses	11	100.0	1	9.1	10	90.9	0
Others	9	100.0	4	44.4	5	55.6	1
Total Usable Replies[a]	205	100.0	16	7.8	189	92.2	55

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 16

REPORTED NUMBER AND PER CENT OF OKLAHOMA NURSES LIVING IN WHO RECEIVE MAINTENANCE IN ADDITION TO SALARY, CLASSIFIED BY TYPE OF DUTY PERFORMED AND BY TYPE OF MAINTENANCE, EARLY 1961[a]

Classification	Type of Maintenance					
	Room		Laundry		Uniforms	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Educational Administrators and Teachers	0	0.0	2	40.0	2	40.0
Institutional Nurses	2	22.2	3	33.3	3	33.3
Office Nurses	0	0.0	0	0.0	0	0.0
Public Health Nurses	1	100.0	0	0.0	0	0.0
Occupational Health Nurses	0	0.0	0	0.0	0	0.0
Private Duty Nurses	0	0.0	0	0.0	0	0.0
General Duty Nurses	0	0.0	0	0.0	1	100.0
Head Nurses	0	0.0	0	0.0	0	0.0
School Nurses	0	0.0	1	50.0	1	50.0
Others	5	27.3	7	31.8	6	27.3
Total	8	20.0	13	32.5	13	32.5

TABLE 16--Continued

Type of Maintenance							
Meals						Total[b]	
One		Two		Three			
Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
1	20.0	0	0.0	0	0.0	5	100.0
1	11.1	0	0.0	0	0.0	9	100.0
0	0.0	0	0.0	0	0.0	0	100.0
0	0.0	0	0.0	0	0.0	1	100.0
0	0.0	0	0.0	0	0.0	0	100.0
0	0.0	0	0.0	0	0.0	0	100.0
0	0.0	0	0.0	0	0.0	1	100.0
0	0.0	0	0.0	0	0.0	0	100.0
0	0.0	0	0.0	0	0.0	2	100.0
0	0.0	1	4.5	3	13.6	22	100.0
2	5.0	1	2.5	3	7.5	40.	100.0

[a]The columns in this table and Table 17, which follows, are partially overlapping. That is, a nurse receiving maintenance in the form of a room may also receive maintenance in the form of meals.

[b]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 17

REPORTED NUMBER AND PER CENT OF OKLAHOMA NURSES LIVING OUT WHO RECEIVE MAINTENANCE IN ADDITION TO SALARY, CLASSIFIED BY TYPE OF DUTY PERFORMED AND BY TYPE OF MAINTENANCE, EARLY 1961

Classification	Type of Maintenance					
	Room		Laundry		Uniforms	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Educational Administrators and Teachers	1	12.5	4	50.0	3	37.5
Institutional Nurses	0	0.0	8	42.1	8	42.1
Office Nurses	0	0.0	4	66.7	2	33.3
Public Health Nurses	0	0.0	1	33.3	2	66.7
Occupational Health Nurses	1	14.3	4	57.1	2	28.6
Private Duty Nurses	2	25.0	0	0.0	2	25.0
General Duty Nurses	1	3.6	13	46.4	12	42.9
Head Nurses	0	0.0	11	37.9	11	37.9
School Nurses	0	0.0	0	0.0	0	0.0
Others	0	0.0	2	18.2	2	18.2
Total	5	4.2	47	39.5	44	37.0

TABLE 17--Continued

Type of Maintenance							
Meals						Total[a]	
One		Two		Three			
Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
0	0.0	0	0.0	0	0.0	8	100.0
3	15.8	0	0.0	0	0.0	19	100.0
0	0.0	0	0.0	0	0.0	6	100.0
0	0.0	0	0.0	0	0.0	3	100.0
0	0.0	0	0.0	0	0.0	7	100.0
4	50.0	0	0.0	0	0.0	8	100.0
1	3.6	1	3.6	0	0.0	28	100.0
7	24.1	0	0.0	0	0.0	29	100.0
0	0.0	0	0.0	0	0.0	0	100.0
4	36.4	2	18.2	1	9.1	11	100.0
19	16.0	3	2.5	1	0.8	119	100.0

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

teachers, one reported receiving one meal, while two reported receiving laundry and two reported receiving a uniform allotment. Of the institutional nurses, two reported receiving maintenance in the form of a room, one received one meal, and six received laundry and uniforms. School nurses received no room or meals, with half of those reporting maintenance received in the form of laundry and half in the form of uniforms.

Turning next to Oklahoma nurses living out who receive maintenance in addition to salary, it was seen that the most common form of maintenance received was laundry (over 39 per cent), while almost as many (37 per cent) received uniforms. Laundry and uniforms were the most common type of maintenance received by all of the other categories examined with the exception of private duty nurses. In the case of private duty nurses, 50 per cent received one meal and 25 per cent received their room. (Nurses living out who received a room as a form of maintenance were allowed the use of a room while on duty, but did not actually live in the room.)

Overtime Compensation

With a significant number of nurses working overtime (see previous discussion), it is important to examine the number of Oklahoma nurses eligible for overtime compensation, and the type of overtime compensation they are eligible to receive. In Table 18 the type of overtime compensation is divided into straight-time pay, time-and-one-half pay, compensatory time off, straight time or time off at the nurse's option, none, and other forms of compensation.

TABLE 18

NUMBER AND PER CENT OF OKLAHOMA NURSES REPORTING ELIGIBILITY FOR OVERTIME COMPENSATION, CLASSIFIED BY TYPE OF DUTY PERFORMED AND TYPE OF OVERTIME COMPENSATION, EARLY 1961

Classification	Type of Overtime Compensation					
	Straight-time Pay		Time-and-one-half Pay		Compensatory Time Off	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Educational Administrators and Teachers	0	0.0	0	0.0	6	37.5
Institutional Nurses	2	8.7	0	0.0	4	17.4
Office Nurses	0	0.0	0	0.0	3	27.3
Public Health Nurses	0	0.0	0	0.0	9	42.8
Occupational Health Nurses	1	25.0	3	75.0	0	0.0
Private Duty Nurses	1	9.1	1	9.1	0	0.0
General Duty Nurses	11	31.4	2	5.7	11	31.4
Head Nurses	9	33.3	2	7.4	5	18.5
School Nurses	1	20.0	0	0.0	0	0.0
Others	1	11.1	1	11.1	1	11.1
Totals[a]	26	16.0	9	5.6	39	24.1

TABLE 18--Continued

Type of Overtime Compensation						Unusable Replies
Straight Time or Time Off (Option)		None		Total		
Number	Per Cent	Number	Per Cent	Number	Per Cent	Number
0	0.0	10	62.5	16	100.0	2
5	21.7	9	39.1	23	100.0	10
0	0.0	8	72.7	11	100.0	3
0	0.0	12	57.1	21	100.0	7
0	0.0	0	0.0	4	100.0	7
1	9.1	8	72.7	11	100.0	37
4	11.4	7	20.0	35	100.0	10
3	11.1	8	29.6	27	100.0	15
1	20.0	3	60.0	5	100.0	6
1	11.1	5	55.6	9	100.0	1
15	9.2	70	43.2	162	100.0	98

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

A large proportion (43.2 per cent) of the nurses questioned reported that they were not eligible for overtime payments of any sort. Sixteen per cent reported that they received straight-time pay for all work over forty hours, and over 24 per cent reported that they received compensatory time off. Only slightly over five per cent of the professional nurses in the state received time-and-one-half pay for working over forty hours in a given week. The only group which offers a major exception to a lack of time-and-one-half compensation were the occupational nurses. About 75 per cent of the nurses in this group received time-and-one-half pay for overtime. Still, the remaining one-fourth received only straight-time pay.[4]

Five categories of nurses reported that they received no time-and-one-half pay for overtime. These were: educational administrators and teachers, institutional nurses, office nurses,

---

[4]It should be pointed out here that the United States Fair Labor Standards Act has established that the work-week shall be forty hours, and that overtime shall prevail for all work over forty hours--providing the industry or profession falls under the coverage of that act.

Because of certain exempt provisions, the nursing profession is not covered by these stipulations. Nevertheless, it appears logical to assume that a forty-hour work week would be as desirable for the nursing profession as for other professions covered by the act. Although the optimum length of the work week for professional nurses may vary slightly from other professions, no reason is readily apparent that would lead to the conclusion that such figures would be significantly different. Hence, the assumption is made in this study that a forty-hour week, with over-time provisions for all work over forty hours, is a desirable goal for the nursing profession.

The 43 per cent figure given above would perhaps be higher had returns to this question been more complete. (63.6 per cent of the replies were not usable.)

public health nurses, and school nurses. Most of the nurses in these categories received no overtime compensation of any type when they worked overtime. Of the nurses in these five categories receiving some type of overtime compensation, the modal group received compensatory time off. A large number of general duty nurses (11 out of 35) and head nurses (9 out of 27) received straight-time pay for overtime work, with many in these two categories receiving an option of straight-time pay or time off.

Other Types of Compensation

Aside from direct salary payments, there are other indirect forms of compensation which are important to the nursing profession.[5] One such form of compensation is paid holidays. The

---

[5]A survey of estimated 1957 fringe benefits made by E. P. Schmidt, of the United States Chamber of Commerce, reported average annual fringe benefits in all industries and professions of $981, representing an increase of 58 per cent from the previous decade. These benefits include: $310 for the employer's share of agreed-upon pension and insurance programs; $311 for time not worked (vacations, holidays, etc.); $170 for the employer's share of social insurance (unemployment compensation, workmen's compensation, old-age and survivors insurance, etc.); $104 for paid rest periods, lunch periods, etc.; and $86 for bonuses and profit-sharing payments. Fringe benefits averaged 21.8 per cent of payroll for all companies, 20.3 per cent in manufacturing, and 24.2 per cent in non-manufacturing. Benefits varied, as would be expected, from industry to industry and from region to region. (Data is taken from: E. P. Schmidt, Fringe Benefits in 1957, Washington, D. C., Chamber of Commerce of the United States of America, 1958, as quoted in Dale Yoder and Herbert G. Heneman, Jr., Labor Economics and Industrial Relations, South-Western Publishing Company, Cincinnati, Ohio, 1959, p. 440.)

The above figures do not, of course, point to any definite level of fringe benefits that would be desirable for the nursing profession in Oklahoma. The figures do, however, point to the increasing emphasis placed on compensation other than direct salary payments. A brief glance at the fringe benefits of Oklahoma

number of Oklahoma nurses receiving paid holidays and the number of holidays received is pointed out in Table 19. The number of nurses who receive extra compensation for holiday work is examined in Table 20.

About 57 per cent of the Oklahoma nurses reported receiving six paid holidays per year, while over 14 per cent receive seven days, and an additional ten per cent receive eight days. All categories of Oklahoma nurses except public health nurses, occupational health nurses, and school nurses reported six paid holidays as the most frequently occurring number. More than 41 per cent of the public health nurses questioned received only five paid holidays, while 50 per cent of the occupational health nurses questioned reported receiving eight paid holidays each year. As one might expect, the school nurses represented a rather unique group, receiving more holidays than other nurses.

By comparison vacations with pay are nearly universally provided to social welfare workers. Of those working for state and local agencies, 97 per cent receive a two-week paid vacation or more, 56 per cent receive three weeks or more, and 16 per cent receive four weeks or more.[6] And, only about one per cent of all office workers and five per cent of all plant workers do not re-

---

nurses makes apparent the fact that nurses in the state do not enjoy fringe benefits in the same magnitude as other professions in the nation.

[6]Toivo P. Kanninen, "Economic Status of Social Welfare Workers," Monthly Labor Review, Vol. 84, No. 8, August, 1961, p. 867.

TABLE 19

REPORTED NUMBER AND PER CENT OF OKLAHOMA NURSES RECEIVING PAID HOLIDAYS, CLASSIFIED BY TYPE OF DUTY PERFORMED AND NUMBER OF PAID HOLIDAYS PER ANNUM, EARLY 1961

Classification	Number of Paid Holidays							
	Less Than Four		Four		Five		Six	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Educational Administrators and Teachers	0	0.0	0	0.0	2	11.8	12	70.6
Institutional Nurses	1	4.2	0	0.0	0	0.0	15	62.5
Office Nurses	2	14.3	0	0.0	4	28.6	6	42.9
Public Health Nurses	0	0.0	0	0.0	7	41.2	4	23.5
Occupational Health Nurses	0	0.0	0	0.0	0	0.0	1	25.0
Private Duty Nurses	0	0.0	0	0.0	0	0.0	0	0.0
General Duty Nurses	1	3.3	1	3.3	2	6.7	20	66.7
Head Nurses	6	17.6	1	2.9	2	5.9	21	61.8
School Nurses	0	0.0	1	14.3	1	14.3	2	28.6
Others	0	0.0	0	0.0	0	0.0	8	100.0
Total	10	6.4	3	1.9	18	11.6	89	57.4

TABLE 19--Continued

Number of Paid Holidays						Total		Unusable Replies
Seven		Eight		Over Eight				
Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent[b]	Number
2	11.8	1	5.9	0	0.0	17	100.0	1
4	16.7	3	12.5	1	4.2	24	100.0	9
2	14.3	0	0.0	0	0.0	14	100.0	0
4	23.5	2	11.8	0	0.0	17	100.0	11
1	25.0	2	50.0	0	0.0	4	100.0	7
0	0.0	0	0.0	0	0.0	0	100.0	48[a]
3	10.0	4	13.3	2	6.7	30	100.0	15
4	11.8	3	8.8	0	0.0	34	100.0	8
0	0.0	1	14.3	2	28.6	7	100.0	4
2	25.0	0	0.0	0	0.0	8	100.0	2
22	14.2	16	10.3	5	3.2	155	100.0	105

[a]Private duty nurses reported receiving no paid holidays.

[b]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 20

REPORTED NUMBER AND PER CENT OF OKLAHOMA NURSES RECEIVING EXTRA COMPENSATION FOR HOLIDAY WORK, CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961

Classification	Nurses Reporting "Yes"	
	Number	Per Cent
Educational Administrators and Teachers	1	5.9
Institutional Nurses	3	12.5
Office Nurses	1	14.3
Public Health Nurses	3	15.0
Occupational Health Nurses	2	100.0
Private Duty Nurses	0	0.0
General Duty Nurses	8	22.8
Head Nurses	7	18.9
School Nurses	1	16.7
Others	1	14.3
Total[a]	27	15.6

TABLE 20--Continued

Nurses Reporting "No"		Total		Unusable Replies
Number	Per Cent	Number	Per Cent	Number
16	94.1	17	100.0	1
21	87.5	24	100.0	9
6	85.7	7	100.0	7
17	85.0	20	100.0	8
0	0.0	2	100.0	9
18	100.0	18	100.0	30
27	77.2	35	100.0	10
30	81.1	37	100.0	5
5	83.3	6	100.0	5
6	85.7	7	100.0	3
146	84.4	173	100.0	87

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

ceive paid holidays. For those who do receive paid holidays, the national average is 7.8 days for office workers and 6.9 days for plant workers. Seven paid holidays is the average number received by office workers, with service workers falling between six and six-and-one-half days. Further, of the service workers, 23 per cent receive four or more weeks of paid vacation per year, 69 per cent receive three weeks or more, 96 per cent receive two weeks or more, and 99 per cent receive one week or more.[7]

Compensation for Holidays Worked

A significant proportion of the nurses in Oklahoma do not receive extra compensation if it becomes necessary for them to work on a holiday. When asked the question, "Do you receive extra compensation for holiday work?" over 84 per cent replied negatively, with less than 16 per cent replying affirmatively. The occupational health nurse group offered the only major exception to this pattern. All of that group reported that they do receive extra compensation for holiday work. But, on the other hand, over 94 per cent of the educational administrators and teachers questioned reported no extra compensation, as did more than 80 per cent of all other groups except the occupational health group and the general duty nurses. About 77 per cent of the general duty nurses received no compensation, however. Thus, it can be seen

---

[7]Otto Hollberg and Alexander Jarrell, "Supplementary Wage Benefits in Metropolitan Areas, 1959-60," Monthly Labor Review, Vol. 84, No. 4, April, 1961, pp. 383-84.

that with the exception of the occupational health nurses, the vast majority of nurses in Oklahoma receive no extra compensation for holiday work.

Sick Leave Provisions

In addition to paid holidays, paid sick leave is another important fringe benefit to any worker. The number of days of paid sick leave received per year by professional nurses in Oklahoma is pointed out in Table 21. A study of this table reveals that about 32 per cent of the Oklahoma nurses receive between 11 and 13 days of paid sick leave each year, and about 31 per cent receive between 14 and 16 days each year. The median number of days of paid sick leave received is more than 12, with about 63 per cent receiving between 11 and 16 days. Surprisingly, more than five per cent reported that the number of days of paid sick leave they received was unlimited. But at the same time, almost seven per cent reported that they received no sick leave at all.

In contrast to Oklahoma nurses, nearly all social welfare workers received ten or more days of paid sick leave in 1960.[8] And, 59 per cent of all service workers in the nation received some form of sick leave, in addition to other insurance plans.[9]

---

[8]Toivo P. Kanninen, op. cit., p. 867.

[9]Otto Hollberg and Alexander Jarrell, op. cit., p. 386.

TABLE 21

REPORTED NUMBER AND PER CENT OF OKLAHOMA NURSES RECEIVING PAID SICK LEAVE, CLASSIFIED BY NUMBER OF DAYS RECEIVED, EARLY 1961

Days of Paid Sick Leave	Number Reporting	Per Cent of Total
None	12	6.8
Under 5	3	1.7
5 - 7	9	5.1
8 - 10	21	11.9
11 - 13	56	31.8
14 - 16	55	31.2
17 - 19	1	0.6
20 - 22	1	0.6
23 - 25	4	2.3
26 - 28	0	0.0
29 - 31	2	1.1
Over 31	3	1.7
Unlimited	9	5.1
Sub-total[a]	176	100.0
Unusable Replies	84	
Grand Total	260	

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

Work Schedules and Shift Rotation

Two other items which may contribute to overall job satisfaction are examined in Tables 22 and 23. The number of nurses who reported that their work schedules were posted at least one week in advance is given in Table 22. Less than half (112) of the nurses questioned reported that their work schedules were posted at least one week in advance, while slightly over half reported that they were not posted at least one week in advance. More than 27 per cent of those answering "yes" were general duty nurses, and almost 27 per cent were head nurses.[10]

The frequency of shift rotation reported by Oklahoma nurses is given in Table 23. Fewer than ten per cent of those questioned reported any shift rotation at all, and one-third of those reporting shift rotation replied that shifts were rotated monthly. Only about five per cent of those reporting said that shifts were rotated as often as weekly.

Insurance and Retirement Coverage[11]

Table 24 contains insurance and retirement plans carried by various categories of professional nurses in Oklahoma. Here an

---

[10] It should be pointed out, however, that the majority of the school nurses, and a substantial number of educational administrators and teachers can be expected to work regular hours during a five-day week. Therefore, the posting of work schedules is unnecessary.

[11] It is difficult to rationalize some of the data regarding social security presented in this section inasmuch as many nurses may not have a clear understanding of who "pays" for social security. However, the data are presented as indicated on the returned questionnaires.

TABLE 22

NUMBER AND PER CENT OF OKLAHOMA NURSES REPORTING WORK SCHEDULES POSTED AT LEAST ONE WEEK IN ADVANCE, CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961

Classification	Nurses Reporting "Yes"	
	Number	Per Cent
Educational Administrators and Teachers	8	7.1
Institutional Nurses	18	16.1
Office Nurses	3	2.7
Public Health Nurses	12	10.7
Occupational Health Nurses	0	0.0
Private Duty Nurses	0	0.0
General Duty Nurses	31	27.7
Head Nurses	30	26.8
School Nurses	1	0.9
Others	9	8.0
Total	112	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 23

FREQUENCY OF SHIFT ROTATION REPORTED BY OKLAHOMA NURSES, EARLY 1961

Frequency of Rotation	Number Reporting	Per Cent of Total
Daily	1	0.6
Weekly	8	4.9
Every two weeks	1	0.6
Monthly	5	3.1
No rotation	90	55.2
Does not apply	51	31.3
Others	7	4.3
Sub-total	163	100.0
Unusable replies	97	
Grand Total	260	

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

attempt was made not only to determine what kinds of insurance and retirement plans are carried by Oklahoma nurses, but to determine who pays for those plans as well. Thus, in Table 24, rows are constructed to indicate whether the plans are paid for by the employer alone, by the employer and by the nurse, or by the nurse alone. Similar information for the various categories of nurses studied is shown in Tables 25 through 33.

Fewer than 21 per cent of the nurses reported insurance and retirement plans paid for wholly by the employer, with retirement, sickness and accident, and hospitalization being the most common types of plans paid by the employer. More than 70 per cent of the Oklahoma nurses reporting said that they alone bear the cost of all of their retirement and insurance plans, with social security and retirement being the only two types of plans falling below this 70 per cent figure. In the cases of social security and retirement, 41.2 per cent and 26.7 per cent, respectively, of those reporting indicated that these costs were shared by the nurse and the employer.

Looking at similar data for educational administrators and teachers in Oklahoma (Table 25), few fringe benefits were paid solely by the employer. Over 80 per cent of the surgical care, medical care, and sickness and accident policies were paid for entirely by the nurse. The major exceptions to this pattern were once again social security and retirement. The employer and the nurse shared the cost of social security in almost 44 per cent of the cases, and shared the cost of retirement plans in around

TABLE 24

NUMBER AND PER CENT OF NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage[a]	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	22	10.9	30	14.9	149	74.1	201	100.0
Surgical Care	10	6.9	26	18.0	108	75.0	144	100.0
Medical Care	11	8.3	23	17.3	99	74.4	133	100.0
Sickness and Accident	10	11.0	14	15.4	67	73.6	91	100.0
Retirement	10	11.1	24	26.7	56	62.2	90	100.0
Life Insurance	13	8.4	29	18.7	113	72.9	155	100.0
Social Security (OASDI)	11	9.6	47	41.2	56	49.1	114	100.0
Others	1	9.1	0	0.0	10	90.9	11	100.0
Total[b]	88	9.4	193	20.6	658	70.1	939	100.0

[a]The rows in this table are partially overlapping. For example, the ten respondents reporting surgical care coverage paid for by the employer may also be among the 22 respondents reporting hospitalization coverage paid for by the employer. This characteristic of overlapping is also present in Tables 25 through 32, which follow.

[b]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 25

NUMBER AND PER CENT OF EDUCATIONAL ADMINISTRATORS AND TEACHERS REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	1	5.9	3	17.6	13	76.5	17	100.0
Surgical Care	0	0.0	2	15.4	11	84.6	13	100.0
Medical Care	0	0.0	2	14.3	12	85.7	14	100.0
Sickness and Accident	0	0.0	1	10.0	9	90.0	10	100.0
Retirement	0	0.0	3	30.0	7	70.0	10	100.0
Life Insurance	3	20.0	3	20.0	9	60.0	15	100.0
Social Security (OASDI)	2	12.5	7	43.8	7	43.8	16	100.0
Others	1	100.0	0	0.0	0	0.0	1	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 26

NUMBER AND PER CENT OF INSTITUTIONAL NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	4	18.2	2	9.1	16	72.7	22	100.0
Surgical Care	0	0.0	3	23.1	10	76.9	13	100.0
Medical Care	0	0.0	3	20.0	12	80.0	15	100.0
Sickness and Accident	0	0.0	1	10.0	9	90.0	10	100.0
Retirement	2	16.7	3	25.0	7	58.3	12	100.0
Life Insurance	0	0.0	7	38.9	11	61.1	18	100.0
Social Security (OASDI)	1	10.0	5	50.0	4	40.0	10	100.0
Others	0	0.0	0	0.0	1	100.0	1	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 27

NUMBER AND PER CENT OF OFFICE NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	1	7.1	0	0.0	13	92.9	14	100.0
Surgical Care	1	8.3	0	0.0	11	91.7	12	100.0
Medical Care	1	12.5	0	0.0	7	87.5	8	100.0
Sickness and Accident	0	0.0	0	0.0	3	100.0	3	100.0
Retirement	0	0.0	0	0.0	5	100.0	5	100.0
Life Insurance	0	0.0	0	0.0	10	100.0	10	100.0
Social Security (OASDI)	0	0.0	6	60.0	4	40.0	10	100.0
Others	0	0.0	2	100.0	0	0.0	2	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 28

NUMBER AND PER CENT OF PUBLIC HEALTH NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	0	0.0	3	13.0	20	87.0	23	100.0
Surgical Care	0	0.0	3	16.7	15	83.3	18	100.0
Medical Care	0	0.0	3	18.8	13	81.2	16	100.0
Sickness and Accident	1	8.3	1	8.3	10	83.3	12	100.0
Retirement	0	0.0	2	28.6	5	71.4	7	100.0
Life Insurance	1	5.0	1	5.0	18	90.0	20	100.0
Social Security (OASDI)	0	0.0	5	33.3	10	66.7	15	100.0
Others	0	0.0	0	0.0	4	100.0	4	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 29

NUMBER AND PER CENT OF OCCUPATIONAL HEALTH NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	1	25.0	2	50.0	1	25.0	4	100.0
Surgical Care	1	33.3	2	66.7	0	0.0	3	100.0
Medical Care	1	50.0	1	50.0	0	0.0	2	100.0
Sickness and Accident	1	33.3	1	33.3	1	33.3	3	100.0
Retirement	2	50.0	1	25.0	1	25.0	4	100.0
Life Insurance	2	50.0	1	25.0	1	25.0	4	100.0
Social Security (OASDI)	0	0.0	2	66.7	1	33.3	3	100.0
Others	0	0.0	0	0.0	0	0.0	0	0.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 30

NUMBER AND PER CENT OF PRIVATE DUTY NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	0	0.0	0	0.0	19	100.0	19	100.0
Surgical Care	1	5.9	0	0.0	16	94.1	17	100.0
Medical Care	1	6.2	0	0.0	15	93.8	16	100.0
Sickness and Accident	1	16.7	0	0.0	5	83.3	6	100.0
Retirement	0	0.0	0	0.0	7	100.0	7	100.0
Life Insurance	0	0.0	0	0.0	16	100.0	16	100.0
Social Security (OASDI)	0	0.0	0	0.0	9	100.0	9	100.0
Others	0	0.0	0	0.0	2	100.0	2	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 31

NUMBER AND PER CENT OF GENERAL DUTY NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	8	25.0	7	21.9	17	53.1	32	100.0
Surgical Care	4	20.0	6	30.0	10	50.0	20	100.0
Medical Care	4	23.5	5	29.4	8	47.1	17	100.0
Sickness and Accident	2	14.3	5	35.7	7	50.0	14	100.0
Retirement	4	23.5	8	47.1	5	29.4	17	100.0
Life Insurance	3	13.6	7	31.8	12	54.5	22	100.0
Social Security (OASDI)	2	15.4	8	61.5	3	23.1	13	100.0
Others	0	0.0	0	0.0	1	100.0	1	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 32

NUMBER AND PER CENT OF HEAD NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	2	5.3	8	21.0	28	73.7	38	100.0
Surgical Care	0	0.0	7	29.2	17	70.8	24	100.0
Medical Care	1	4.2	6	25.0	17	70.8	24	100.0
Sickness and Accident	0	0.0	3	20.0	12	80.0	15	100.0
Retirement	0	0.0	5	35.7	9	64.3	14	100.0
Life Insurance	1	3.8	6	23.1	19	73.1	26	100.0
Social Security (OASDI)	3	16.7	8	44.4	7	38.9	18	100.0
Others	0	0.0	0	0.0	0	0.0	0	100.0

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

TABLE 33

NUMBER AND PER CENT OF SCHOOL NURSES REPORTING INSURANCE AND RETIREMENT COVERAGE IN OKLAHOMA, CLASSIFIED BY TYPE OF COVERAGE AND SOURCE OF PAYMENT, EARLY 1961

Type of Coverage	Paid by Employer		Paid by Employer and Nurse		Paid by Nurse		Total	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Hospitalization	1	10.0	1	10.0	8	80.0	10	100.0
Surgical Care	1	22.5	1	22.5	6	75.0	8	100.0
Medical Care	1	14.3	1	14.3	5	71.4	7	100.0
Sickness and Accident	2	28.6	0	0.0	5	71.4	7	100.0
Retirement	0	0.0	1	25.0	3	75.0	4	100.0
Life Insurance	0	0.0	2	25.0	6	75.0	8	100.0
Social Security (OASDI)	0	0.0	7	100.0	0	0.0	7	100.0
Others	0	0.0	0	0.0	1	100.0	1	100.0

Source: Compiled from a mail questionnaire of a sample of registered Oklahoma nurses.

30 per cent of the cases.

In Table 26 it can be seen that the insurance plan most frequently paid for by the employer for institutional nurses is hospitalization. Plans paid for by the employer and the nurse are a little more common for institutional nurses. Still, nurses paid for almost 77 per cent of their surgical care plans, 80 per cent of the medical care plans, and 90 per cent of the sickness and accident plans.

More than 85 per cent of the office nurses in the state pay the full cost of all of the insurance and retirement plans they carry, the only exception being social security.

As can be seen in Table 28, the cost of retirement plans carried by public health nurses is shared by the employer and the nurse in over 28 per cent of the cases. Still, more than 80 per cent of the public health nurses report that they alone pay the cost of hospitalization, surgical care plans, medical care plans, sickness and accident policies, and life insurance which they carry. A small number (five per cent) of the nurses questioned reported that the employer alone paid for their life insurance program.

Employers of occupational health nurses take a much more active part in providing insurance and retirement plans for those nurses. One-fourth of those nurses carrying hospitalization reported that the cost of that coverage was paid entirely by the employer. One-half of the nurses carrying hospitalization reported that the cost was shared by the employer and the nurse, and one-

fourth said that they alone bore the cost. Surgical care and sickness and accident policies present an even more favorable picture for the occupational health nurse. One-third of the nurses carrying these two policies indicated that the employer paid the full cost of the policies. The employer and the nurses shared the cost of surgical care plans in two-thirds of the cases. No policies were financed solely by the employer. In the case of sickness and accident insurance, one-third reported that they alone paid the cost. Of those nurses carrying medical care plans, one-half reported that the cost of such plans was shared and one-half reported that the employer paid the full cost.

The private duty nurse represents the other end of the spectrum from the occupational health nurse. In Table 30 it can be seen that over 80 per cent of the private duty nurses in Oklahoma pay the full cost of all of their insurance and retirement plans. A high per cent of insurance paid solely by the private nurse is, however, to be expected because of the nature of their employment in most situations.

In the case of general duty nurses the cost of insurance and retirement plans is more evenly spread between the three categories. The employer pays more, the employer and the nurse share more of the cost, and less of the cost is paid by the nurse alone. Moreover, one-fourth of the general duty nurses carrying hospitalization reported that the employer paid the full cost. Over 23 per cent of the medical care plans, 20 per cent of the surgical care plans, and 23 per cent of the retirement plans were paid for by

the employer.

Head nurses present much the same picture as did the private duty nurse, though head nurses do not bear quite as much of the cost of their insurance and retirement as do private duty nurses. It is pointed out in Table 32 that few of the various plans were paid for by the employer alone.

Table 33 shows insurance and retirement coverage of school nurses in Oklahoma. Over 70 per cent of all school nurses carrying any type of insurance or retirement plans must pay the cost of such plans themselves. Of those not paid for by nurses, about half reported that the cost was shared by the employer. This pattern held for hospitalization, surgical care, and medical care. Almost 29 per cent of the school nurses questioned reported that their sickness and accident insurance was paid by their employer, while none of the nurses reported that their retirement or life insurance was paid by the employer.

By way of comparison, about one-third of all social welfare workers in the nation are covered by hospitalization and surgical benefits insurance paid for in whole or in part by their employers. And, more than half of all social welfare workers are eligible for both social security and a private retirement (or pension) plan, with nearly all of the remainder covered under one, but not both, such plans.[12] Further, of all the social welfare

---

[12]Toivo P. Kanninen, op. cit., p. 868.

workers in the nation, 82 per cent are covered by life insurance, 44 per cent by accidental death and dismemberment insurance, 68 per cent by hospitalization, 66 per cent by surgical insurance, 50 per cent by medical insurance, 34 per cent by catastrophe insurance, 33 per cent by sickness and accident insurance, and 53 per cent by some form of retirement pension plan. Only six per cent of the service workers have no health insurance or pension plan.[13]

Determination of Policy

Probably of equal importance with salaries, insurance policies, and paid holidays is the feeling which nurses have about the contribution they make to their profession. A nurse who feels that she has something to say about policies which affect her work situation is likely to be more satisfied in her work than one who has policy dictated to her. In the survey taken of Oklahoma nurses, those nurses were asked to report on how policy was determined. That is, who decides what the various employment and personnel policies will be? The results of the tabulation of this question are shown in Table 34.

The professional nurses in Oklahoma were asked if policy was determined by group discussion, by the workers alone, by the administration alone, or by individual bargaining. The overwhelming answer was that policy was determined by the administration alone. Almost 67 per cent of the educational administrators

---

[13]Otto Hollberg and Alexander Jarrell, op. cit., p. 386.

TABLE 34

NUMBER AND PER CENT OF OKLAHOMA NURSES REPORTING VARIOUS TYPES OF POLICY DETERMINATION, CLASSIFIED BY TYPE OF DUTY PERFORMED AND BY SOURCE OF POLICY DETERMINATION, EARLY 1961

Classification	Source of Policy Determination			
	Group Discussion		Workers	
	Number	Per Cent	Number	Per Cent
Educational Administrators and Teachers	4	22.2	0	0.0
Institutional Nurses	3	14.3	0	0.0
Office Nurses	0	0.0	0	0.0
Public Health Nurses	7	30.4	1	4.3
Occupational Health Nurses	0	0.0	0	0.0
Private Duty Nurses	8	44.4	7	38.9
General Duty Nurses	4	10.8	0	0.0
Head Nurses	12	33.3	0	0.0
School Nurses	3	42.8	0	0.0
Others	1	11.1	0	0.0
Total	42	23.7	8	4.5

TABLE 34--Continued

Source of Policy Determination						
Administration		Individual Bargaining		Total		Unusable Replies
Number	Per Cent	Number	Per Cent	Number	Per Cent[a]	Number
12	66.7	2	1.1	18	100.0	0
16	76.2	2	9.5	21	100.0	12
4	66.7	2	33.3	6	100.0	8
14	60.9	0	0.0	23	100.0	5
2	100.0	0	0.0	2	100.0	9
3	16.7	0	0.0	18	100.0	30
29	78.4	4	10.8	37	100.0	8
20	55.5	4	11.1	36	100.0	6
4	57.1	0	0.0	7	100.0	4
8	88.9	0	0.0	9	100.0	1
112	63.3	14	7.9	177	100.0	83

[a]Total does not add to 100 per cent due to rounding.

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

and teachers in the state reported this answer, as did 76.2 per cent of the institutional nurses, 66.7 per cent of the office nurses, all of the occupational health nurses, and 78.4 per cent of the general duty nurses. The only significant group of nurses reporting that policy was determined by the workers were the private duty nurses. The second most important source of policy determination for Oklahoma nurses is through group discussion. The groups of nurses reporting that group discussion played a really significant part were the private duty nurses, school nurses, and public health nurses. Individual bargaining played an important role in policy determination only in the case of the office nurse. Of the six office nurses reporting, two indicated that policy was determined by individual bargaining. In no other group did the percentage attributing policy decisions to individual bargaining exceed 12 per cent.

Job Satisfaction

One of the final questions asked of the professional nurses in Oklahoma was their degree of job satisfaction. The results received from this question are presented in Table 35. Interestingly, none of the occupational health nurses or school nurses reported that they were "not very satisfied." All of the nurses in both these categories reported that they were either "satisfied" with their work, or "very satisfied" with their work.

Although educational administrators and teachers were the only group reporting some nurses "not at all satisfied,"

TABLE 35

DEGREE OF JOB SATISFACTION EXPRESSED BY OKLAHOMA NURSES, CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961

Classification	Degree of Job Satisfaction			
	Very Satisfied		Satisfied	
	Number	Per Cent	Number	Per Cent
Educational Administrators and Teachers	3	17.6	10	58.8
Institutional Nurses	7	29.2	15	62.5
Office Nurses	11	78.6	2	14.3
Public Health Nurses	5	20.8	14	58.3
Occupational Health Nurses	3	75.0	1	25.0
Private Duty Nurses	7	35.0	11	55.0
General Duty Nurses	8	21.0	18	47.4
Head Nurses	15	37.5	16	40.0
School Nurses	9	90.0	1	10.0
Others	2	20.0	7	70.0
Total	70	34.8	95	47.3

TABLE 35--Continued

Degree of Job Satisfaction						
Not Very Satisfied		Not at All Satisfied		Total		Unusable Replies
Number	Per Cent	Number	Per Cent	Number	Per Cent	Number
3	17.6	1	5.9	17	100.0	1
2	8.3	0	0.0	24	100.0	9
1	7.1	0	0.0	14	100.0	0
5	20.8	0	0.0	24	100.0	4
0	0.0	0	0.0	4	100.0	7
2	10.0	0	0.0	20	100.0	28
12	31.6	0	0.0	38	100.0	7
9	22.5	0	0.0	40	100.0	2
0	0.0	0	0.0	10	100.0	1
1	10.0	0	0.0	10	100.0	0
35	17.4	1	0.5	201	100.0	59

Source: Compiled from a mail survey of a sample of registered Oklahoma nurses.

31.6 per cent of the general duty nurses reported that they were "not very satisfied" with their work, as did 17.6 per cent of the educational administrators and teachers, 20.8 per cent of the public health nurses, and 22.5 per cent of the head nurses.

Over 47 per cent of the nurses questioned indicated that they were "satisfied" with their work. And over 78 per cent of the office nurses reported they were "very satisfied," and 90 per cent of the school nurses reported that they were "very satisfied" with their work.

In total, 34.8 per cent of all nurses questioned were "very satisfied" with their work, 47.3 per cent were "satisfied" with their work, only 17.4 per cent were "not very satisfied" with their work, and a scant 0.5 per cent were "not at all satisfied." These data indicate an extremely high degree of job satisfaction for over one-third of the professional nurses in Oklahoma. The fact that only about one-third were very satisfied does indicate that areas of dissatisfaction exist. The causes of dissatisfaction were made evident by the shortcomings pointed out in this chapter.

Summary of Survey Findings

It is possible to reach several broad conclusions based on this chapter's survey of registered professional nurses in Oklahoma. Most of the nurses responding to the questionnaire were found to be employed on a full-time basis. Further, about one out of six of these nurses had been employed as a professional nurse for over 30 years.

The average salary for the typical nurse was reported to be $348 per month for a five-day week. Salary increases were seen to be based on a combination of length of service and merit for most nurses. Several kinds of salary supplements were examined. The majority of nurses reported that they received no compensation for professional expenses incurred in their work, but many did report receiving meals, rooms, laundry and uniform allotments.

Over half of the nurses questioned reported receiving six paid holidays each year, but a significant number said they received no compensation for holiday work. Sick leave provisions were seen to vary greatly, with most nurses receiving between 11 and 16 days of paid sick leave per year.

In another important area of fringe benefits, almost three-quarters of the nurses stated that they alone bore the cost of all their retirement and insurance plans.

In the area of policy determination, the majority of nurses reported that policy was determined by the administration, with no opportunity for the nurse to participate in policy formulation.

Finally, the results of the survey showed that many nurses are satisfied with their work although some dissatisfaction exists among nurses.

Further implications of these data are discussed in the chapter which follows.

CHAPTER IV

POLICY IMPLICATIONS OF THE EMPLOYMENT ANALYSIS OF REGISTERED PROFESSIONAL NURSES IN OKLAHOMA

The data presented in the previous chapter are useful in pointing to certain economic areas in which improvements may be needed for professional nurses in Oklahoma. It is the purpose of this chapter to examine some of these areas and to reach conclusions based upon the data previously presented.

The policy recommendations presented in this chapter are based upon the data presented earlier. However, the author's own value judgments of necessity permeate such policy recommendations. The proposals presented here follow from the author's interpretation of the survey results of Chapter III. The proposals seem socially desirable, and would, it is felt, be harmonious with the objectives of the OSNA.

Salaries

This study has borne out the fact that salaries paid to professional nurses in the state of Oklahoma, as elsewhere, are much too low to add to the attractiveness of the field of nursing to young people considering nursing as a career. Thus, some

upward adjustment in salaries appears warranted. The average salaries for professional nurses in the state ran from a high of $488 per month for occupational health nurses to a low of $310 per month for office nurses. This was seen to compare favorably with nurses' salaries in the United States as a whole. However, these salary structures do not appear to be adequate in light of the professional qualifications necessary for one to become a professional nurse.[1]

The groups which appear most in need of salary increases are the office nurses, general duty nurses, head nurses, public health nurses, private duty nurses, and school nurses. It seems advisable, then, to suggest negotiations with employers of these categories of professional nurses in an attempt to increase the salary structure. This is not to say, of course, that nurses in other categories are being paid an adequate salary. Rather, it is simply to point out that these categories appear most in need of increased salaries.

Another problem also becomes apparent upon examination of the data from the questionnaire survey. When asked to state the bases upon which salary increases are granted, a significant

---

[1] Depending upon the particular category of professional nurse, the professional qualifications include graduation from a state-accredited school of nursing, a bachelor's or master's degree, a current license to practice nursing, extensive experience, an awareness of the legal implications of nursing practice, and some additional educational preparation. The standards for the various classifications of professional nurses are stated in their entirety in Appendix V.

percentage of those nurses replying indicated that some basis other than length of service, merit, or length of service and merit combined, was used as a basis for granting these salary increases. Most of those answering "other" to this question indicated that salary increases were almost solely at the discretion of the employer and the employer's conception of his ability to grant increases. It would seem advisable, then, to suggest that some attempt be made to negotiate with employers to establish in contracts the basis upon which salary increases will be granted. Although this may not directly increase salaries in the short run, such a written contract would serve to keep nurses in this area informed as to the bases upon which such increases are granted.

The Five-Day Week

Although data in Chapter III showed that over 64 per cent of the nurses in Oklahoma work a five-day week, they also showed that over 12 per cent work either six or seven days each week. Thus, it seems advisable that a "normal work week" be adopted as standard for professional nurses, and that it conform to the conventional forty-hour week. Some provision may be made for overtime payment on the basis of a daily maximum working time of eight hours and a weekly maximum working time of forty hours.[2]

---

[2]Once again, the social welfare worker may be compared to the professional nurse in Oklahoma. In contrast to the Oklahoma nurse, nearly half of all social welfare workers employed by state or local governments work a 40-hour week, and nearly all of

On-Call Duty

Almost half of the nurses questioned, as reported in the questionnaire survey, reported that they were on call at any time when they were needed. Others reported on-call duty up to 100 hours per week. While on-call duty does not require the nurses' presence at their place of employment, it nevertheless imposes restrictions upon their free time. Therefore, there might well be an attempt to establish some form of compensation for each category of nurse for on-call time when the nurse is not actually called to duty. This compensation might be in the form of pecuniary compensation, compensatory time off, etc., or it might be included in the salary increases requested. Another alternative would be to decide how many hours of on-call duty each week can be tolerated as a regular part of the nurse's employment, all over that amount being grounds for additional compensation.[3] At the present time, the majority (over 61 per cent) of the nurses in the state receive no compensation in any form for on-call duty when they are not actually called.

---

the remainder work less than 40 hours. And, generally overtime work is compensated for by allowing equal time off. In addition to social welfare workers, the 40-hour week is by far the most typical work schedule for both office and plant workers over the nation. Almost two-thirds of the office workers and four-fifths of the plant workers have 40-hour weeks. And nearly all other office workers have work schedules of less than 40 hours. Most other plant workers, on the other hand, were seen to have longer schedules. (Kanninen, et. al., op. cit., pp. 862-68 and pp. 379-87.)

[3]The total expense of on-call compensation might not be as great as hospital administrators would initially suppose, since a relatively small number of nurses would need to be on strictly obligatory call if they were receiving compensation for such duty.

Professional Expenses

Since professional trips are undertaken by the nurse with the objective of improving her ability to perform her job, attendance at certain professional meetings should be encouraged. The contractual arrangement between employers and nurses could contain a paragraph indicating the professional meetings which the OSNA considers to be essential to the nurse. The contract might also request that the employer allow time off with pay for the nurse attending those meetings, as well as providing mileage and other expenses associated with the meeting. At least a portion of those expenses might be borne by the employer, since he as well as the nurse involved benefits from the increased knowledge gained by the nurse.

Over-Time Compensation

As was pointed out in the previous chapter, almost 27 per cent of the state's nurses received no compensation for over-time work. In addition, about six per cent receive only straight-time pay for over-time work. Others receive compensatory time off or have an option between straight-time pay or time off. Certainly provisions for additional compensation for over-time work should be one of the main contractual provisions in bargaining with the various employers. The writer sees no reason why all nurses working for an institution of any type and private duty nurses should not be entitled to time-and-one-half pay for all work exceeding forty hours in a given week. Such compensation is required by law in

interstate employment (with certain exceptions). If it is deemed advisable by Oklahoma nurses and the OSNA, an option could be presented to the employer stating that all work in excess of eight hours per day or forty hours per week would be paid at a rate equal to one-and-a-half times the regular salary, or that the nurse receive compensatory time off, the choice being at her option. (Such a policy, however, might be difficult to implement in small hospitals or doctors' offices.)

Holidays

According to the information in Chapter III, office nurses and head nurses appear to be discriminated against concerning the number of paid holidays received each year. Careful attention should be directed toward these two groups when contractual stipulations are being developed regarding paid holidays. Perhaps more important, however, is the fact that more than 55 per cent of the nurses reporting said that they received no additional compensation for work on a holiday. Definite provisions might be included in a contract for pay when holidays are worked (at the rate of time-and-one-half or double-time, as is the case in many industries).

Insurance and Retirement Plans

As was indicated previously, less than 21 per cent of the state's nurses reported insurance and retirement plans paid for entirely by their employers. At the same time, more than 70 per cent of the nurses reported that they alone bear the cost of all of their retirement and insurance plans. Each category of nurses

should be carefully examined by the OSNA to determine the possibilities of having a greater number of employers participate in the payment of insurance and retirement plans.

Source of Policy Determination

Of particular significance is the fact that over 43 per cent of Oklahoma's nurses report that policy is determined by the administration alone, with the individual nurse or her representatives having no voice in the determination of these policies. In addition to the collective bargaining machinery which could be set up in employment contracts, this information indicates that it may also be advisable to establish some sort of "clearing house" of ideas on policy, wherein the employees could voice their opinions and perhaps have a vote in the ultimate decisions. Most of the major policy decisions, of course, could be included in a contract. This suggested policy-making board would, however, allow the employees to air their objections in minor areas before they became grievances. It is interesting to note at this point that the majority of nurses who expressed some degree of dissatisfaction with their work also reported that policy was determined by the administration alone.

The empirical data presented in the previous chapter have enabled the writer to reach several conclusions regarding working conditions of registered professional nurses in the state of Oklahoma. Policy recommendations based upon these conclusions have been presented in this chapter. Certain areas of needed improvement have been suggested.

The following chapter is presented on the assumption that the survey data presented in the prior chapter, and the implications of those data discussed in this chapter, warrant some kind of positive action. The chapter contains an examination of some of the problems of collective bargaining by professional organizations and a brief look at the economic security program advanced by the ANA as a partial solution to the economic problems faced by professional nurses.

CHAPTER V

NURSES AND COLLECTIVE BARGAINING

Inflation has long been the particular enemy to persons receiving relatively fixed salaries. In these cases, the salary recipient fails to maintain his standard of living when costs begin rising while the salary does not. Herbert R. Northrup has examined this problem somewhat in detail.[1] He points out that the failure of salaried groups to maintain their living standards has encouraged the expansion of collective bargaining among professional employees. But this expansion has, in turn, led to a conflict within professional societies over two points: (1) whether collective bargaining is consistent with "professional ethics," and (2) whether collective bargaining should be controlled by professional societies or by unions.

Northrup further notes that the nursing profession is the only profession of the three under his study (engineering, teaching, and nursing) which does not have unions with special jurisdiction for the nurse group. He points out that many

---

[1]Herbert R. Northrup, "Collective Bargaining and the Professions," The American Journal of Nursing, Vol. 48, No. 3 (March, 1948), pp. 141-44.

employee groups turned to the unions to gain support in their endeavors to obtain decent working conditions during the depression years of the 1930's and that the professional groups tended to attempt to find solutions to their problems through their respective professional organizations.[2] It was the professional organization that attempted to initiate personnel programs, raise salaries, and provide jobs. With this foothold gained in the 1930's, the professional groups turned to their professional societies for help also during the war years and the subsequent inflationary period. With war and postwar inflation creating stronger economic pressures, the professional societies began to turn to collective bargaining as the appropriate technique to meet the needs of their members who were employed in large groups. The professional groups (including nurses), then, tended to rely on the professional society as their bargaining agent. This reliance appeared especially significant in the case of professional nurses, since they voluntarily relinquished their right to strike in the interest of public welfare.

Yet, with the ever-increasing dependence upon the professional society, a great deal of reluctance was observed regarding the use of collective bargaining techniques by the professional organizations. Many nurses, who perhaps feel a sense of dedication to the general public more strongly than many professional groups, have been reluctant to endorse collective bargaining as a means of

---

[2] Ibid., pp. 141-42.

gaining desirable economic goals because they have felt that collective bargaining is not consistent with professional ethics.

J. B. Gillingham explained the interrelationship between collective bargaining and professional ethics in the following way.[3] In defining the concept of professional ethics, Gillingham points out that professional ethics have tended to develop where the services involved in performing duties are vital. These services may be required at any time, and are of such a nature that the patient or client may be incapable of judging the propriety of the actions of the professional person involved.[4] Thus, for the professional nurse, professional ethics involves, simply speaking, her conduct in the treatment of patients.

However, other considerations must be looked at in discussing professional ethics. For example, professional ethics cannot be limited to the face-to-face encounter of the nurse with her patient. All other factors affecting the nurse and the performance of her duty must be considered. And certainly her employment standards, her relationship with her employer, and the general conditions under which she works must be considered as important factors affecting her well-being and, therefore, affecting her ability to perform her duties in keeping with her set of professional ethics. Gillingham aptly points out that "... It is a

---

[3] J. B. Gillingham, "Collective Bargaining and Professional Ethics," The American Journal of Nursing, Vol. 50, No. 4 (April, 1950), pp. 214-16.

[4] Ibid., p. 214.

matter of professional ethics if, in the face of a shortage of nursing personnel all over the nation, nurses passively accept an economic status which discourages capable persons from entering the profession. Particularly, in the face of the present shortage it is an issue of professional ethics if nurses concur in a flagrant waste of their scarce skills by continuing to perform a myriad of unskilled tasks which could be performed by non-professional personnel."[5]

On the other hand, collective bargaining is simply a process whereby employees participate as a bargaining unit in determining jointly, with employers, the conditions of their employment relationship. The Federal government itself endorses the policy of collective bargaining, and its attendant freedom of association, self-organization, and choosing of representatives by the group to negotiate terms of contracts. Thus, there appears to be no reason why the process of collective bargaining should be in conflict with professional ethics in the nursing profession. Further, since collective bargaining often appears to be the most advantageous method of obtaining needed improvements in employment situations, it seems apparent that collective bargaining techniques could be considered by the OSNA as a partial means of achieving the goals of an economic security program for Oklahoma's professional nurses.

The results of such action by professional nurses cannot,

---

[5] Ibid., p. 215.

of course, be predetermined. There is a great deal of diversity in the character and results of collective bargaining. If the OSNA should engage in collective bargaining techniques, the degree of success of such techniques will of necessity depend upon the economic, the technological, and the labor relations environment existing in the state at the time.

At least two possible objections to the use of collective bargaining techniques may be mentioned at this point: (1) collective bargaining gives a union or a professional organization undue pressure to use against management; and (2) the collective bargaining process may serve as an impediment to technological advancement. Whether or not either of these possible objections to collective bargaining on the part of Oklahoma's professional nurses would be valid cannot be accurately predicted.

In the case of all types of union activity, Sumner Slichter, et al. point out in their study of the impact of collective bargaining that appeasement on the part of management does have some tendency to perpetuate itself. This is true, the authors claim, because once management yields to threats the union gains more incentive to use threats. However, these authors also state that pressure tactics become less necessary as the labor organization gains stability and experience.[6]

Regarding the argument that unions, through the use of

---

[6] S. H. Slichter, J. J. Healy, and E. R. Livernash, The Impact of Collective Bargaining on Management (Washington, D. C.: The Brookings Institution, 1960), p. 947.

collective bargaining, impede technological progress, Slichter states:[7]

> Going back in union history one can find a few cases where unions were destroyed largely because they were unable or unwilling to adapt themselves to technological changes. . . . However, no national union in recent years has destroyed itself fighting technological change.
>
> Nor is there record of any union in recent years being able to prevent technological change by opposing it. . . . Union wage policies appear to have been partly responsible for stimulating technological change under some circumstances and may have affected the distribution of gains. Three principle effects have been produced by union policies toward technological change:
>
> (1) They have tended to give to the holders of jobs on the new machines or new processes somewhat higher wages relative to other workers in the same plant . . . ; (2) they have tended to a slight extent to cause the new techniques to be operated with excessive crews and under make work rules; (3) they have considerably eased the hardship of displacement. . . .

As was pointed out earlier, it is impossible to draw definite conclusions concerning the possible effects of collective bargaining on the part of the professional nurses of Oklahoma. However, the history of collective bargaining in other areas may serve as a guide to the situation in Oklahoma. Further, regarding the history of collective bargaining in general, Slichter concludes that:[8]

> . . . The American collective bargaining system must be regarded as one of the most successful economic institutions in the country. In the great majority of plants it has produced rules and policies that are fair to both sides and that permit managements to conduct operations efficiently. . . .

---

[7] Ibid., p. 371.

[8] Ibid., pp. 960-61.

> . . . Collective bargaining must be reckoned among the influences that make the American society stable and conservative. . . .
>
> . . . Free collective bargaining produces compromises which cannot be expected to meet fully all definitions of the public interest. Nevertheless, experience to date evidences a degree of social progress that few would have predicted twenty years ago.

It would appear, then, that there is some support both for the institution of collective bargaining, and for collective bargaining by professional organizations. Whether or not the OSNA will resort to collective bargaining as a means of attaining better working conditions is at this time open to conjecture. However, should such a program be followed, it is likely that the framework for their use of collective bargaining will be found in an economic security program advanced by the American Nurses Association. It is to this plan that attention is directed in the following section.

The Economic Security Program of the American Nurses Association

One action program upon which the Oklahoma State Nurses Association may base its quest for better working conditions is the economic security program of the American Nurses Association. The purpose of this section is to examine that economic security program as it is presented in the ANA's Manual for an Economic Security Program.[9] This manual will be summarized in some detail,

---

[9]American Nurses Association, Inc., A Manual for an Economic Security Program (New York: American Nurses Association, Inc., January, 1956).

and its applicability to the OSNA will be indicated. For purposes of expediency, this examination is divided into two sub-divisions: The Functioning Economic Security Program, and Counseling and Placement. Although the desirability of such a program for Oklahoma nurses cannot be decided without additional research by the state association, this ANA document is summarized and examined at this time inasmuch as it represents the major effort of the ANA to present an instrument which may be used to raise both the standards of employment for nurses and the quality of nursing care available to the public.[10] This section deals only with the collective bargaining aspects of the security program. In Chapter VI the legislative activities and laws attendant to such a program will be examined.

The American Nurses Association has stated that it does not purport to be a bargaining agent for state associations with wage problems. The national association acts only in the capacity of advisor and data gatherer for the state associations. Therefore,

---

[10]Currently 49 of the 54 jurisdictions affiliated with the ANA have officially adopted the economic security program. The associations which have not adopted the program are the Canal Zone, Georgia, Maine, Maryland, Virginia, and the Virgin Islands. Texas was the most recent state to formally adopt the program.

In June, 1960, there were 75 agreements in effect under the economic security program provisions of the ANA. These agreements involved 115 institutions and covered approximately 8,000 professional nurses. Six state associations had negotiated 74 of these and a district association the other one. The number of nurses covered by each agreement varied from less than 10 to 2,500. Almost three-fourths of the agreements covered less than 50 nurses, and about one-eighth involved 100 or more. (Daniel H. Kruger, "Bargaining and the Nursing Profession," Monthly Labor Review, Vol. 84, No. 7, July, 1961, pp. 702-03).

the success or failure of an economic security program in any given state is largely dependent upon the state association (the OSNA in the state of Oklahoma).

In its preparation to adopt an economic security program, the ANA suggests that the state association obtain full authorization for the adoption of the program from the membership of the association.[11] And, in order to insure success in the implementation of the plan, the ANA suggests that leaders be carefully chosen to suggest beneficial avenues of approach and to carefully supervise the beginning phases of the program.

According to the ANA Manual, preliminary plans need to be made by a temporary committee established for that purpose. Included on this committee would be representatives from all of the various interest groups who would be included in the economic security program. By including the various interest groups in the preliminary planning stage of the program, chances for dissension by one or another group at a later date would be lessened, and a plan more nearly representative of the wishes and needs of each group covered would be more likely to emerge.

One of the prime purposes of the temporary committee, as outlined by the ANA, is to help the members of the state association understand the nature and purpose of the proposed program.

---

[11] Although the ANA calls for authorization of the economic security program by the house of delegates of the state association, the OSNA does not have a house of delegates. Instead, the total membership at conventions vote, and all members vote for candidates by mail. It is here suggested that the OSNA would want to obtain full authorization for such a program by a vote from the total membership of the association.

Periodic workshops could aid in this educational process, as could a series of articles in monthly publications. Also of help would be meetings held on a local level to answer questions regarding the program. The temporary committee would work closely with the ANA to insure the alignment of their goals.

Before the state association adopts the economic security program, the ANA recommends that the state association's articles of incorporation and bylaws be carefully scrutinized to determine if there is a need for changes. In addition, the labor laws of the state would be carefully studied to avoid conflicts between those laws and the economic security program. Finally, the budget of the state association would be carefully reviewed, keeping in mind that the adoption of such a program would require field work, legal and advisory services, surveys, and a minimum number of additional personnel. Dues could be adjusted to cover these additional costs if necessary.

After the above preparations have been made, the ANA suggests that a report be made to the state board of directors by the temporary committee. This report would point to the preparation of the membership of the association, the results of the various surveys, and the need for an economic security program. Following the presentation of this report (and its subsequent approval by the board of directors), a resolution would normally be drafted for adoption by the state association. (A sample resolution appears in Appendix I of this study.) This resolution

would then be presented to the membership of the association, and its acceptance of the resolution would be publicly announced.

After the preliminary stages of adoption have been completed, the temporary committee on economic security would be dissolved, since its purpose for existence was preliminary planning and the establishment of sound policies. The board of directors of the state association then would assume responsibility for the overall administration of the security program. The board would appoint an executive secretary to administer the program, but would keep continuously informed of the program's progress.

The executive secretary would now become the official administrator of the program, and would report directly to the board of directors. The executive secretary has the responsibility of directing the program, recommending needed changes, keeping the board of directors informed regarding the progress of the program, and coordinating the program with other programs of the state association.

In addition to the executive secretary, other staff members and special consultants must be provided to insure the success of the program. These additional staff members would be added after the adoption of the program, and would include members for the purpose of field work, compilation of facts and research, legal consultation, and public relations. This staff need not be large, but must be well informed about the program.

Once the economic security program has been set in motion, the state headquarters of the association must assume

certain general responsibilities and functions. Among these are:[12]

1. To set up sound procedures which will help the program function smoothly and efficiently.

2. To maintain official records and files of basic and related facts, i.e., salary data, case histories, etc.

3. To offer field service to groups of nurses in any area in which economic security needs have arisen.

4. To help organize and maintain sections and local units which are democratic in operation and which encourage active participation of all nurses.

5. To assist sections in the preparation of employment standards and give guidance in their distribution and use, as well as handle the printing and mailing.

6. To maintain a continuing educational program among the members and the public on the philosophy and functioning of the economic security program.

7. To provide supporting data, sample contracts, and other materials to nurses preparing for negotiations, and represent them when authorized to do so.

8. To assume responsibility for the maintenance of a contract and its renewal.

9. To continuously enrich the knowledge of the staff in the field of industrial and human relations, in order to bring increased skill to the nurses using the service.

10. To evaluate the program regularly in the light of ANA criteria, current trends and history, and recommend new policies or changes to the board.

11. To inform the ANA of current program trends in the state, relationships with allied groups, problems encountered in specific negotiations, and the over-all status of the ANA economic security program.

---

[12] American Nurses Association, Inc., A Manual for an Economic Security Program, op. cit., p. 14.

Turning from the role of the state association, an examination of the role of the state sections (occupational groups) is in order. One of the prime responsibilities of the sections of the state association is keeping the membership on the local level informed regarding the principles upon which the program is founded. That is, the membership at the local level must be convinced that nurses have the right to promote their economic security through their professional association. Further, they must be convinced that they, as well as other professional groups, have the right of freedom of association and liberty of contract. Lastly, they must be informed of their responsibility to participate actively in determining the conditions of employment that are to exist in the state. It may be suspected that convincing professional nurses of these rights and obligations may be more difficult than convincing, say, an industrial group. Thus, the job of the state sections is not an easy one.

While the state association provides the necessary leadership for the development and maintenance of the program, and reviews the activities of the sections, the implementation of the program itself depends in large measure upon the state sections. These sections must study the needs within their groups and establish acceptable standards of employment. They must plan meetings to discuss problems inherent in the adoption of the program and problems arising in the employment situation. They must elect officers to make recommendations to the state

association. And, most importantly, they must lend support to the program and the local unit.

Although the sections are established according to occupational groups, it may often be advisable to establish sub-units within the various sections. These sub-units would represent various economic interests and groups whose employment conditions may differ somewhat from those of the section. The establishment of sub-units would, of course, guarantee a member of the smaller group a voice in the determination of employment conditions affecting her. The establishment of sub-units would also serve as a deterrent to public or member criticism.

In summary, the strata of organization necessary for the establishment of an economic security program include the ANA in an advisory capacity, a temporary committee for preliminary planning, the board of directors of the state association, the executive secretary, sections (or occupational groups), and sub-units to protect the economic interests of smaller groups within the sections.

The ANA has established criteria which can be used to evaluate the effectiveness of a state program. All of the above groups would be expected to constantly scrutinize their program in light of these criteria or principles:[13]

> 1. Principle I: The state nurses association should assume dynamic leadership in the realm of action in building an economic security program based upon points of view, or philosophy, in accord (1) with currently accepted ethical,

---

[13] Ibid., p. 19.

legal, social, and economic principles of employer-employee relations; and (2) with objectives and ethical standards of the nursing profession.

2. Principle II: The economic security program should have a sound plan of organization within the established organizational structure of the American Nurses Association and its constituent units. Responsibility, functions, and authority should be clearly defined and properly allocated. The plan should be in accord with currently accepted principles of democratic employee organization and with legal rules governing agencies proposing to speak and act for employed persons and groups.

3. Principle III: Sound principles and practices of administration are essential to a successful economic security program. Administrative practice should ensure effective planning, direction, co-ordination and control of the program by the staff within the scope of basic policies established and authority delegated by the board of directors.

4. Principle IV: The state nurses association should use all appropriate, including legal, instruments for putting the economic security program into effect.

The Functioning Economic Security Program

After plans for the implementation of the security program have been made, and after the state association and interested members have accepted the plan for adoption, other important steps would be taken under the ANA plan. One of the first necessary steps is the establishment of employment standards.

The establishment of employment standards involves drafting a schedule, the adoption of that schedule by the sub-unit or section, and the distribution of the adopted employment standards. The first of these steps, the establishment of employment standards, would be accomplished by a committee on employment

conditions. This committee would be elected by the section or sub-section, and would be responsible not only for the initial establishment of standards, but for annually reviewing those standards as well.

The state association, of course, accepts certain responsibilities to aid the committee on employment conditions. The association would compile and interpret the economic data necessary to the intelligent preparation of employment standards. In addition, they would recommend provisions which would be considered by the committee in drafting standards. As the committee on employment conditions began the actual drafting of standards, the state association would provide for that committee a headquarters staff member who would be responsible for the program. This staff member would advise and assist in the drafting of the standards. Lastly, the state association would review the employment standards established by the committee, and make whatever recommendations for revisions that are deemed necessary because of economic changes or additional provisions needed.

The next step to be considered is the actual adoption of the employment standards by the sub-unit or section. The sub-unit committee on employment conditions, after drafting the employment standards, would present those standards to the membership at a regular business meeting. At that time the provisions would be discussed and their adoption voted on. Once the adoption of the standards by the section is complete, the section chairman would present the employment standards to the state association's

board of directors. The board of directors subsequently reviews and approves these standards, or it recommends revisions as needed. Finally, as soon as the standards are approved by the board of directors of the state association they become the official standards recommended by the state association.

In review, then, several requirements would have to be met by the OSNA in establishing employment standards under the ANA security program. The employment standards to be presented for adoption would first be drafted by a committee on employment conditions, a committee elected by a section or sub-section. The state association would aid in the drafting of these standards. The OSNA would have to compile the necessary economic data, suggest provisions to be considered, provide the committee with a responsible staff member, and review the recommended standards of the committee, suggesting changes where necessary. The sub-unit committee would then present the standards to the membership for adoption. After adoption, the standards would be submitted to the OSNA's board of directors and, upon their subsequent adoption, would become the official standards for the state association.

At this point, the headquarters staff of the OSNA would assume the responsibility of distributing the new employment standards by those means available to it. This would include press and radio releases, the publishing of the standards in the state nurses association bulletin, sending standards to the employers of nurses affected by them, and notifying local units of the availability of new or revised employment standards.

Earlier it was indicated that several steps must be taken after the official adoption of the security program by the state association. The first such step was the establishment of employment standards by the state association. The second step to be taken would be the development of the local units. A "local unit" is defined by the American Nurses Association as "an organization of registered professional nurses regularly employed at the same level in one institution, plant or agency."[14] This would include, for example, all of the general duty nurses in one hospital. The purpose of the local unit is to bring about improvements in employment standards through the economic security program adopted by the state association.

The values of an early and effective development of the local unit would be several. The nurse within the well-developed local unit would gain a certain amount of freedom from anxiety due to job insecurity. In addition, the strong local unit would reduce turnover in the nursing profession, when such turnover is caused by dissatisfaction with employment conditions. Finally, the strong local unit would develop a democratic atmosphere in which nurses could freely discuss their problems, participate together, and share responsibility.

Further, the local unit would have several important relationships to the state and district associations and to the section. One of the most important of these relationships would

---

[14] Ibid., p. 22.

lie in providing an effective channel of communication from the local unit to the section, the district association, and the state association. In return, the state and district associations would have distinct relationships with the local unit. The state association would promote the local unit and help in its organization. It would assist the local unit in identifying the needs of the group and in advising on the use of parliamentary procedure, the adoption of rules, and so forth. The state association would also supply the local unit with economic data and give direct aid in the preparation of contracts. Finally, the state association could act as spokesman for the local unit and could aid in the development of industrial relations, public relations, and legal counsel.

The district association would have certain obligations toward the local group as well. Most of the help given by the district associations, however, would lie in encouraging and promoting the organization of those units, and in encouraging the free exchange of information between the local units and the district association.

The local unit might develop as a natural tendency; that is, the unit might develop on the basis of two or more nurses sharing common problems and desiring to air their opinions to a responsible organization. But perhaps the most effective units would be those that developed under the guidance and sponsorship of state nurses associations with active economic security programs. In the early stages of the development of the local unit,

two or more nurses may call a meeting of all nurses on the same level of employment. At this meeting group discussions would be held to discuss the purpose of the organization, how it functions, and how the members can use the unit for their own betterment. Of course, the unit with a more formal organization would probably be the one most likely to succeed. And, in order to become fully effective, the group should elect officers and adopt by-laws. From that point on, any problems with employment would be discussed with the employer by a committee and not by an individual nurse. It should be pointed out that the establishment of the local unit is not designed to preclude staff meetings that exist for purposes of communication between a director of nurses, supervisors, head nurses, and general duty or staff nurses. Meetings of the local unit would serve as a supplement to those meetings, and not in lieu of them. However, the only members attending the meetings of the local units would be those members belonging to the specific category of nurses for which the local unit was established.

The functions of a local unit are severalfold. Of primary importance is promoting contractual improvements in employment conditions. The unit would also serve as a central point through which grievances could be aired and the contract administered. It would also accept the responsibility of submitting to the headquarters of the state nurses association a list of all the names, addresses, and telephone numbers of its officers.

Under the guidance of the OSNA the local unit would

engage in the collection of useful economic data on salaries and personnel policies within the community, and would keep a current file of newspaper articles and other materials that have direct bearing upon salary increases and local economic trends. Very importantly, the local unit would interpret the clauses of the negotiated contract and set up grievance machinery.

In addition to the establishment of employment standards and the development of a well-functioning local unit, the state association must also consider developing a program of giving assistance to nurses. In developing this program, it would perhaps be well to divide the plan into two categories: assistance to nurses in non-official institutions, agencies, or other establishments; and assistance to nurses in official institutions, agencies, or other establishments. Non-official institutions are here defined as non-civil service institutions, and official institutions as civil service institutions. The need for this division should become apparent in the discussion which follows.

Assistance to Nurses in Non-Official Institutions, Agencies, or Other Establishments. When nurses who can be classified in the non-official category find themselves with problems concerning employment conditions, wages, and hours of work, which they have not been able to solve individually, the local unit would call a meeting to discuss these problems. This group would also give consideration to the possibility of requesting help from the state nurses association if problems could not be solved locally.

If it is decided that negotiations are needed between the local unit and their employees, a request may be made for assistance in establishing a negotiating committee. If a request is made for assistance from the state association, a staff member of the association would answer the request, and keep the district informed of his actions. To facilitate the establishment of collective bargaining machinery the staff member would explain to the nurses the nature of collective bargaining, the appropriate bargaining unit, and the designation of the state nurses association as the collective bargaining agent. The local group would then decide if they wished the state association to assist them in the negotiations with their employer for a contract. If the group should ask for assistance from the state association, written authorization would be obtained by the association, with a majority of the members of the bargaining unit signing the authorization. Such authorization would enable the state association to act for the total membership of the local group.

Under the ANA plan, if a contract is to be negotiated by the local group, the OSNA would offer assistance in the formulation of tentative proposals which the group agrees should be included in the contract. Among these proposals would be the state association's minimum employment standards and a sample contract. Plans would also be laid for the collection of needed data by the nurses and the state association. The OSNA staff member then would incorporate the groups' suggestions into the tentative contract, consulting industrial relations council as

needed. Following this, the tentative contract would be presented to the group for acceptance or change. Such assistance from the state association would enable the local unit to avail itself of material and information provided to the state association by the ANA.

In preparing for negotiations, the local unit officers, and possibly a few elected members, would constitute the negotiating committee. A representative from the OSNA designated by the association normally would act as the spokesman for the committee if requested to do so.

Finally the bargaining process itself would begin. Arrangements would have to be made by the OSNA with the employer for a negotiating conference. The nurses' contract proposals usually would take precedence when the negotiations actually begin. During the negotiations, each section of the proposed contract would be read and discussed by those present at the conference. Amendments would probably be suggested, and both parties would probably make concessions before a final agreement was reached. When agreement could not be secured upon a particular issue, that issue would be tabled for discussion at a later time. As agreement was reached on other issues, solutions or concessions might be forthcoming which would effect a willingness to make an adjustment on the tabled issue.[15]

---

[15]It is important to note at this point that the nurses association is not free to use the strike or the threat of a strike as a weapon in negotiations because of their "non-strike" agreement. The significance of this fact is discussed more fully in Chapter VI of this study.

After the contract is tentatively agreed upon by the nurses' negotiating committee and the employer, the membership of the local unit would still have to approve the contract before negotiations would be concluded.

Upon the acceptance of the contract by the local unit, the representatives of both parties would meet and sign the contract, at which time it would be formally accepted by the parties involved. Subsequently, public announcement of the terms of the contract would be made by the OSNA, and copies of the contract would be provided by the association for all members of the local unit.

Assistance to Nurses in Official Institutions, Agencies, or Other Establishments. In non-civil service groups, public employees generally have the same right to have their grievances presented by representatives of their own choosing as do nurses in non-official institutions (discussed above). Accordingly, the preliminary steps taken by nurses employed in public service not included in an established civil service system would be the same as those taken in non-official hospitals or other agencies.

Nurses employed under a civil service system represent a unique group, but one which nevertheless might benefit from an association with a central organization such as the Oklahoma State Nurses Association.

The salaries of nurses employed under a civil service system are determined by law. If the nurses wish to air their grievances, they may request the state nurses association to

prepare the case of the nurses in the form of an economic brief or statement. This statement would then be discussed with the superintendent or director of the individual institution or agency, the director of the institutions within the civil service system, and the director of civil service. These discussions with the various directors would serve to enlist the support of each division and to determine what changes, if any, would be feasible at that time.

Under a state civil service system, the state legislature generally must meet and amend certain laws before any adjustments can be made in salaries or other working conditions. And, it may be necessary for them to increase appropriations before the requests of the nurses can be met. Letters and active political participation by individual nurses to influence their own senators and representatives could be a very effective tool in a situation of this kind.

Other Problems. An active economic security program in Oklahoma would very likely present many problems which the majority of nurses have not been accustomed to handling. In these cases the OSNA would be expected to do everything possible to assist the local groups. Aid in interpreting the contract and in handling grievances might be necessary. When problems arise because of conflicting interests it might be possible to effectively use mediation or voluntary arbitration when negotiations reach a stalemate. Under the process of mediation, a disinterested third party would intervene at the invitation of the employer and the

nurses. Under mediation, there would, of course, be no compulsory acceptance of the recommendations made. If, however, both the nurses and the employer should decide upon voluntary arbitration, the decision of the dispute by the disinterested third party would be binding. Both the nurses and the employer would be bound to abide by his decision regarding the settlement of the problem.

As members of the state nurses association, all nurses could expect some form of economic security assistance from their state headquarters, although in some cases goals might have to be achieved rather gradually. While this program is basically designed to serve groups of nurses, help and advice on economic security matters would also be available to nurses individually employed or in single-type positions.

Nurses employed individually might benefit from considering an individual contract. Private duty nurses could act through their own state sections and through the OSNA to promote programs for advancing the economic interests of their group. Statewide standards of employment might be established by the state private duty section and enforced by the nurses themselves after approval from the state association's board of directors.

Provision might also be made in the state private duty section rules for a standing committee on employment conditions. The function of this committee would be to prepare tentative employment standards for the group, with assistance from the OSNA if desired. After drafting tentative employment standards, the committee would present a draft of the suggested standards

to the state private duty section for approval. After suggested revisions were agreed upon, the state section would adopt the standards, and forward them to the state association's board of directors for review and approval. The state board would then either officially approve the standards or return the schedule of employment standards to the section with suggestions for revision. After the standards were adopted by the section and approved by the board, they would become the official standards of the private duty section, subject to annual review and possible revision.

As before, the OSNA would be expected to arrange for the printing and distribution of the accepted standards, and to send a notification of a change in standards to registries, hospitals, individuals currently employing private duty nurses, and other interested groups. It would then be up to the private duty nurses who were members of the state association to begin to charge the patient the new private-duty fee at the effective date.

Counseling and Placement

Another aspect of the American Nurses Association's economic security program is counseling and placement activities. The ANA has established a Professional Counseling and Placement Service (PC&PS) which provides services both to the nurse and to the employer. A program of this nature might also be helpful on the state level. The PC&PS would be responsible for providing information to interested nurses about positions which were

currently available, available salaries, and working conditions at various establishments.

The PC&PS on the state level could become a great deal more than its name implies. For in addition to providing needed information about employment possibilities and nurses available for employment, the PC&PS could also engage in several other tactics which might serve to strengthen the nurses' position in the state. For example, the PC&PS could be provided with the employment standards developed by the association for each category of nurse in Oklahoma. With a knowledge of these standards the PC&PS could bring them to the attention of all employers of nurses within the state, and request that they attempt to meet these standards. The group could also strongly encourage nurses to seek employment with employers who have met the required standards. Also, it might become advisable for the PC&PS to make clear to employers who refuse to meet the minimum standards that positions which have to be filled would not be listed with the PC&PS until the minimum standards set by the OSNA were met in full.

Lastly, some professional organizations (such as the American Association of University Professors) have had success with a plan wherein the names of employers who refuse to meet certain professional standards are published monthly for distribution to members of the association and to the general public. This aspect of the PC&PS program could have a great deal of impact for the nurses of Oklahoma. The employers concerned would, of course, be told of the intended listing and would be given

opportunity to remedy the situation. However, upon failure to do so, a listing of this type would certainly put pressure upon the delinquent employers--pressure which otherwise may not be available due to the non-strike position of the ANA. Once the minimum standards of the association were met by the employer, his name and organization would be removed from the circulating list. A list of this type would be kept current and cumulative.

Summary

In this chapter various facets of collective bargaining for professional nurses were discussed. Inasmuch as the economic security program of the American Nurses Association is one possible program which might be adopted by the Oklahoma State Nurses Association as a vehicle for initiating collective bargaining, this program was also examined. This examination outlined the framework of the economic security program and pointed out some of the problems inherent in it.

The economic security program was seen to depend upon the state associations for success. The ANA acts only in an advisory and data-gathering capacity, not as the force implementing the program for the various states. It was seen that carefully laid plans are first necessary if a program such as this is to be fully realized. Only after cautiously examining all aspects of the problem could the OSNA move forward toward the realization of its goals under the program. The necessary preliminary plans would be made by a temporary committee established

for that purpose. Its report would be presented to the OSNA's board of directors for approval or changes. After acceptance of the proposal by the board of directors, a resolution for the adoption of the economic security program would be presented to the membership of the association. At this point, the temporary committee would be dissolved and the board of directors would accept the responsibility of administering the program and would appoint an executive secretary to carry out the administrative details.

Broadly, the responsibilities and functions of the OSNA under such a program were seen to revolve around aid in organization, assistance to interested groups, the maintenance of necessary records, education of the member nurses and the public, the compilation of necessary economic data, and the continuous evaluation of the program's success and progress. Several criteria were offered by the ANA to evaluate the effectiveness of the state program, among which were the quality of leadership and sound practices of administration.

After examining the general nature of the economic security program, a brief description was made of the functioning of that program. Two significant processes were examined: the establishment of uniform employment standards and the development of local units, whose broad purposes would be the improvement of employment standards and the provision of channels of communication between the local, district, and state groups.

Two groups of nurses were noted regarding the approach

which would be most useful in the negotiating procedures. It was pointed out that in the case of nurses in non-official institutions, agencies, or other establishments, meetings could be called by two or more nurses on the local level to discuss employment problems. This group might, in turn, solicit help from the OSNA in preparing for negotiations. Finally, the negotiation procedure for nurses in non-official institutions was studied up to, and including, the final acceptance of the written contract by both the nurses and the employer.

It was seen that nurses in official institutions, agencies, or other establishments often present a different picture. In the case of non-civil service groups the procedure is much the same as for nurses in the non-official groups. However, in the case of nurses working in a civil service situation, salaries were seen to be determined in large part by legislation. And for this reason, the suggestion was made that nurses, as individuals, might take an active part in writing their senators and representatives in an effort to persuade them to pass legislation favorable to the nurses. Also, the possibilities of mediation and voluntary arbitration were discussed as possible alternatives when an impasse is reached around the negotiating table.

While this chapter has examined one possible approach to solving employment problems--the use of collective bargaining--many other areas must be studied before a definite conclusion can be reached by the OSNA regarding the specific type of program they may wish to adopt. One such area is examined in the following

chapter by discussing more specifically the relationship between professional nurses and various types of legislation which concern professional nurses.

CHAPTER VI

NURSES AND LEGISLATION

Some of the economic data necessary to the evaluation of the economic status of the nursing profession in the state of Oklahoma were examined in Chapters III and IV. Collective bargaining was suggested in Chapter V as one possible method of remedying adverse conditions in the profession. However, there are other areas which have to be examined before a conclusion can be drawn regarding the most appropriate avenue of bettering working conditions. This chapter contains an examination of one of the most important of these areas--state and Federal legislation.

Any program of organized action to improve working conditions on the part of a nurses association must be advanced subject to whatever constraints Federal or state statutes may provide, as well as subject to whatever rights and privileges may be statutorily present.

Federal Legislation

There are three Federal laws which are significant in their effect upon nurses. These are the Federal Social Security

Act, the Labor-Management Relations Act (Taft-Hartley Act), and the Fair Labor Standards Act (Wage and Hour Law).

The Federal Social Security Act provides for two nationwide systems of social insurance which give protection to workers and their families against loss of income due to unemployment, old age, and death. The Old Age and Survivors Insurance System (OASI) is an all-Federal system. The Social Security Administration of the Department of Health, Education and Welfare is responsible for carrying out this program. Unemployment insurance is a Federal-state plan under which each state sets up its own law and administrative agency, with the Federal government paying the operating costs. The ANA has historically suggested proposals to amend the Social Security Act, and supports proposed changes which would extend coverage or improve benefits for nurses. As a result of these activities, the majority of nurses have now been brought under OASI coverage. However, in most states they are not covered under the unemployment insurance system.

The Labor-Management Relations Act (Taft-Hartley Act) guarantees the right of workers to organize and to bargain collectively with their employers (in interstate commerce only). Certain groups of employees, however, are exempted from the provisions of the Taft-Hartley Act. Among those exempted from the provisions of this Act are employees in non-profit hospitals, government employees, supervisors, and independent contractors. Still, there is no provision that bars employees from negotiating with their employers in these areas. The American Nurses

Association and the state nurses associations have, for several years, endeavored to secure the elimination of the non-profit hospital exemption from the Federal law.

The Fair Labor Standards Act is administered by the Secretary of Labor through the administration of the Department's Wage and Hour Division. This law sets minimum wages and overtime standards which apply in interstate commerce. However, as is the case under the Taft-Hartley Act, this act also contains provisions for exempting non-profit institutions, and has the effect of excluding nurses from this overtime coverage.

Thus, the major Federal legislation under which Oklahoma's nurses might seek to better their working conditions are seen to be the Federal Social Security Act, the Taft-Hartley Act, and the Fair Labor Standards Act. Further, since most nurses are now included under the OASI coverage provided for by the Federal Social Security Act, it appears likely that any attempt to change existing Federal legislation would have to be directed at the Taft-Hartley Act, the Fair Labor Standards Act, or unemployment insurance laws.

As was previously pointed out, the Taft-Hartley Act exempts non-profit hospitals from the necessity of negotiating with their employees. And the Fair Labor Standards Act exempts non-profit hospitals from minimum wage provisions. Thus, it appears that the state association would most likely aim any pressure for changes in Federal legislation at the exempt provisions of these two acts.

Though the ANA and the state associations do, in fact, desire changes in these exempt provisions, it seems unlikely that such changes would come about--or even be desirable--under the existing framework of this legislation. Both the Taft-Hartley Act and the Fair Labor Standards Act apply to interstate commerce only. This alone would preclude coverage of most non-profit hospitals.

Neither of these acts specifically bar negotiations or the establishment of minimum wages on the state level; thus, the way is clear for the OSNA to pursue such legislation provisions on the state level. But the guarantee by Federal legislation of the right of negotiation and minimum wages for intrastate commerce oversteps the traditional bounds set for these two Federal acts.

Therefore, rather than trying to change the framework of these two Federal acts, the state association would, in all likelihood, do better to concentrate upon achieving its objectives through state and local channels, not by means of the Taft-Hartley Act or the Fair Labor Standards Act.

State Legislation

State labor relations acts have long recognized the right of employees to organize and bargain collectively to prevent disputes, but in some states hospitals and other non-profit institutions have been exempted from the state labor laws, and in other states no such laws exist. Since the membership of the American Nurses Association (and hence all state nurses associations) have voluntarily relinquished the right to strike, it is particularly

important for the state association to be aware of existing legislation within the state and the need for additional legislation. Oklahoma does not have a state labor relations law at the present time.[1]

The ANA has suggested certain principles of labor legislation upon which any action by state nurses associations to gain recognition and protection of nurses' rights under state laws regulating employer-employee relations should be based.[2] The main provisions of these principles are summarized here for their relevance to the OSNA.

According to the ANA, state labor relations acts should guarantee the rights of nurse employees to full freedom of association, to form their own organizations, and to bargain collectively through representatives of their own choosing. In addition, these laws should require the employers to bargain in good faith with the duly-chosen representatives of the nurses in the exercise of their rights to bargain. The law should explicitly state that refusal to bargain with the representatives chosen by his employees, interference with, restraint, or coercion of the employees in the exercising of their guaranteed rights, domination or interference

---

[1]Only 12 states and Puerto Rico now have labor relations acts, and their coverage of hospitals is not uniform. Five of these acts provide no protection of bargaining rights in private hospitals, and four of the acts make no mention of bargaining in non-profit hospitals. (Daniel H. Kruger, "Bargaining and the Nursing Profession," Monthly Labor Review, Vol. 84, No. 7, July, 1961, p. 705.)

[2]American Nurses Association, Labor-Management Relations as They Affect the Economic Interests of Nurses (New York: American Nurses Association, December 27, 1956), pp. 2-4.

with the formation or administration of the professional association which seeks to represent his employees, and discrimination against an employee because of his activities in an employee organization all constitute unfair labor practices on the part of the employer.

Further, the ANA recommends that the state association provide explicit machinery for the determination of employee bargaining units by secret ballot. (It should be remembered at this point that the bargaining unit would be a homogeneous group of employees with similar interest, duties, and preparation, as was explained earlier.)

As was pointed out above, many non-profit institutions, such as non-profit hospitals, are currently exempt from coverage under state labor laws. The Oklahoma association may wish to prevent such an exemption clause from being incorporated into the state labor laws of Oklahoma.

These areas, then, represent some provisions which might be included in effective state labor legislation in Oklahoma. These proposals have been suggested by the ANA as desirable goals for state associations. If the state of Oklahoma should decide to implement a state labor relations law, it would appear advisable for the OSNA to make every attempt to carry out these proposals in order to insure adequate protection of nurses under that law. As an alternative to the actual introduction of such state legislation--with the possible risk of numerous anti-labor provisions--the OSNA might be well advised to attempt to insure that these

provisions are included in a state labor relations act should such an act be introduced in the state legislature. However, if a state labor relations law in Oklahoma were patterned after the National Labor Relations Act, and if such legislation did not exempt non-profit organizations, there can be little doubt that the state nurses would gain additional legislative protection.

Should the OSNA desire to introduce a state labor relations law, its successful introduction and subsequent passage would, of course, be partly dependent upon the support of that legislation provided by the member nurses in the state. And, in this respect, the OSNA might find it necessary to convince the nurses of the need for such legislation. The state association would need to point out to its members that professional nurses have the same need for collective bargaining as do other groups, and that there is a need for an examination of existing state laws to determine if those laws discriminate against nurses.

Many persons, nurses included, tend to give sanction to the exemption of non-profit organizations from the operation of the state laws. Thus, the state association would need to point out to its member nurses that the inclusions of such exemption provisions denies recourse to many of the professional nurses employed within the state, and in addition, that there is nothing inherent in the organization of non-profit institutions which should make them eligible for such exemptions.

Another type of labor legislation which deserves the careful attention of the OSNA is the "right-to-work" law.

Several states at the present time have union security laws termed "right-to-work" which prohibit the requirement of membership in a labor organization as a condition of employment.[3] None of the state laws now in existence contain an exemption of non-profit employers or of non-profit hospitals. The OSNA should determine its policy regarding right-to-work laws in anticipation of the introduction of such a law in the state of Oklahoma. One does not yet exist, although agitation for such a law is becoming increasingly prevalent. The terms "labor organization" and "labor union" in the right-to-work laws are usually defined rather broadly, and it would appear that a state nurses association might well be included if it has an economic security program.[4]

The OSNA would probably find it advantageous to take a position of opposition to the introduction of a right-to-work law in the state of Oklahoma, inasmuch as such a law would undoubtedly prohibit the requirement of membership in a labor organization as a condition of employment, and would probably apply to the state nurses association. Thus, if such a law were to be passed in Oklahoma, the OSNA would lose much of its potential strength as the possible bargaining agent for the state's professional nurses.

Another significant type of legislation which might be of concern to the OSNA is the "fair employment practice law."

---

[3] Julius J. Manson, "Statutory Support for the Economic Security Program," The American Journal of Nursing, Vol. 55, No. 9 (September, 1955), pp. 1065-67.

[4] Ibid.

These laws are intended to eliminate discrimination in employment based on race, color, creed, national origin, or ancestry. Several states now have these laws, but Oklahoma is not one of them. Such a law in the state would serve as additional protection for nurses who are members of minority groups inasmuch as discrimination by an employer would then be illegal. Once again, however, the introduction and passage of legislation of this type in Oklahoma would not be an easy matter. Because the fair employment practice law deals with a problem in which many people in many sections of the nation are emotionally involved, special care would have to be taken in gaining support for such a law in Oklahoma. Still, it would seem that the state association's support for a fair employment practice law would be quite consistent with their state goal of non-discrimination. And for this reason it might prove advantageous for the OSNA to introduce such an act.

In summary, the major fields in which the OSNA might seek to initiate legislation advantageous to the state's nurses include a state labor relations law, machinery for settlement of disputes, and a fair employment practice law. In addition, the OSNA would be well advised to oppose any "right-to-work" law should one be introduced in the state legislature. Finally, the state association would probably find little advantage in attempting to work through the Federal Social Security Act, the Taft-Hartley Act, or the Fair Labor Standards Act.

CHAPTER VII

CONCLUSIONS

The purpose of this study has been to examine the economic status of registered professional nurses in the state of Oklahoma. In order to accomplish this objective, it was necessary to divide the study into several areas, which included a detailed analysis of statistical data showing the economic status of nurses in the state.

In Chapter III information was presented which indicated that the professional nurse in Oklahoma is at a disadvantage when compared to other occupational groups or to certain accepted standards of employment. Among the problem areas examined were low salaries, an overly-long work week, a general lack of reimbursement for professional expenses incurred, an absence of over-time compensation in many instances, inadequate retirement plans, and ill-defined policy-making procedures. Certain groups of nurses were seen to experience other economic difficulties, but the problems mentioned above applied to all groups within the profession. Specific proposals were suggested by the author to help remedy these problems.

It was stated that the American Nurses Association has

an active interest in the economic welfare of its members, but that in general that organization has been ineffective in terms of promoting an active program to secure those interests. Thus it was suggested that any program to alleviate the economic problems of the state's professional nurses would have to come from the state association.

In addition, it was pointed out that the Oklahoma State Nurses Association has not, at the present time, been able to alleviate adverse employment conditions. However, the leadership of that association is currently showing an active interest in bringing about better working conditions, and appears to be willing to put forth the necessary effort to do so. The conclusion was reached by the author that the state association should be quite active in this respect.

While the ANA economic security program was briefly reviewed as a possible framework for the solving of some of the economic problems faced by the state's nurses, it was mentioned that this program is but one possible alternative; and before a definite program is adopted, additional research will be necessary, particularly in the areas of legislation and collective bargaining.

Certain areas of resistance to an economic security program were pointed out--the most important being employer resistance to the program and a lack of understanding of the nature of the program by the nurses themselves. Therefore, if the OSNA should decide upon a program of this kind, it would be necessary for the association's leaders to engage in an extensive educational

program designed to eliminate hostility on the part of persons who employ nurses, and to educate the member nurses of the state regarding the purpose and objectives of such a program. Only in this manner could state support for an economic security program be obtained.

It is hoped that the data presented here, and the suggestions made as a result of this study, will provide some valuable insight into the nursing profession in the state of Oklahoma, and that the study will serve as an important part of the foundation needed for the elimination of economic problems facing the state's professional nurses. However, the research results contained in this study cannot solve those problems. The value of research of this nature lies in the aid it can lend to those who will ultimately provide intelligent direction and control to a state economic program.

BIBLIOGRAPHY

Books

American Nurses Association, Inc. A Manual for an Economic Security Program. A manual prepared by the Economic Security Unit. New York: American Nurses Association, Inc., January, 1956.

Cody, Elwyn L., Jr. Law and Contemporary Nursing. Nurses' Handbook Series. Paterson, New Jersey: Littlefield, Adams and Company, 1961.

Hughes, Everett C., Hughes, Helen MacGill, and Deutscher, Irwin. Twenty Thousand Nurses Tell Their Story. Philadelphia: J. B. Lippincott Company, 1958.

Slichter, Sumner H., Healy, James J., and Livernash, E. Robert. The Impact of Collective Bargaining. Washington, D. C.: The Brookings Institution, 1960.

Spalding, Eugenia Kennedy. Professional Nursing Trends and Relationships. 5th ed. revised. Philadelphia: J. B. Lippincott Company, 1954.

U. S. Department of Commerce, Bureau of the Census. Statistical Abstract of the United States. Washington, D. C.: U. S. Government Printing Office, 1960.

Yoder, Dale, and Heneman, Herbert G., Jr. Labor Economics and Industrial Relations. Cincinnati, Ohio: Southwestern Publishing Company, 1959.

Articles and Periodicals

Gillingham, J. B. "Collective Bargaining and Professional Ethics," The American Journal of Nursing, Vol. 50, No. 4 (April, 1950), pp. 214-16.

Hollberg, Otto and Jarrell, Alexander. "Supplementary Wage Benefits in Metropolitan Areas, 1959-60," Monthly Labor Review, Vol. 84, No. 4 (April, 1961), pp. 379-87.

"If a Hospital Strike Occurs," The American Journal of Nursing, Vol. 60, No. 3 (March, 1960).

Kanninen, Toivo P. "Economic Status of Social Welfare Workers in 1960," Monthly Labor Review, Vol. 84, No. 8 (August, 1961), pp. 862-68.

Kassalow, Everett M. "Organization of White-Collar Workers," Monthly Labor Review, Vol. 84, No. 3 (March, 1961), pp. 234-38.

Kruger, Daniel H. "Bargaining and the Nursing Profession," Monthly Labor Review, Vol. 84, No. 7 (July, 1961), pp. 699-705.

Lesansky, Helene T. "Federal Classified Employees' Salary Changes, 1958-60," Monthly Labor Review, Vol. 84, No. 5 (May, 1961), pp. 489-99.

Manson, Julius J. "Statutory Support for the Economic Security Program," The American Journal of Nursing, Vol. 55, No. 9 (September, 1955), pp. 1065-67.

Northrup, Herbert R. "Collective Bargaining and the Professions," The American Journal of Nursing, Vol. 48, No. 3 (March, 1948), pp. 141-44.

Schutt, Barbara G. "The ANA Economic Security Program...What It Is and Why," The American Journal of Nursing, Vol. 50, No. 4 (April, 1958), pp. 520-24.

Surveys, Studies, and Reports

American Nurses Association, Inc. Facts About Nursing. New York: Research and Statistics Unit, American Nurses Association, 1960.

_____. Labor-Management Relations as They Affect the Economic Interests of Nurses. New York: American Nurses Association, Inc., December 27, 1956.

_____. Spot Check of Current Hospital Nursing Employment Conditions, February, 1959. New York: Research and Statistics Unit, American Nurses Association, Inc., 1959.

_____. Survey of Employment Conditions of Professional Registered Office Nurses, June, 1958. New York: Research and Statistics Unit, American Nurses Association, Inc., 1958.

_____. Survey of Salaries and Personnel Practices in Effect October, 1958, for Teachers and Administrators in Nursing Educational Programs. New York: Research and Statistics Unit, American Nurses Association, Inc., 1959.

Division of Nursing Resources. Survey of Nursing Needs and Resources in Oklahoma--1956. Oklahoma City: Federal Security Agency, Public Health Service, Division of Nursing Resources, April, 1951.

Oklahoma State Hospital Advisory Council. Survey of Health Facilities and Needs--Oklahoma County, Oklahoma. Oklahoma City: Oklahoma State Hospital Advisory Council, December, 1959.

Rogers, William E. Employment Practices With Respect to Nurses of Oklahoma. Studies in Business and Economics Number Ten. Norman, Oklahoma: Bureau of Business Research, College of Business Administration, The University of Oklahoma, October, 1953.

Spohn, Roberta. A Survey of Selected Issues and Statistical Facts Concerning Health Insurance. A survey prepared for the American Nurses Association, Inc., Committee on Legislation. New York: December, 1957.

U. S. Department of Labor, Bureau of Labor Statistics. The Economic Status of Registered Professional Nurses, 1946-47. Bulletin No. 931. Washington, D. C.: U. S. Government Printing Office, December, 1947.

_____. 1960 Handbook on Women Workers. Bulletin No. 275. Washington, D. C.: U. S. Government Printing Office, 1960.

Pamphlets

American Nurses Association, Inc. Functions and Qualifications for School Nurses. A pamphlet prepared by the School Nurses Branch of the American Nurses Association, Inc. New York, n.d.

_____. Functions, Standards, and Qualifications for Occupational Health Nurses. A pamphlet prepared by the Occupational Health Nurses Section of the American Nurses Association, Inc. New York, n.d.

_____. Functions, Standards, and Qualifications for Practice for Educational Administrators and Teachers. A pamphlet prepared by the Educational Administrators, Consultants and Teachers Section of the American Nurses Association, Inc. New York, n.d.

_____. Functions, Standards, and Qualifications for Practice for the Head Nurse. A pamphlet prepared by the Head Nurses Branch, General Duty Section, of the American Nurses Association, Inc. New York, n.d.

_____. Functions, Standards, and Qualifications for Practice of the General Duty Nurse. A pamphlet prepared by the General Duty Nurses Section of the American Nurses Association, Inc. New York, n.d.

_____. Functions, Standards, and Qualifications for Public Health Nurses. A pamphlet prepared by the Public Health Nurses Section of the American Nurses Association, Inc. New York, n.d.

_____. Functions, Standards, and Qualifications for the Practice of Private Duty Nursing. A pamphlet prepared by the Private Duty Nurses Section of the American Nurses Association, Inc. New York, n.d.

U. S. Department of Labor, Women's Bureau. Nurses and Other Hospital Personnel. Pamphlet Six. Washington, D. C.: U. S. Government Printing Office, 1958.

APPENDIX I

SAMPLE RESOLUTION RELATIVE TO ADOPTION OF ECONOMIC SECURITY PROGRAM BY STATE NURSES ASSOCIATIONS[1]

WHEREAS, The nurses of this state association believe that professional employees, regardless of degree of preparation or level of responsibility, are subject to the economic problems and forces that affect other workers; and

WHEREAS, We believe that nurses are entitled to the rights of full freedom of association and liberty of contract accorded to all employees by contemporary legal and social sanctions; and

WHEREAS, We recognize the necessity for unified action through organization to maintain these rights; therefore be it

Resolved, That the officers and directors of this association be authorized and directed to proceed with the development of an economic security program to improve the employment conditions of registered nurses in this state by using all appropriate instruments, including collective bargaining, terminating in written contracts, wherever this technique is applicable.

---

[1]The form for Appendices I-IV is adopted from the suggested form contained in the American Nurses Association, Inc., A Manual for an Economic Security Program, op. cit.

APPENDIX II

SAMPLE FORM FOR ASSIGNMENT OF BARGAINING RIGHTS

OKLAHOMA STATE NURSES ASSOCIATION

OKLAHOMA CITY, OKLAHOMA

ASSIGNMENT OF BARGAINING RIGHTS

I hereby authorize the Oklahoma State Nurses Association to act as my sole representative or bargaining agent in negotiations or collective bargaining on matters of salaries, hours of work and all other terms and conditions of employment.

Signed: _____

Street & Number: _____

City & Zone: _____

Date: _____

APPENDIX III

SAMPLE CONTRACT COVERING HOSPITAL GENERAL DUTY, ASSISTANT HEAD, AND HEAD NURSES

Instruction Sheet for Sample Contract

The attached sample contract should be used as a guide only. It is not intended that it will furnish the complete text for use in any one situation. It is probable that changes and additions based on the particular employment situation will need to be made in each provision of the agreement, elaborating on particular provisions to give as great a degree of protection as it is possible to secure as a result of the bargaining process. Samples of additional contract clauses are available from the American Nurses Association Economic Security Unit.

No provisions for "social insurance" plans have been included. In the case of nonprofit hospitals that have not accepted federal social security, provision should be included requiring the hospital to take the necessary steps to make those benefits available. When agreement can be secured for the inauguration of a retirement plan which is supplemental to federal social security, this should be specified in the text of the contract or in a separate agreement. Provisions should be added covering life,

sickness and accident hospitalization, surgical care, medical care, or other employee benefit plans which are negotiated. (The majority of such plans in business and industry are noncontributory.)

Preamble

In the preamble to the contract the first blank spaces should be filled in with the day, the month, and the year. The remaining blanks specify the name of the hospital and the state nurses association. A brief explanation of the remainder of the contract follows:

Article I: Scope of Contract

This paragraph should specify the classification of the nurses for whom the Association is acting as bargaining agent. The contract should cover all nurses who are eligible for inclusion in an appropriate bargaining unit. Supervisors and administrative and executive personnel having authority to hire, discipline, discharge, adjust grievances, or to recommend such action should be excluded from the bargaining unit of general duty nurses.

If the Association has been certified as the bargaining agent by any federal or state agency, the certification should be referred to in this section.

Article II: Association Membership and Security

If federal or state laws are applicable to the institution in question, this clause should be written in compliance with any specified regulations.

Article III: Nondiscrimination

Self-explanatory.

Article IV: Salaries

This paragraph should include basic minimum monthly salaries for each classification of nurses listed in Article I. In filling in the blanks for additional compensation as recognition of length of service, your proposal for the number of increments and for the period of time to elapse between increments should be determined by the nurses, as should the monetary value of the increment. It may be that more than three increments will be desired. If so, additional periods can be added.

Article V: Hours of Work and Premium Pay

Hours and overtime pay. Self-explanatory.

Shift differentials. If the premium for night shift work is to be the same as for the evening shift, the two sentences under "Shift Differentials" can be combined.

In determining the premium for special service, it should be decided which special duties are applicable to the particular hospital and such special duties enumerated, e.g., "operating-room work," "delivery-room work," "communicable disease nursing," etc.

Special service differentials. If employees work less than one month on a premium shift or special duty, a clause specifying the rate of pay for such services should be included in the agreement.

On call and call back pay. The first blank in the "on call"

provision is for the amount the nurse should receive because of the fact that she is on call. This is best expressed in terms of a rate based on the straight-time hourly rate (e.g., one-half time).

The second blank is for the amount she shall be paid or the amount of compensatory time off she shall receive if she actually works during the period of time she is on call.

Rest periods. Self-explanatory.

Article VI: Staff Relief

The first blank should be filled in with the maximum number of days that an employee may work and still be considered staff relief.

Article VII: Part-time Nurses

Self-explanatory.

Article VIII: Vacations

The blanks in this article should be filled in with the number of weeks' vacation granted after specified periods of employment. If you wish to include more periods of eligibility, they could be added to this provision in the same manner.

Length of vacations. The first blank should be filled in to specify the period of time required before a nurse is entitled to a vacation. The second and third blanks should be filled in with the number of working days per month and the number which are cumulative as negotiated.

Terminal vacation pay. Self-explanatory.

Article IX: Holidays

The first blank should be filled in with the total number of holidays, and in the second blank these holidays should be enumerated. The third blank is for the period of time within which the nurse shall receive a day off in place of a worked holiday.

Article X: Sick Leave

The first blank should be filled in with the number of days' sick leave granted for each month of employment. The second blank should be filled in with the maximum number of days that can be accumulated if the sick leave is not used currently.

Article XI: Leaves of Absence

Self-explanatory.

Article XII: Health Program

This blank should be filled in with specifications of the type of examination to be given (e.g., x-ray, etc.).

Article XIII: Seniority and Promotions

The method for notifying employees of vacancies and new positions should be specified. Whether departmental or hospital-wide seniority shall prevail can be determined at the time of negotiating the agreement or, if it is deemed desirable to have seniority applicable to layoffs and re-employment, appropriate articles incorporating such provisions should be included in the agreement.

Article XIV: Termination of Employment

Self-explanatory.

Article XV: Maintenance

Self-explanatory.

Article XVI: Retention of Benefits

This article is of great importance because every condition of employment may not be a subject of current negotiations. This article will therefore protect the employees from losing any benefits just because they were not specified in the contract.

Article XVII: Adjustment of Grievances

The blanks in this article should be filled in with a given number of days so that grievances will be handled promptly and settlements reached. If time limits are not set on the grievance procedure, pressure of work may delay the settling of the grievance for many months.

Provision may be added regarding the method of selecting the grievance committee and employer recognition of the committee referred to in step 2, if it is deemed necessary.

In specifying, under step 4, who should select the impartial umpire, if the grievance committee cannot agree, it would be well to select a public official, such as a state labor conciliator. Naturally, his consent to do this will have to be obtained. However, this determination should be made during negotiations and not by one party or the other.

Article XVIII: General Provisions

Prior contracts. Self-explanatory.

Duration of benefits. The first two blanks specify the length of period covered by the contract. In case of delay in signing the contract, the provisions of the contract may be made retroactive to the date of expiration of the previous contract or to a date agreed upon by the parties.

The contract should be signed on behalf of the state nurses association by the individual to whom the board gives the authority to sign in its name, and signed by two nurse employee members of the negotiating committee. The contract is signed in behalf of the hospital by its designated agent(s). In the case of a contract covering more than one hospital, the contract should be signed by the authorized representative of the Association or other employer group, and the name of each hospital listed.

Text of Sample Contract

Preamble

Entered into this _____ day of _____ between _____ hospital, hereinafter referred to as the Hospital, and the Oklahoma State Nurses Association, hereinafter referred to as the Association. The parties hereto agree as follows:

Article I: Scope of Contract

Recognition: Bargaining Unit. The Hospital recognizes the Association as the exclusive representative for all graduate

registered nurses employed in the Hospital as _____ for the purpose of collective bargaining with respect to rates of pay, hours of work, and other conditions of employment. Administrative and supervisory personnel, having the authority to hire, discharge or recommend for discharge, are not included or covered by the terms of this contract.

"Nurse employees" covered. For the purposes of this contract the term "nurse employees" refers to those professional nurses who are members of the bargaining unit as above defined.

Article II: Association Membership and Security

All nurse employees covered by this contract shall be required as a condition of continued employment to become and remain members of the Association on and after the thirtieth day following the beginning of such employment, or the effective date of this agreement, whichever is later. Names of nurses employed to fill positions covered by this contract shall be furnished to the Association by the Hospital.

Article III: Nondiscrimination

The Hospital, either in hiring, promoting, advancing, or assigning to jobs, or any other term or condition of employment, agrees not to discriminate against any nurse employee because of race, color, national origin, religious affiliation, sex, marital status, or membership or activity on behalf of the Association.

Article IV: Salaries

Basic cash salary. The following standard salary schedule shall become effective _____. The beginning base cash salary shall be the following:

General Duty Nurse $_____

Assistant Head Nurse $_____

Head Nurse $_____

Tenure increases. Nurse employees who have been employed continuously in the Hospital for six months or longer shall receive the following additional compensation as recognition of length of service:

After ___ months of service, an additional $____ per month

After ___ months of service, an additional $____ per month

After ___ months of service, an additional $____ per month

Temporary assignment to higher position. A nurse assigned temporarily to a higher position shall be compensated for such work at the rate of pay applicable to the higher position.

Article V: Hours of Work and Premium Pay

Hours. The regularly scheduled work-week shall consist of not more than five (5) consecutive eight-hour days, or a total of not more than forty (40) hours in any one week. There shall be no split shifts.

Overtime. (a) All hours worked in excess of forty (40) hours in one week or eight hours in one work day shall be compensated at the rate of time and one-half (1½) the regular straight-time hourly rate.

(b) No employing hospital shall be liable for overtime premium pay for work beyond forty (40) hours per week, if such excess work is required by reason of rotation of shifts or rotation of work on Saturdays and Sundays.

(c) For purposes of computing overtime pay, the regular working day is eight (8) hours and the regular working week is forty (40) hours. The formula for calculating rates of pay shall be as follows:

Appropriate monthly rate x 12 divided by 52 equals work week rate.

Work week rate divided by 40 equals straight-time hourly rate.

Shift differentials. (a) Evening shift: Nurse employees working the _____ p.m. to _____ p.m. shift shall be paid $_____ per month more than the specified salary for day shift work.

(b) Night shift: Nurse employees working the _____ p.m. to _____ a.m. shift shall be paid $_____ per month more than the specified salary for day shift work.

Special service differentials. Nurse employees assigned to _____ shall receive an additional $_____ per month.

On call and call back pay. Nurse employees "on call" for operating and delivery room work, but not called, shall be paid at the rate of _____ when "on call." When called to work, nurses "on call" shall be compensated at time and

one-half the straight-time rate, or time off within _____ days at the rate of one and one-half hours for each hour worked.

Rest periods. A 15-minute rest period shall be allowed each nurse, within each four-hour period.

Article VI: Staff Relief

Any nurse employee employed for less than _____ consecutive days shall be considered staff relief. The daily fee for staff relief shall be the same as the prevailing fee for eight-hour private duty nursing.

Article VII: Part-time Nurses

A nurse regularly employed for less than the scheduled work week shall receive not less than the hourly rate and fringe benefits proportionate to those for full-time employees in the same positions.

Article VIII: Vacations

Length of vacations. Nurse employees who have been employed continuously for _____ shall be entitled to vacations with pay at the rate of _____ working days per month for each month worked, cumulative up to _____ working days.

Terminal vacation pay. Nurse employees leaving the employ of the Hospital shall receive vacation pay at the time employment terminates. If employment is terminated after _____ months of service, the nurse shall receive payment for the proportionate share (1/12) of her annual vacation for each full month worked.

Article IX: Holidays

All nurse employees shall be granted the following _____ holidays with pay: _____. If a nurse employee is required to work on a holiday or if the holiday falls on one of the nurse's scheduled days off, one day off in lieu thereof shall be given within a _____-day period before or after the holiday. If a holiday falls within a nurse employee's vacation period, one day shall be added to the vacation period.

Article X: Sick Leave

Each nurse employee shall be entitled to sick leave with pay on the basis of _____ working days for each month of continuous employment, cumulative to _____ working days.

Article XI: Leaves of Absence

Maternity leave. Maternity leave of at least _____ months shall be granted, and seniority rights in such events shall not be impaired.

Leave for illness or death in family. A leave of absence without pay shall be granted for a period of up to _____ days for critical illness or death in the immediate family and personal business of an emergency nature.

Military leave. Military leave shall be granted so that the nurse may maintain her status in the military reserve.

Educational leave. Educational leave shall be granted up to _____ months, on written application, to further professional growth and advancement.

Attendance at professional meetings. Time off, with pay, shall be granted to attend at least the following professional meetings: _____

_____

_____

_____.

Article XII: Health Program

A physical examination including _____ shall be given each nurse employee within one week of employment, and repeated annually without cost to the nurse employee. The nurse employee shall be given a report of each of her examinations.

Article XIII: Seniority and Promotions

Seniority shall be defined as length of service since the last day of hiring.

Preference for promotion to all vacancies and new positions shall be given to present nurse employees. Among nurse employees whose ability is approximately the same, seniority shall determine the choice for promotion. Present nurse employees shall be notified of all vacancies and new positions and shall be given an opportunity to apply for such positions.

Article XIV: Termination of Employment

The Hospital shall give the nurse employee at least two weeks' written notice of termination of employment, or two weeks' pay in lieu thereof. A nurse employee shall give the Hospital at least two weeks' notice of termination of employment.

Article XV: Maintenance

The purchase of maintenance shall not be obligatory.

Article XVI: Retention of Benefits

Except as otherwise expressly provided herein, all privileges and benefits which nurse employees have hitherto enjoyed shall be maintained and continued by the Hospital during the term of this agreement.

Article XVII: Adjustment of Grievances

Any complaint of a nurse employee concerning salaries, hours of work, or other conditions of employment, or concerning the interpretation or application of this agreement, shall be discussed by the nurse with her supervisor.

Definition of grievance. A "grievance" is defined as any complaint of a nurse which has not been settled satisfactorily as a result of the discussions between the nurse and her supervisor or any dispute or controversy between the Association and the Hospital.

Step 1. Any grievance of a nurse employee which has not been satisfactorily adjusted within _____ days shall be stated in writing and presented by the aggrieved nurse employee, a member of the grievance committee, and the Association representative, to the director of nursing.

Step 2. If no settlement of the grievance has been arrived at within _____ days, the Association representative and the nurse employee's grievance committee shall attempt to settle

the grievance with the executive officer of the Hospital and/or any other members of management designated by the Hospital to handle grievances at this step.

Step 3. If agreement is not reached within _____ days, the grievance shall be submitted to arbitration before an impartial umpire selected and agreed upon by the Association and Hospital representatives. If the Association and Hospital representatives fail to agree upon the arbitrator within _____ days after arbitration is requested in writing, the arbitrator shall be selected by _____. The decision of the arbitrator shall be rendered in writing and shall be final and binding upon both the Association and the Hospital.

Article XVIII: General Provisions

Prior contracts. This contract supersedes the contract of _____ and all supplements thereof, which are hereby terminated.

Duration of contract. This contract dated _____ shall continue in full force and effect from _____ to _____ and from year to year thereafter, subject to amendment, alteration or termination by either party upon sixty (60) days' notice given prior to the annual expiration date.

All notices provided for in this contract shall be served by registered mail, return receipt requested, and, if served upon the Hospital, shall be directed to its place of business at _____ _____; or, if served upon the Association,

shall be directed to its office at _____ or at such other address as either party shall have furnished the other in writing.

In Witness Whereof the parties hereto have executed this contract this _____ day of _____, 19___.

_____	_____
State Nurses Association	Hospital
By: _____	By: _____
_____	_____
_____	_____

APPENDIX IV

SAMPLE CONTRACT COVERING POSITIONS OF NURSES INDIVIDUALLY EMPLOYED OR IN SINGLE TYPE POSITIONS

Comments and Instructions

Many nurses occupy positions in which collective bargaining is not feasible, either because the nurse is considered an executive employee or because she is the only nurse in the employ of her employer. In business and industry individual employment contracts are commonly used. An individual contract presents the following advantages:

1. It enables the nurse to obtain favorable salary and working conditions. If the nurse does not take the initiative, the employer may attempt to negotiate a contract favorable to himself but giving less protection and fewer benefits to the employee.

2. Periodical review of such employment contracts upon their expiration (or at the automatic renewal date) will give a greater opportunity to obtain needed improvements in salary and personnel policies.

3. An employment contract improves the status and increases both the dignity of the position and the amount of respect given the employee. Employers are less likely to disregard a written contract than mere oral understandings.

4. An employment contract gives increased security of tenure. If the employer should commit a breach of the agreement, the nurse would have a right to damages, which could be enforced in court. In many jurisdictions, small claims courts are available which reduce the delay and

expense of litigation to a minimum. If an attorney is required, the nurse may be able to arrange for his retainer on a contingent basis. The assistance of the state nurses association might be given, if necessary, in test cases. Many breaches of employment contract cases (not confined to the positions of nurses) are settled by a cash payment on the part of the employer, without the necessity of going to court.

5. The employment contract does not present an insuperable obstacle to other changes which may be desired during its life, since it can be modified or rescinded at any time by arrangement of the employer and the employee.

On the other hand, there are certain dangers in the indiscriminate use of individual employment contracts:

1. An individual agreement has sometimes been used by an employer as a method of attempting to forestall collective bargaining in cases where the latter would otherwise be appropriate. Usually in such cases the terms offered by the employer are less advantageous than those which could be negotiated through collective bargaining.

2. In cases where collective bargaining may be used and labor laws are applicable, a national or state labor relations board could declare an individual agreement invalid as an unfair labor practice, and order that it be rescinded or disregarded. For example, before an industrial nurse enters into an individual agreement with her employer, she should make certain that she is not included in a bargaining unit represented by a union, and that she is not one of a group of nurses which should be represented by a state nurses association.

The attached sample individual contract is offered as a guide to nurses who desire a contract covering their positions. It is not intended that it will furnish the complete text for use in any one situation. It is probable that changes and additions based on the particular employment situation will be desirable in order to obtain the most advantageous provisions possible under the particular circumstances. The instructions below refer to the specific clauses in these parts of the sample contract which follows.

Preamble

In the preamble to the contract, the first blank spaces should be filled in with the day, the month, and the year. The remaining blanks specify the name, state of incorporation, and address of the employer; the name and residence of the employee; and the title of the position. It is customary in formal contracts of all kinds to specify whether the parties other than individuals are corporations, partnerships, or unincorporated associations. Where appropriate the word "agency" should be substituted for the word "institution."

Article I: Position

Employment contracts commonly run for periods of one to ten years.

Article II: Duties, Responsibilities, and Authority

This article should specify the duties to be performed and the areas of responsibility.

Article III: Salary

The suggested language contemplates three salary increases during the life of the contract. It can be adapted to situations where there are more or fewer or no such increases.

Article IV: Hours of Work and Premium Pay

If the position is covered by the Federal Wage-Hour Law (Fair Labor Standards Act), time and one-half must be paid even for occasional overtime in excess of forty hours a week.

Articles V, VI, and VII: Vacation, Holidays, and Sick Leave

The amount of these benefits is subject to negotiation.

Articles VIII to XII Inclusive

Self-explanatory.

Article XIII: Equal Benefits and Maintenance of Salary Differentials

This Article should be omitted if there is only one nurse employed, e.g., office nurse. However, if increases to subordinates are likely to occur before the nurse's individual contract expires, it is especially important to include this clause.

Article XIV: Non-Cancellation of Agreement

Without this clause, an easy way for an employer to destroy the contract is to offer the nurse a salary increase. The courts have held that, if an employee accepts a salary increase not provided for in the employment contract, the contract has in effect been rescinded by mutual consent. The suggested clause is designed to prevent such rescission.

Article XV: Waiver

This Article will prevent disputes as to what each party to the contract allegedly said to the other.

Article XVI: Duration

Self-explanatory. The automatic renewal clause may be omitted if desired.

Sample Individual Contract

This agreement made and entered into this _____ day of _____, 19___, by and between _____, an incorporated institution, organized and existing under the laws of the State of Oklahoma, located at _____, (hereinafter called "the Employer") and _____, residing at _____, (hereinafter called "the _____ (insert job title)") WITNESSETH:

WHEREAS the Employer desires to employ the _____ and the _____ desires to accept such employment, all upon the terms and conditions set forth herein below,

NOW THEREFORE it is hereby agreed by and between the Employer and the _____ as follows:

Article I: Position

The Employer hereby employs the _____ for the period set forth in Article _____ hereof, and the _____ hereby accepts such employment.

Article II: Duties, Responsibilities, and Authority

The duties, responsibilities, and authority of the _____ _____ in said position shall be as follows:

_____

_____

_____

_____

Article III: Salary

The Employer shall pay the _____, for the first _____ months hereunder, a salary of $_____ per month; and for the remainder of the life of this agreement, a salary of $_____ per month. Each of said salaries shall be exclusive of maintenance.

Article IV: Hours of Work and Premium Pay

The above salary is based upon a regular forty-hour week. It is contemplated that the _____ will occasionally be required by her duties to work additional hours without further compensation. If, however, the regular work week of the _____ _____ shall be regularly extended to more than forty hours per week, time and one-half shall be paid for all work in excess of forty hours per week.

Article V: Vacation

The _____ shall be granted a vacation with pay at the rate of _____ working days per month, and cumulative up to _____ working days. Vacations shall be scheduled to fit the requirements of the Employer, but, insofar as possible, preference shall be given to the expressed wishes of the _____.

Article VI: Holidays

The _____ shall be granted the following holidays with pay: _____

_____

_____

If the _____ shall be required to work on a holiday, or if a holiday shall fall on her day off, she shall be permitted and expected to take one day off in lieu thereof within _____ weeks before or after the holiday. If one of the above holidays shall fall during the _____ vacation, one day shall be added to her vacation.

Article VII: Sick Leave

The _____ shall be entitled to sick leave with pay on the basis of _____ working days for each month of continuous employment, cumulative to _____ working days.

After the period of accumulated sick leave shall have expired, the _____ shall be granted a leave of absence without pay for a period up to _____ days for personal illness.

Article VIII: Leaves of Absence

Leaves of absence for critical illness or death in the immediate family, professional and educational purposes, and maternity leave shall be granted by mutual agreement between the Employer and the _____.

Article IX: Health Program

A physical examination, including _____ shall be given the _____ within the first week of employment under this agreement, and repeated annually, without cost to the _____, who shall be given a report of each of her examinations.

Article X: Maintenance

The purchase of maintenance shall not be obligatory.

Article XI: Other Benefits

The _____ shall participate in the following employee benefit plans: _____

_____

_____

Article XII: Retention of Benefits

Except as otherwise expressly provided herein, all privileges and benefits which _____ has hitherto enjoyed shall be maintained and continued by the Employer during the term of this agreement.

Article XIII: Equal Benefits and Maintenance of Salary Differentials

During the life of this agreement, the _____ shall at all times receive benefits at least equal to the benefits of every kind received by her nurse subordinates. In the event that the Employer shall grant any increases in vacations, holidays, sick leave, or other benefits to such subordinates during the life of this agreement, he shall grant to the _____ whatever increases in the respective benefits shall be necessary to equalize such benefits. The Employer shall also maintain existing dollar differentials or percentage differentials between the salary of the _____ and those of her subordinates; and, in the event of any general increase to such subordinates,

during the life of this agreement, the Employer shall increase the salary otherwise payable to the _____ under this agreement by the amount necessary to preserve such dollar or percentage differentials.

Article XIV: Non-Cancellation of Agreement

In the event that the salary or other benefits payable to the _____ shall be increased during the life of this agreement or of any extension thereof, such increase shall not operate as a cancellation of this agreement or of such extension thereof, but merely as an amendment thereto; and all other terms, provisions, and conditions of this agreement shall remain as herein provided, after such increase in salary or other benefits.

Article XV: Waiver

No waiver of any provision of this agreement shall be valid unless the same shall be in writing and signed by the party to be charged therewith. Failure of either party to insist upon the fulfillment of any of the provisions of this agreement shall not be deemed a waiver thereof or a precedent for any future action by the other party.

Article XVI: Duration

This agreement shall be effective for the period commencing _____ and ending _____, and shall continue in effect for subsequent periods of one year each, unless either party shall give to the other written notice by registered

mail, return receipt requested, not later than two months prior to the end of any contract year, that the party giving such notice desires to cancel and terminate this agreement at the end of such contract year. Such notice shall be given to the other party at the address hereinabove set forth, or to such other address as such party shall have furnished in writing to the party giving such notice.

IN WITNESS WHEREOF the parties hereto have executed this agreement this _____ day of _____, 19___.

_____
(Institution, agency, or individual employer)

By _____
(Representative of employer)

_____
(Employee)

Attest:

_____
(Witness)

_____
(Witness)

APPENDIX V

DEFINITIONS OF, AND PROFESSIONAL AND PERSONAL STANDARDS FOR, VARIOUS CLASSIFICATIONS OF PROFESSIONAL NURSES

General Duty Nurses[1]

Definition

A general duty nurse is a registered professional nurse, employed by a hospital or an institution, who is responsible for the direct and/or indirect total nursing care of the patient.

Professional Qualifications

1. Graduation from a state accredited school of nursing and holding a current license to practice professional nursing.
2. Evidence of interest in continuous professional growth.

Personal Qualifications

1. Appreciation of the value of professional general duty nursing in the care of the patient.
2. Maintenance of optimum physical and emotional well-being.
3. Competence in the area of practice in which the nurse functions.
4. Ability to plan for and evaluate total nursing care.
5. Possession of personal qualities which make it possible for the nurse to maintain good interpersonal relationships. Examples of these are: kindliness, sympathy, understanding,

---

[1] General Duty Nurses Section, American Nurses Association, "Functions, Standards, and Qualifications for practice of the General Duty Nurse," (New York) n.d.

interest in and respect for people as individuals, good judgment, integrity, loyalty, and sense of humor.

6. Evidence of knowledge and ability to use recognized channels of communication.

7. Evidence of knowledge of new trends and developments in the field of nursing based on research.

8. Interest in the profession of nursing as evidenced by membership and active participation in professional nursing organizations.

9. Demonstrated interest and willingness to participate in community affairs.

Head Nurses[2]

Definition

A head nurse is a professional nurse who is responsible for an organized hospital within which nursing care is directly and/or indirectly provided.

Professional Qualifications

1. Graduation from a state-accredited school of nursing.
2. Currently licensed to practice professional nursing.
3. Additional educational preparation is desirable.
4. Progressive experience in the nursing field with at least one year's experience as a general duty nurse.
5. Active participation in the professional nursing organization.

Personal Qualifications

1. Accepts, understands, and abides by: "The Code of Professional Nurses." (Adopted by the ANA House of Delegates, May, 1950, Revised 1956.)
2. Possesses those personal qualities desired in a professional nurse.
3. Maintains optimum physical and emotional health.
4. Demonstrates knowledge of and ability to apply principles of administration, personnel supervision and teaching.
5. Demonstrates knowledge and competence in area of practice.

---

[2]Head Nurses Branch, General Duty Nurses Section, American Nurses Association, "Functions, Standards, and Qualifications for Practice for the Head Nurse," (New York) n.d.

6. Exercises good judgment.
7. Possesses qualities of leadership.
8. Communicates in an effective manner.
9. Possesses the ability to recognize and understand the common needs of all individuals.
10. Maintains an up-to-date knowledge of current trends and new developments.
11. Applies to the current situation new concepts, knowledge, and skills gained from education and experience.

Private Duty Nurses[3]

Definition

A private duty nurse is a registered professional nurse who independently contracts to give expert nursing care to one patient.

Professional Qualifications

1. Graduation from a school of professional nursing approved by the state board of nursing.
2. A current license to practice as a registered professional nurse.
3. Additional experience and/or education in a specific clinical field.

Personal Qualifications

1. Knowledge of current nursing principles and procedures with the ability to apply this knowledge in the practice of direct patient care.
2. Ability to use good judgment and initiative in evaluating situations and making decisions.
3. Ability to communicate in an effective manner.
4. Good physical health.
5. Emotional stability.
6. A genuine liking for people.
7. A definite preference for the practice of direct patient care.
8. Tact, versatility, and adaptability.
9. Integrity.

---

[3]Private Duty Nurses Section, American Nurses Association, "Functions, Standards, and Qualifications for the Practice of Private Duty Nursing," (New York) n.d.

10. Recognition of the need for self-evaluation and the willingness to utilize constructive ideas.

11. Awareness of personal responsibility to the nursing profession.

Office Nurses[4]

Definition

An office nurse is a professional nurse whose functional sphere is the physician's office. She works in a team relationship with the physician and office personnel in promoting the health and welfare of those under the physician's care.

Professional Qualifications

1. Knowledge and understanding of the code for professional nurses.
2. Awareness of legal implications of nursing practice as related to the practice of allied professions.
3. Graduation from an accredited school of nursing.
4. Registration with current licensure in the state of employment.
5. Participation and membership in professional organizations.

Personal Qualifications

1. Ability to adjust to individuals and situations.
2. Ability to counsel and to teach.
3. Ability to create an atmosphere of efficiency and confidence.
4. Understanding and acceptance of patient as an individual.
5. Awareness of professional responsibility for continuing growth and development.
6. Understanding and appreciation of the art and value of communications.
7. Understanding of her professional responsibilities to the community.

---

[4]Office Nurses Section, American Nurses Association, "Functions, Standards, and Qualifications for the Practice of Office Nurses," (New York) n.d.

Public Health Nurses[5]

Professional Qualifications for Public Health Nurses in Staff Positions

1. Graduation from a school of professional nursing with state accreditation at time of graduation.

2. Holds a current license to practice as a registered professional nurse.

3. A degree from a university program in nursing approved by the National League for Nursing for public health nursing preparation; or completion of the public health content in an educational program approved by the National League for Nursing. In this case the university may certify that the credits earned by the applicant meet the requirements . . . such approved public health programs provide understanding, attitudes, and skills basic to competence in the following areas:

a) Preventive health care including such aspects as nutrition, safety, rehabilitation, mental health, environmental sanitation, and communicable disease control.

b) Application of basic epidemiologic and statistical principles.

c) Counseling, interviewing, and group work.

d) Individual and group teaching.

e) Recognition and interpretation of:

(1) Physical, mental and social health.

(2) Biological, occupational, and other environmental causative factors in disease.

(3) Personality structure and development.

(4) Patterns of human growth and development.

(5) Family relationships.

(6) Effects of cultural patterns on health.

f) Program planning in relation to:

(1) Development of nursing services in health departments, schools, and voluntary agencies.

(2) Patterns of administration and content of public health programs including school health programs.

(3) Patterns of community organization for planning and action in health, education, and welfare.

(4) Trends and patterns in educational philosophy and methods including curriculum construction.

Personal Qualifications for Public Health Nurses in Staff Positions

---

[5]Public Health Nurses Section, American Nurses Association, "Functions, Standards and Qualifications for Public Health Nurses," (New York) n.d.

1. Express ideas clearly and in an acceptable manner.
2. Accept people in a nonjudgmental way.
3. Gain satisfaction through the development and growth of others.
4. Stimulate others to constructive actions.
5. Value and use contributions of other professional groups, volunteers, and the general public, and relate these to nursing service.
6. Adjust pace to realities of the situation.
7. Evaluate self in relation to work, and accept help from others.
8. Accept responsibility in professional and civic organizations.

Professional Qualifications for Public Health Nurses in Administrative, Supervisory, and Consultative Positions

1. Graduation from a school for professional nursing with state accreditation at the time of graduation.
2. Holds a current license to practice as a registered professional nurse.
3. Preparation in public health nursing as recommended in the statement of qualifications for public health nurses in staff positions.
4. A master's degree with a major in administration, supervision, or consultation, or in a special field; or a master's degree in public health from a university program approved by the American Public Health Association; or a bachelor's degree from a university program approved by the National League for Nursing for beginning public health nurse positions which included or was supplemented by academic preparation in administration, supervision, consultation, or advanced preparation in a special field.
5. Content in the fields of administration, supervision, and consultation should be sufficiently comprehensive to provide a basis for competence in the areas of:
    a) Administration of public health nursing services.
    b) Supervisory, consultative, and education processes.
    c) Personnel administration.
    d) Research, including use of epidemiologic and administrative study procedures and statistical evaluation.
    e) Interpersonal and intergroup relations, communications, and action.
    f) Relating nursing services and programs to:
        (1) Trends and developments in public health services and administration.
        (2) Structure and services of local, state, and federal government.
        (3) Educational philosophy and methods.

6. For the Supervisor:

a) A minimum of two year's experience in public health nursing, at least one of which was in a generalized service under public health nursing supervision.

b) For the supervisor of school nursing, at least one of the two years of experience in public health nursing should include school nursing in either a specialized or general program.

c) Other qualifications listed above.

7. For the Consultant:

a) The general consultant will have need for more experience than that demanded by the supervisor--a total of four years of experience in public health nursing of which a minimum of one year should be in a supervisory capacity.

b) The public health nursing consultant in a special field should have a minimum of four years' experience. This experience may be in public health nursing, or in a combination of public health nursing and another type of nursing in a specialty, and one year in supervision in public health nursing.

8. For the Director:

a) The director of nursing service should have a minimum of five years' experience in public health nursing, including at least three years of experience in a supervisory or consultative capacity.

b) Experience in more than one type of agency is desirable.

Personal Qualifications for Public Health Nurses in Administrative, Supervisory, and Consultative Positions

1. Apply the personal competencies required of public health staff nurses in relatively complex and involved situations.
2. See and work for long-range goals.
3. Work effectively with professional and civic leaders.
4. Think creatively and independently about existing and anticipated needs and means of meeting them.
5. Accept responsibility for decisions without undue strain.

School Nurses[6]

Definition

School nurse is the term used for the registered professional nurse working in a school, who meets the qualifications set forth below.

---

[6]School Nurses Branch, Public Health Nurses Section,

Professional Qualifications for School Nurses
Employed in Staff Positions

1. Graduation from a school of nursing with state accreditation at the time of graduation.
2. Possession of a current license to practice as a professional registered nurse.
3. Possession of a baccalaureate degree.
4. Completion of a program of study, including field experience in school nursing as a part of the baccalaureate program, or at the graduate level, which assures that the nurse has attained a knowledge and understanding of:
   a) The total school program.
   b) Specific school nursing responsibilities.
   c) Factors influencing the learning process.
   d) Public health.
   e) Health education and public relations.

Personal Qualifications for School Nurses
Employed in Staff Positions

1. Interpret the school health program to individuals and groups.
2. Interpret the policies and procedures established by the administration and board of education.
3. Recognize deviation from normal in the physical, mental, and emotional health of pupils.
4. Interpret the health needs of pupils to parents, school personnel, and community groups.
5. Teach health to individuals and groups.
6. Make health services contribute to the health education program for pupils.
7. Work with pupils in the classroom effectively.
8. Interpret medical recommendations.
9. Organize work effectively.
10. Keep accurate records.
11. Carry on screening programs.
12. Cooperate and work harmoniously with others in school and community.
13. Work effectively with other professional personnel from public and private agencies and those in private practice in the community.
14. Recognize safety hazards.

American Nurses Association, "Functions and Qualifications for School Nurses," (New York) n.d.

15. Give first aid.
16. Compile and interpret data.
17. Evaluate her own performance as a school nurse.

Professional Qualifications for School Nurses Employed in Administrative and Supervisory Positions

1. Graduation from a school of nursing with state accreditation at the time of graduation.
2. Possession of a current license to practice as a professional registered nurse.
3. Preparation in school nursing as recommended in the statement of qualifications for school nurses in staff positions.
4. Verification of successful experience as a school nurse, the number of years of experience required corresponding with that for other school personnel in the state.
5. Possession of a master's degree (or equivalent).
6. Completion of a program of studies as part of the master's program or beyond, which assures that the nurse has attained a knowledge of:
   a) Principles and techniques of supervision and administration.
   b) Philosophy of the educational process.
   c) School finance and school law.
   d) Organization in the public school.
   e) Evaluation techniques.
   f) School environment conducive to health and safety.
   g) Adequate facilities for the health program.
   h) Research procedures and statistical methods.
   i) Techniques of in-service education.
   j) Dynamics of human behavior.

Personal Qualifications for School Nurses Employed in Administrative and Supervisory Positions

1. Ability to:
   a) Assume leadership in the formulation of policies for the school health program.
   b) Promote the participation of others in the school health program.
   c) Relate effectively to other administrative, supervisory, and all other personnel within the school.
   d) Relate effectively to individuals and to community groups interested in the health of the school child.
   e) Communicate skillfully.
   f) Substantiate budget data in order to achieve financial support.

g) Keep abreast of trends in school health and in related professional fields.

h) Recognize and accept individual differences.

i) Evaluate nurse performance and encourage improvement in performance through individual and group counseling.

j) Recognize and cultivate qualities of leadership in individual staff members.

k) Recognize and foster unique contributions of each staff member.

Educational Administrators and Teachers[7]

Definition

The educational administrator is a professional nurse who has the responsibility of assuming the leadership for the educational program.

Professional Qualifications for Educational Administrators

1. A broad general education which includes the study of the humanities and the biological, physical, and social sciences.

2. A professional education which includes sound preparation in basic nursing.

3. Advanced preparation in administration of nursing education, including methods of teaching as well as principles and practice of administration.

4. A degree, with a major in administration of nursing education or its equivalent, the degree to be beyond that which learners will achieve upon completion of the program with which the administrator is concerned.

5. Academic preparation should include the following broad areas:

a) Administration of nursing education.

b) Philosophy of education.

c) Teaching.

d) Curriculum development.

e) Guidance and counseling.

f) Communications, interpersonal and intergroup relations.

g) Current trends in education, with special emphasis on nursing education.

---

[7]Educational Administrators, Consultants and Teachers Section, American Nurses Association, "Functions, Standards and Qualifications for Practice for Educational Administrators and Teachers," (New York) n.d.

h) Applied social sciences.

i) Research.

6. Progressive nursing experiences, such as staff nurse, head nurse, assistant teacher, teacher, assistant administrator.

7. A broad professional experience which would tend to develop skills in administration, teaching, nursing, communication, interviewing and counseling (This experience should include experience obtained inthe type of educational program in which the administrator would function as a head).

Personal Qualifications for Educational Administrators

1. Possesses a democratic way of life which is demonstrated by warm human relationships, ability to deal constructively with suggestions and criticisms and ability to work effectively with individuals and as a participating member of inter- and intra-disciplinary groups.

2. Has leadership ability as demonstrated in application of the principles of administration and education.

3. Assumes responsibility as a nurse and as a citizen by active participation in appropriate organizations.

4. Demonstrates qualities of integrity, stability, imagination, courage of convictions, discriminating judgment, and is richly endowed with inner resources.

5. Exhibits breadth of interest in nursing, in people, and in cultural, social and civic affairs.

Professional Qualifications for Teachers

1. A broad general education which includes the study of the humanities and the biological, physical and social sciences.

2. A professional education which includes sound preparation in basic nursing.

3. Advanced preparation for teaching in nursing, including principles and practice of teaching.

4. A degree, with a major in teaching in nursing and advanced preparation in the content area. (A master's degree is recommended.)

5. Academic preparation should include the following broad areas:

a) Philosophy of education.

b) Teaching.

c) Curriculum development.

d) Specialization in the content area of nursing.

e) Communications, interpersonal and intergroup relations.

f) Current trends in education, with special emphasis on nursing education.

g) Applied social sciences.
h) Research.

6. Progressive nursing experience, such as staff nurse, head nurse, assistant teacher.

7. A broad professional experience which would tend to develop skills in nursing, teaching, communication, interviewing and counseling, and administration.

Personal Qualifications for Teachers

1. Possesses a democratic way of life which is demonstrated by warm human relationships, ability to deal constructively with suggestions and criticisms and ability to work effectively with individuals and as a participating member of inter- and intra-disciplinary groups.

2. Has leadership qualities, as evidenced by ability to stimulate interest of learners and to motivate them to constructive action.

3. Assumes responsibility as a nurse and as a citizen by active participation in appropriate organizations.

4. Demonstrates qualities of integrity, stability, imagination, courage of convictions, discriminating judgment, and is richly endowed with inner resources.

5. Exhibits breadth of interest in nursing, in people, and in cultural, social, and civic affairs.

Occupational Health Nurses[8]

Definition

Occupational health nursing is the application of nursing principles and procedures for the promotion, restoration and maintenance of optimum health of employees through their places of employment.

Definitions of Positions

One-nurse service. An occupational nurse in a one-nurse service is a professional registered nurse who is responsible for the development, interpretation and administration of the nursing

---

[8] Occupational Health Nurses Section, American Nurses Association, "Functions, Standards, and Qualifications for Occupational Health Nurses," (New York) n.d.

service in an industrial or commercial organization employing only one registered nurse in the employee health service department. (This definition could also apply to the situations where one nurse is working in a subsidiary or branch employee health service department under the indirect guidance and supervision of a nursing director.)

Multiple nurse service. A director of an occupational health nursing service is a registered professional nurse who is responsible for the development, interpretation, administration, control and coordination of the nursing service in an industrial or commercial organization employing registered professional nurses in supervisory and staff positions, in a large central employee health service and in one or more subsidiary or branch plants.

A supervisor of an occupational health nursing service is a registered professional nurse who is responsible for the interpretation, administration and supervision of the nursing service in an employee health service having one or more registered professional staff nurses. (The supervisor may work with a staff of nurses in a central or subsidiary employee health service and be responsible for the supervision and implementation of the nursing service under the guidance and direction of a nursing service director.)

An occupational health staff nurse is a registered professional nurse working in an employee health service department rendering nursing service under nursing supervision.

An occupational health visiting nurse is a registered professional nurse employed by an industrial or commercial organization to provide visiting nurse service to ill or injured employees.

An occupational health nursing consultant is a registered professional nurse employed by an official or non-official agency to provide consultation service, guidance and leadership to occupational health nurses, employers and others having occupational health interest related to nursing.

A part-time occupational health nurse is a registered professional nurse, employed by one or more companies on a fee basis to provide services to employees where full time nursing service is not warranted.

Professional Qualifications for Occupational Health Nurses in a One-Nurse Service

1. Graduation from a school of professional nursing with a state accreditation at the time of graduation.

2. Currently licensed to practice as a registered professional nurse in the state of employment.

3. Desirable additional preparation for occupational health nursing as evidenced by:

a) University courses in occupational health nursing, public health nursing, and related subjects.

b) Attendance at institutes, seminars, and other educational programs pertaining to occupational health and safety.

4. Experience desirable:

a) Employment in varied fields of nursing, such as:

(1) Community health agencies.

(2) Industrial clinics.

(3) Accredited hospitals, especially out-patient or emergency departments.

b) One year or more in an employee health service working under nursing supervision.

5. Maintains active membership in professional nursing organizations and understands and participates in the major programs.

Personal Qualifications for Occupational Health Nurses in a One-Nurse Service

1. Sincere interest for and skill in working with people.

2. Ability in interpersonal relationships to recognize and understand the common needs of all individuals.

3. Skill in communication--verbal and written.

4. Receptive attitude toward suggestions and ideas from others and the ability to relate them to the health service program.

5. Willingness and ability to evaluate own performance and knowledge of specific methods used in job rating.

6. Thorough knowledge of approved occupational health nursing principles, practices, procedures; judgment and skill in giving good nursing care.

7. Thorough knowledge of approved first-aid procedures and ability to teach these procedures to others.

8. Thorough understanding and skill in the use of good interviewing and health counseling techniques.

9. Working knowledge and understanding of the purposes and provisions of workmen's compensation laws, group insurance, health and welfare plans related to occupational health.

10. Knowledge and understanding of all phases of rehabilitation.

11. General knowledge of the philosophy and principles of business organization and administration and the place of an employee health service in the organizational pattern.

12. General knowledge of the objectives of an effective occupational health program.

13. Working knowledge of the legal aspects of medical and nursing practice, particularly as it relates to an employee health service.

14. General knowledge of the principles of suitable location, adequate equipment and physical layout, and reference material for an employee health service department.

15. Thorough knowledge and understanding of the need for, and value of, accurate, concise, complete, and legible records and reports, and the confidential nature of these records and reports.

16. Knowledge of materials and industrial operations as related to plant processes, occupational injuries and illnesses, and measures for prevention and control.

17. Knowledge and understanding of preventive health care.

18. Knowledge of state and local codes related to employee health, safety, and welfare in industrial and commercial establishments.

19. Knowledge of state and local codes, ordinances, and recommendations pertaining to food facilities and services.

20. Knowledge of the official health department regulations regarding communicable disease control.

21. Knowledge of community health and welfare resources, referral policies, and procedures.

22. Knowledge of available occupational health nursing consultant services.

23. General knowledge of the purpose and use of job analyses in relation to proper placement of employees.

24. General knowledge of epidemiological methods and procedures for evaluation of the service.

Professional Qualifications for a Supervisor, Occupational Health Nursing Service

1. Graduation from a school of professional nursing with state accreditation at the time of graduation.

2. Currently licensed to practice as a registered professional nurse in the state of employment.

3. Baccalaureate degree in nursing desirable.

4. Additional preparation as evidenced by:

   a) University courses in occupational health nursing, public health nursing, nursing supervision and related subjects.

   b) Attendance at institutes, seminars and other educational programs pertaining to occupational health.

5. A minimum of three years' experience in occupational health nursing at least one year of which was under nursing supervision.

6. Public health nursing experience desirable.

7. Maintains membership in the American Nurses Association and allied organizations, understands and actively participates in the major programs.

Personal Qualifications for a Supervisor, Occupational Health Nursing Service

1. A supervisor of an occupational health nursing service must possess the personal competence, qualifications and essential knowledges and skills as outlined for the nurse in a one-nurse service. She should also possess qualities of leadership, have broad vision and understanding and superior ability to work effectively with all kinds of people. In addition she should be able to:

a) Competently handle relatively complex and involved situations.

b) Delegate authority.

c) Think creatively and independently about existing and anticipated needs and means of meeting them.

d) Work effectively with professional and civic leaders.

e) Accept responsibility for making decisions.

f) Coordinate the nursing service to the end that employees receive the highest potential health care.

g) Communicate effectively orally and in writing.

Professional Qualifications for a Director, Occupational Health Nursing Service

1. Graduation from a school of professional nursing with state accreditation at the time of graduation.

2. Currently licensed to practice as a registered professional nurse in the state of employment.

3. Baccalaureate degree in nursing.

4. Additional preparation as evidenced by:

a) University courses in occupational health nursing, nursing education, public health nursing, and additional subjects such as: business administration, industrial relations.

b) Attendance at institutes, seminars, and other educational programs pertaining to occupational health and safety.

5. A minimum of five years' experience in occupational health nursing including at least two years in head nurse or supervisory capacity is essential.

6. Public health nursing experience is desirable.

7. Maintains membership in the American Nurses Association and allied organizations, understands and actively participates in the major programs.

Personal Qualifications for a Director, Occupational Health Nursing Service

1. A director of an occupational health nursing service must possess the personal competence, qualifications and essential knowledges and skills as outlined for the nurse in a one-nurse service and for a supervising nurse. She should also possess qualities of leadership, have broad vision and understanding, and superior ability to work effectively with all kinds of people. In addition she should be able to:

a) Plan.
b) Organize.
c) Direct.
d) Control.
e) Coordinate the nursing service to the end that employees receive the highest potential of health care.

APPENDIX VI

QUESTIONNAIRE FOR PROFESSIONAL NURSES

The Oklahoma State Nurses Association is currently sponsoring a study to determine the economic status of the nursing profession in Oklahoma. It is hoped that this study will greatly benefit the professional nurses in the state. However, a great deal of statistical information is needed to insure the success of this undertaking. Will you help by promptly answering the attached questionnaire and returning it in the envelope provided? Your name need not appear on the questionnaire; and all information given will be confidential. Thank you.

1. Check the classification which best describes your position:

1)____Educational administrator or teacher	6)____Private duty nurse
2)____Institutional nurse	7)____General duty nurse
3)____Office nurse	8)____Head nurse
4)____Public health nurse	9)____School nurse
5)____Occupational health nurse	10)____Other (specify) _____

2. Are you employed: ____Full-time? ____Part-time?

3. Is your monthly salary before deductions:

1)____Less than $150	3)____$201-250
2)____$151-200	4)____ 251-300

5)_____$301-350
6)_____ 351-400
7)_____ 401-450
8)_____ 451-500
9)_____$501-550
10)_____ 551-600
11)_____ 601-650
12)_____ Over $650

4. Do you "live in?" _____Yes _____No

5. Indicate type of maintenance in addition to salary, if any:

	Nurses Living In (Check)	Nurses Living Out (Check)
Room	_____	_____
Meals -- One	_____	_____
Two	_____	_____
Three	_____	_____
Laundry	_____	_____
Uniforms	_____	_____

6. On what basis are you granted salary increases? (Check)

1)_____Length of service (automatic)
2)_____Merit
3)_____Length of service and merit (non-automatic)
4)_____Other (Specify)_____.

7. How long have you been a professional nurse? _____.

8. How much are you paid per month, in addition to base salary, for work in:

1) Operating room	$_____
2) Delivery room	_____
3) Nursery	_____
4) Communicable disease	_____
5) Psychiatric cases	_____
6) Other special assignments (Specify)	_____
_____	_____
_____	_____

9. Indicate average number of hours worked per week: _____

10. How much are you paid per month, in addition to base salary, for work on:

1) Evening shift $_____
2) Night shift _____
3) Broken shift _____
4) Rotating shift _____
5) Other (Specify) _____ _____.

11. Indicate type of overtime compensation which you are eligible to receive:

1)_____Straight-time pay
2)_____Time-and-one-half pay
3)_____Compensatory time off
4)_____Straight-time or time off at your option
5)_____None
6)_____Other (Specify)_____.

12. How many days per week do you work?

1)_____One day
2)_____Two days
3)_____Three days
4)_____Four days
5)_____Five days
6)_____Six days
7)_____Seven days

13. Indicate when shifts are rotated:

1)_____Daily
2)_____Weekly
3)_____Every two weeks
4)_____Monthly
5)_____No rotation
6)_____Does not apply
7)_____Other (Specify)_____.

14. Are daily and weekly work schedules posted at least one week in advance?

_____Yes _____No

15. How many holidays with pay are you granted during the year?

_____

16. Do you receive extra compensation for work on a holiday?

_____Yes _____No

17. How many working days of sick leave with pay are you allowed annually?

_____

18. Is sick leave cumulative from year to year? ____Yes ____No

If yes, maximum amount you can accumulate _____.

19. Do you receive compensation, in addition to your base salary, for professional expenses? _____Yes _____No

If yes, average amount per month _____.

20. What is the average number of hours per week you are "on-call"?

_____

21. Indicate type of compensation you receive for "on-call" time when you are not actually called:

1)_____Compensatory time off
2)_____Half-time pay
3)_____Time-and-one-half pay
4)_____No compensation
5)_____Other compensation (Specify) _____.

22. Indicate by check marks in the appropriate spaces the types of insurance or retirement plans which you carry:

	Paid by hospital	Paid by both hosp. & nurse	Paid by nurse
1) Hospitalization	_____	_____	_____
2) Surgical care	_____	_____	_____
3) Medical care	_____	_____	_____
4) Sickness and accident	_____	_____	_____
5) Retirement	_____	_____	_____
6) Life insurance	_____	_____	_____
7) Social security	_____	_____	_____
8) Other (Specify)	_____.		

23. How are policies determined in your area of practice?

1)____Determined by group discussion
2)____Determined by the workers
3)____Determined by the administration
4)____Determined by individual bargaining between worker and employer
5)____Other (Specify) _____.

24. How would you rate your job satisfaction?

1)____Very satisfied
2)____Satisfied
3)____Not very satisfied
4)____Not at all satisfied

25. What do you like least about your work? _____

_____

_____.

26. What do you like most about your work? _____

_____

_____.

APPENDIX VII

SAMPLING PROCEDURE

Construction of the Sample

In order to construct the appropriate sampling procedure, a current mailing list of registered professional nurses in Oklahoma was obtained from the OSNA. The list contained 1,888 names and addresses of nurses located throughout the state. These nurses were listed according to the type of duty performed. Table 36 shows the number of nurses in each category.

Because of financial limitations, it was decided that a maximum of 500 questionnaires could be used, representing a 26.5 per cent sample of the population. While a larger sample would have been desirable, it was felt that this sample size of 500 would provide sufficient reliability.

In order to give appropriate weight to each of the duty classifications in the heterogeneous nursing population, the population was divided into homogeneous subgroups based on the type of duty performed. With an established sample size of 500, the number of names to be selected from each subgroup was determined by applying the percentages in Table 36 to 500, yielding the results shown in Table 37.

TABLE 36

NUMBER AND PER CENT OF REGISTERED PROFESSIONAL NURSES IN OKLAHOMA, CLASSIFIED BY TYPE OF DUTY PERFORMED, EARLY 1961

Classification	Number	Per Cent of Total
Educational administrators and teachers	119	6.3
Institutional nurses	249	13.2
Office nurses	114	6.0
Public health nurses	217	11.5
Occupational health nurses	80	4.2
Private duty nurses	370	19.6
General duty nurses	361	19.1
Head nurses	218	11.6
School nurses	83	4.4
Others	77	4.1
Totals	1,888	100.0

Source: 1961 membership roster of the Oklahoma State Nurses Association, Oklahoma City, Oklahoma.

TABLE 37

NUMBER AND PER CENT OF QUESTIONNAIRES FOR EACH SUBGROUP OF REGISTERED PROFESSIONAL NURSES IN OKLAHOMA, EARLY 1961

Subgroup	Number	Per Cent of Total
Educational administrators and teachers	32	6.3
Institutional nurses	66	13.2
Office nurses	30	6.0
Public health nurses	57	11.5
Occupational health nurses	21	4.2
Private duty nurses	98	19.6
General duty nurses	95	19.1
Head nurses	58	11.6
School nurses	22	4.4
Others	21	4.1
Totals	500	100.0

Source: Computed from data contained in Table 36.

Having chosen the number of nurses to be sampled in each subgroup, a number was randomly selected as a starting point. Every n^{th} name was then selected in each subgroup. (For example, if a subgroup contained 100 names, and if 50 of these names were to be selected, a starting point would be determined and every other name would be selected beginning at that starting point.) Questionnaires were sent to each selected name.

To maximize the reliability of the sample, follow-up letters were mailed to those who had not answered the questionnaires one month after the initial mailing. In addition, the OSNA strongly encouraged its membership to complete and return the questionnaires. Of the 500 questionnaires mailed, 260 (52 per cent) usable replies were returned. Those who filled out and returned usable questionnaires represented over 13 per cent of the 1,888 currently registered nurses in Oklahoma. Table 38 shows the percentage returns for each subgroup in the population.

Chi-Square Test for Significant Differences Between the Number of Questionnaires Mailed and the Number Returned, on the Basis of Subgroup Stratification

A chi-square test was employed to determine whether there was a significant difference between the number of questionnaires received from each subgroup and the number of questionnaires that would be expected from each subgroup.

In order to conduct the chi-square test certain information is needed. It is necessary to know the total number of nurses in the sample, the number of nurses in each of the various subgroups,

TABLE 38

NUMBER AND PER CENT OF QUESTIONNAIRES MAILED AND RETURNED, CLASSIFIED BY SUBGROUP, EARLY 1961

Subgroup	Number of Questionnaires Mailed	Number of Questionnaires Returned	Number Returned as a Per Cent of Number Mailed
Educational administrators and teachers	32	18	56.3
Institutional nurses	66	33	50.0
Office nurses	30	14	46.7
Public health nurses	57	28	49.1
Occupational health nurses	21	11	52.4
Private duty nurses	98	48	49.0
General duty nurses	95	45	47.4
Head nurses	58	42	72.4
School nurses	22	11	50.0
Others	21	10	47.6
Totals	500	260	52.0

Source: Computed on the basis of questionnaires mailed and received in a questionnaire survey of registered professional nurses in Oklahoma, early 1961.

the per cent of the total number of nurses represented by each subgroup, the total number of questionnaires mailed and the number mailed to each subgroup, the total number of questionnaires returned, the number returned by each subgroup, and the per cent of the total returns represented by each subgroup. Once these data are known, the chi-square test can be conducted. Table 39 contains such data.

Some additional information is needed in order to complete the chi-square test. It is necessary to note the observed frequency of occurrence (the percentage return in each category), the expected frequency of occurrence (the percentage distribution of nurses in each category), and the difference between these two values. In addition, these differences must be squared, and the squared differences must be divided by the expected frequency in each case. The figures have been computed, and are shown in Table 40.

The value for chi-square may now be obtained by summing the values obtained by dividing the value of the squared differences between the observed and expected frequencies by the value of the computed frequency in each case. Thus, the chi-square value is 2.2223 when the degrees of freedom are seven, as in this case. This chi-square value means that there is a probability of between 90 and 95 per cent that any deviations from the expected frequencies are due to random error. A 90 per cent probability level was considered adequate in this study.

TABLE 39

NUMBER AND PER CENT OF NURSES IN POPULATION, QUESTIONNAIRES MAILED TO THE SAMPLE OF NURSES, AND QUESTIONNAIRES RETURNED, CLASSIFIED BY SUBGROUP

Subgroup	Number and Per Cent in Subgroup		Questionnaires Mailed		Questionnaires Returned	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Educational administrators and teachers	119	6.3	32	6.5	18	6.9
Institutional nurses	249	13.2	66	13.8	33	12.7
Office nurses	114	6.0	30	6.0	14	5.4
Public health nurses	217	11.5	57	11.5	28	10.8
Occupational health nurses	80	4.2	21	4.2	11	4.2
Private duty nurses	370	19.6	98	19.6	48	18.5
General duty nurses	361	19.1	95	18.1	45	17.3
Head nurses	218	11.6	58	11.6	42	16.2
School nurses	83	4.4	22	4.6	11	4.2
Others	77	4.1	21	4.1	10	3.8
Totals	1,888	100.0	500	100.0	260	100.0

Source: Computed on the basis of questionnaires mailed and received in a questionnaire survey of registered professional nurses in Oklahoma, early 1961.

TABLE 40

VALUES FOR CHI-SQUARE TEST OF SUBGROUP STRATIFICATION

Subgroup	Observed Frequency (f)	Expected Frequency (f_c)	$f-f_c$	$(f-f_c)^2$	$\frac{(f-f_c)^2}{f_c}$
Educational administrators and teachers	6.9	6.3	+0.3	.09	.0143
Institutional nurses	12.7	13.2	-0.5	.25	.0189
Office nurses	5.4	6.0	-0.6	.36	.0600
Public health nurses	10.8	11.5	-0.7	.49	.0426
Occupational health nurses	4.2	4.2	0.0	.00	.0000
Private duty nurses	18.5	19.6	-1.1	1.21	.0617
General duty nurses	17.3	19.1	-1.8	3.24	.1696
Head nurses	16.2	11.6	+4.6	21.16	1.8241
School nurses	4.2	4.4	-0.2	.04	.0091
Others	3.8	4.1	-0.3	.09	.0220
Totals	100.0	100.0	-0.3	26.93	2.2223

Source: Computed on the basis of questionnaires mailed and received in a questionnaire survey of registered professional nurses in Oklahoma, early 1961.