With God on Our Side

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Santa Rosa Memorial Hospital (SRMH) is nestled in a residential neighborhood a few blocks away from downtown Santa Rosa, an exurban community about an hour north of San Francisco. Even with the prominent blue “H” hospital signs leading the way, the hospital can be difficult to find for an out-of-towner. A statue of St. Joseph, the earthly father of Jesus, welcomes visitors at the hospital’s main entrance, and an old convent, long ago converted into administrative offices, sits adjacent to the facility, a buffer between the hospital and the surrounding community.

Since its founding in 1950, the hospital has been owned by the Sisters of St. Joseph of Orange, a group of nuns who preside over thirteen hospitals in California, New Mexico, and Texas that together make up the not-for-profit St. Joseph Health System (SJHS). Although these Sisters were once actively involved in nursing and administration at Memorial Hospital, their numbers have become too small and too elderly to maintain an active presence there. Yet they still actively govern the health system as a whole
and still work to infuse each of their facilities with the values they see as central to hospital care.\footnote{1}

The Sisters of St. Joseph of Orange are widely regarded as one of the most progressive orders of nuns in the state, if not the country. Not only were they among the first sisters in the United States to abandon the habit but they actively supported Cesar Chavez and the United Farm Workers throughout the 1960s and 1970s. Several spent time in a Fresno jail with grape strikers in the summer of 1973. Much to the dismay of these same Sisters, workers at Santa Rosa Memorial Hospital spent more than six years trying to organize a union.

In this book I follow workers’ union organizing efforts at Santa Rosa Memorial Hospital between 2004 and 2010. In 2004 and 2005, workers and union leaders attempted to organize within the standard framework of the federal National Labor Relations Board (NLRB). Yet in the face of a concerted and sophisticated antiunion campaign led by management and supported by the hospital’s religious leadership, workers and union leaders were forced to withdraw from this election in the face of imminent defeat. The campaign then became more open-ended as the union sought what it termed a “fair election agreement,” a set of ground rules and accountability mechanisms that would limit the hospital’s antiunion practices. In this effort workers and union leaders organized in the political and religious communities in new ways. Between 2007 and 2008, the union built a community coalition that sought to link the Memorial campaign with the county’s broader healthcare crisis. Although the coalition was unsuccessful in its narrower political goals, it was an important part of the union’s broader project. Between 2005 and 2009, the union built a powerful religious and political coalition to highlight the contradictions between the values the hospital asserted and its antiunion practices, a project that did win important concessions from the hospital corporation in the fall of 2008. At the very moment of greatest hope, however, the union was thrown into disarray by an internecine labor dispute. When workers finally voted on unionization in December 2010, they did so with few resources and in opposition to the Service Employees International Union (SEIU), the organization that had helped to initiate the campaign.

Throughout this process workers faced intimidation and harassment from their supervisors, from hospital administrators, and ultimately from the members and leadership of an opposition union. As important, workers
had to reconcile their desire for more power and voice in their workplace with their vocational commitments to their patients. The obstacles these workers faced, and their ultimate success, make the organizing drive at Santa Rosa Memorial Hospital a crucible within which to examine the challenges and possibilities facing labor unions in service industries across the country.

The Hospital, the Union, and the Twenty-First-Century Workplace

Today’s healthcare sector is one of the largest industries in the United States, employing 14.3 million people, approximately 35 percent of whom work in hospitals. The hospital has replaced the factory as the main source of employment in many communities. In cities such as Rochester, Minnesota, and Cleveland, Ohio, well-known centers of medical practice and innovation overshadow the manufacturing industries the hospitals were first constructed to serve. Catholic hospitals are a major player in this industry. In 2009 there were fifty-nine Catholic health systems that together provided almost 15 percent of all hospital care in the United States.

Hospital work has also, in some ways, come to resemble work in the large unionized workplaces of the mid-twentieth century. The fiefdoms of midcentury hospital work have given way to integrated hierarchical organizations that have made even doctors feel less like professionals and more like wage earners. Medical specialization and fragmentation have diminished the importance of the physician-patient relationship by introducing new technologies and new delivery systems that divide treatment into its component parts. Unlike manufacturing industries, which have moved production offshore in the face of high labor costs, hospitals cannot as easily transfer operations to places where labor is cheaper, nor can they as easily replace labor power with technology. The workforce is fairly centralized and fairly integrated. And as financial pressures increase in the industry, many workers are being squeezed by being asked to work more hours and take on more responsibilities without commensurate increases in pay.

Finally, far from ushering in a free market of relatively autonomous and competitive buyers and sellers, the corporate transformation of the
U.S. healthcare system has been accompanied by large-scale processes of organizing by the market’s constituent parts. Hospitals have merged in order to negotiate better rates with insurers and physicians, physicians have organized groups in order to negotiate better rates with hospitals and insurance companies, and all three groups have sometimes merged (into health maintenance organizations or preferred provider organizations) in order to negotiate with employers and individual patients. All of these constituencies have used principles of combination to increase their economic leverage with the others.

In these ways the hospital seems a natural site for labor organizing, representing a glimmer of hope in the face of labor’s forty-year decline across the private sector. In other ways, however, the hospital is strikingly different from those workplaces in which the labor movement was born. Since workers in not-for-profit hospitals were first excluded from the protections of the National Labor Relations Act as part of the Taft-Hartley Act of 1947, hospital work has been distinguished legally from other sorts of labor. Not only were hospitals primarily oriented around noneconomic values, it was argued, and so inappropriate targets for unionization, but they were also dealing with matters of life and death, making the threat of work disruption dangerous and immoral. Even after the protections of the NLRA again were extended to hospital workers in 1974, the law has sought to balance the rights of hospital workers against the rights of the public to uninterrupted hospital care.

If hospital work was the anomaly at midcentury, in 2010 it is representative of the interactive care work so prevalent in today’s U.S. economy. The future for American labor seems likely to hinge on its success in industries like health care: industries that orient themselves at least in part toward public goods; industries in which workers’ values and emotional lives are closely entangled with their jobs. Even public sector employees such as teachers and social service workers, recently regarded as the last bastion of U.S. unionism, have found their political and bureaucratic sources of power coming under increasing attack, and must identify new sources of power and legitimacy. The lessons that can be learned from an analysis of hospital organizing have implications far beyond the hospital’s walls.

These lessons have implications outside the labor movement as well. Healthcare workers, teachers, social service workers, and other service-sector employees are often those in closest contact with the patients,
students, and clients they serve. A revitalized labor movement can and must be closely linked to the protection and revitalization of patient care, student learning, and the public good. Union membership is one of the few mechanisms that allow workers to advocate on behalf of the constituencies they serve without fear of reprisal.  

Most broadly, this book explores the relationship between vocational values and worker power in the contemporary hospital and beyond. More specifically, it addresses three questions. First, how do hospital workers understand the noneconomic dimensions of their work, and how do these noneconomic values relate to their participation in labor unions? Second, in a context in which confrontational politics is understood by multiple constituencies as anathema to organizational mission, what should be the character of labor struggle? How can workers successfully challenge their disempowerment when this challenge is itself construed as inappropriate? And finally, how do these two dimensions of labor struggle—workers’ noneconomic values and the ideological face of the corporation—complicate existing debates about labor’s power both on the shop floor and in the political arena? 

Throughout this book, I argue that for unions to remain relevant in the hospital industry and beyond—winning support among workers, winning campaigns against employers, and winning broad-based political power—they must recognize the cultural dimension of labor struggle, and must be concerned as much with putting forward a vision of the public good as with winning material advantage. The campaign at Santa Rosa Memorial Hospital—and its relationship to broader successes and failures in the labor movement—illustrates the possibilities and perils of this approach to labor struggle.

Case and Methods

I focus on Santa Rosa Memorial Hospital because it epitomizes the values-based not-for-profit employer. Although vocational ethics infuse many care contexts, they are perhaps nowhere more prominent than in the Catholic hospital, where these ethics are articulated explicitly in the form of religious values. When I asked the deacon of a local church why it mattered whether or not a hospital was Catholic, he responded: “You ever
been scared? . . . There isn’t any time in the world when religion makes more sense than when you have a problem, especially a health problem, or [are] confronting death.” A lead organizer in the union told me that these religious values are “often deeply felt by the workers.” This is not to say that workers are necessarily religious themselves, but rather that the religious mission of the hospital resonates with their experience of the noneconomic aspects of their work. According to Sioban Nelson, a professor of nursing, workers want “to provide healthcare to all in their facilities with the highest respect and dignity for the patient and their families.” People “feel good about those missions.” Nelson documents how Catholic nuns established modern nursing “as a hybrid religious and professional practice.” This legacy lives on in the way that many workers relate to hospital work, perhaps most acutely in those hospitals founded by Catholic nuns.

It was Fred Ross Jr. who brought me up to Santa Rosa for the first time in the spring of 2006. As a first-year graduate student in sociology at UC Berkeley, I was interested in learning more about the theory and practice of labor organizing, and made a deal with myself to keep one foot in the world of practice. Like any good organizer, Ross wasn’t satisfied with just one foot, and he suggested that I become one of the union’s religious organizers. So over the next year and a half I worked about fifteen hours a week for the union, building relationships with local religious leaders, introducing them to hospital workers, and asking them to support the campaign in various ways. No matter that I was a nonpracticing Jew whose religious experience was limited to bar and bat mitzvahs and the occasional High Holy Days.

Throughout my involvement with the campaign I took detailed field notes, oftentimes reluctantly, as my world of practice had come temporarily to overshadow my academic ambitions. When I dove back into graduate work more wholeheartedly, between February 2009 and October 2010, I conducted open-ended interviews with worker leaders, union organizers, religious leaders, and hospital administrators and executives.

This book also makes use of a rich body of primary documents produced by both union and management over the course of the campaign. These include strategic memos written by union staff; public memos from the hospital administration to workers; flyers both for and against the union that were distributed to workers at the hospital; public advertisements taken out by both union and administration in local media outlets; media stories
on the struggle; correspondence between union representatives and hospital administrators; correspondence between union representatives and religious and community leaders; and several “reports” produced by the union that were part of its campaign to gain public support. Perhaps most useful of all was a report produced at the culmination of the campaign by Eileen Purcell, a leader of SEIU’s Catholic hospital strategy, which was intended to illustrate the campaign’s successes and failures.12

My comparative case studies of different periods in the campaign to unionize Santa Rosa Memorial Hospital help us understand the important role that cultural ideas and broad-based organizing play for unionization efforts in the healthcare industry, and the possibilities for this sort of struggle throughout the modern labor movement.13

Workers and the Union: The Power to Care

The scholarship on service work has tended to treat emotional investment in work as something produced by corporations themselves. In her pathbreaking study of airline attendants and bill collectors, the sociologist Arlie Hochschild studied what happens when workers’ emotions become part of the commodity being sold.14 The attendants, she found, were trained to feel nurturing, cheerful, and flirtatious on the job. Hochschild compared this learning of a role to Constantin Stanislavski’s method of “deep acting.”15 Emotion work succeeded as a service to the extent, and only to the extent, that it was perceived as being “real.” When workers’ emotional lives were made a part of the product being sold, Hochschild argued, workers’ experiences of alienation—and the possibilities for workers’ resistance to it—were short circuited. Rachel Sherman pushed this line of inquiry even further in her study of workers at luxury hotels.16 She found that the relationships workers had with hotel patrons became important to workers’ senses of self, helping them feel equal to (and in some senses superior to) their affluent customers. Moreover, Sherman argued that workers’ different access to these relationships created distinctions among them that undermined the potential for organized resistance. Although these “class acts” were somewhat illusory, given that workers were still structurally less powerful than the clients they served, they were experienced as real and important.
The meaning that healthcare employees attribute to their work as they help patients make sense of profound fear and uncertainty is difficult to dismiss as part of a commodity produced by hospital administrators. Workers take pride in their capacity to feel empathy for and provide assistance to vulnerable patients. And the results of their work—the physical and emotional well-being of patients—is also of real importance to healthcare workers. It is more immediately manifest to healthcare workers than it is to those making widgets on the assembly line, and of more significance than the contentment of passengers in airplanes or the well-being of patrons in hotels. The hospital worker may not be in control of the rhythm of his or her work. He or she may struggle to make ends meet. But this worker is often profoundly invested in the wellness of patients and so feels a sense of connection to the work itself and to the hospital within which it takes place.

In other words, the way that workers make sense of hospital work is embedded in their interactions with patients and is not merely a product of the corporation. For Hochschild, emotions were “engineered and administered by large organizations.” Workers’ identification with their work, then, meant that they were estranged from that most personal aspect of themselves. In an illuminating turn of phrase she called this phenomenon “the managed heart.”

But if workers’ emotional investments in work might have autonomy from management—as they seem to have in the hospital—we can identify other ways in which these investments might also affect workers’ power on the job. First, emotional investment with work might become a reason not to protest unfairness—the martyred heart. Paula England and her colleagues have shown that “care work” is devalued and underpaid in our culture. They suggest that the meaning workers attribute to this work may be at least part of the explanation for the devaluation, since “if the marginal worker sees the intrinsic properties of the work as an amenity, this permits a lower wage.” One’s identification with one’s work may come to be seen as replacing a part of one’s wage—or one may feel so identified with one’s workplace that one is willing to subordinate oneself to the organization for the “good of the whole.” Second, identification with work might be understood as resistance to hospital leadership—the misrecognized heart. Workers may experience their own caring as reclaiming the noneconomic parts of their work from impersonal market pressures or bureaucratic imperatives. The paradox of this strategy, of course, is that it benefits the very
organization from whose leadership workers feel estranged. Like those workers in sociologist Michael Burawoy’s *Manufacturing Consent* who “make out” by increasing their own productivity, caring can be experienced as resistance at the same time that it boosts the hospital’s reputation and bottom line.21

Finally, identification with work might become a reason to advocate for oneself, one’s co-workers, one’s capacity to do one’s work well, and thus for one’s patients—the *mobilized heart*. Workers may conclude that the only way they will be able to deliver the standard of care to which they are committed is to increase their own power within the organization as a whole. Because of the lack of protections afforded by U.S. labor law, workers who are not in unions are “employees at will” and can be fired summarily, without “just cause.” The First Amendment’s guarantees of free speech do not apply to the workplace and workers who want to advocate for their patients can be fired or disciplined without legal recourse. In nonunion workplaces, employers have no obligation to talk with workers about their concerns or bargain with them about working conditions that are connected to patient care. The only protected speech in the American workplace is what is known as “protected concerted activity,” which is what unions provide.

All of which is to say, when workers in hospitals consider unionization, they do not merely weigh how a union will affect their economic position, although this is certainly a factor. They also take into account the degree to which a union will let them have a say in the way that the hospital takes care of its patients, and the extent to which a union will enable them to express (or prevent them from expressing) the noneconomic values that are central to the way they think about their work. In order to be successful, then, labor unions must engage with the cultural dimensions of hospital work, and they must help workers interpret their own participation in the union as being consistent with their own emotional commitment to their work.

In the first stage of the Santa Rosa Memorial Hospital campaign, worker leaders and union representatives treated the campaign as a struggle that was nearly indistinguishable from campaigns in other industries. After workers contacted SEIU-UHW in 2004, union representatives helped to develop an organizing committee of worker leaders and community supporters. Throughout this process the union sought to build what sociologist Rick Fantasia calls a “culture of solidarity” among workers that could overcome a market-driven management style.22 Fantasia’s rich case
study of an organizing campaign among hospital workers in Springfield, Vermont, demonstrates the ways in which organizing committees can “provide an area of social space within the employer-dominated workplace where an alternative definition of social relations and power can be provided and maintained.”23 In Fantasia’s success story, a culture emerged among union activists “with opposition as its central, defining feature.”24

Yet this strategy was not enough at Santa Rosa Memorial Hospital, for two reasons. Most unsurprisingly, the very imbalance of power that union supporters sought to rectify through unionization meant that hospital management controlled the environment in which the union election was to take place. Managers intimidated workers, spread misinformation, and selectively raised wages in anticipation of the election. The uneven playing field during the election process, combined with a weak and loosely enforced labor law, meant that the union and its supporters were at a distinct disadvantage, as unions are throughout the country.25

But while hospital administrators stuck to standard antiunion strategies and tropes throughout this initial campaign, their underlying message also had a powerful impact on workers. The union was cast as an economically interested third party that would undermine the hospital’s mission. In actuality, the local and international unions had already established productive partnerships with management at both Catholic Healthcare West (CHW), the largest Catholic health system in California, and at Kaiser Permanente, a large integrated managed care organization also based in California. At the workplace and at the political level, the union had worked with these hospital systems on shared goals, from healthcare reform and immigrant rights to patient ratios for non-RNs and procedures to prevent workplace injuries. Moreover, union leaders had met with the leadership of Saint Joseph Health System before any organizing began to explore the possibility of avoiding a protracted and adversarial unionization campaign. These conversations had gone nowhere, however, and union leaders concluded that the health system would not dialogue without feeling some pressure. But SJHS consistently interpreted this pressure as a kind of symbolic violence, and this interpretation played powerfully into some workers’ hesitation about the union. The oppositional culture of solidarity fostered among union organizers and worker leaders was effectively portrayed by the hospital as something that threatened workers’ capacity to care for their patients.
The limits of oppositional politics may be especially apparent in the healthcare context, but these limits are likely more general. Research suggests that while a majority of U.S. workers do want some say over how their workplace is organized, and do see the value in collective representation over issues of wages and working conditions, most do not want the adversarial relationship with their employer that they worry a union entails.26 The paradoxical question, then, is, how can unions win power and voice for workers without this struggle being understood as conflictual?

Fantasia’s oppositional solidarity fails to take into consideration the deep emotional relationship many hospital workers have with their work—an investment that makes certain kinds of conflict especially uncomfortable. His attention to workers’ understandings and practices is critically important, yet his case study of hospital workers sits alongside studies of workers in the steel-casting and corn-processing industries, implying that labor and capital (and the struggle between them) can be understood similarly in these different contexts. That is, while Fantasia is careful to discuss the plural “cultures of solidarity” in order to “afford analysis of discrete case studies of collective actions,”27 nevertheless he seems to describe a particular type of process common across his cases—a process in which workers move from alienation to collectivity, from estrangement to solidarity, establishing autonomous “cultural formations that arise in conflict, creating and sustaining solidarity in opposition to the dominant structure.”28 Even scholars who grapple more deeply with the particular nature of healthcare work argue along similar lines. The sociologist Paul Johnston recognizes what he calls “the dilemma of autonomy and care”29 among nurses, but suggests that nurses’ “self-assertion” through unionization “implies turning away from the ‘Florence Nightingale’ attitude and demanding respect, fair pay, and the right ‘to take care of myself’.”30 He does not interrogate the conditions under which unionization can come to be seen as enhancing the capacity to care.

The prototypical example of labor’s oppositional solidarity is the strike, or the collective withdrawal of labor power. Yet given the high stakes of hospital care, many hospital workers are reluctant to strike, worrying about the effects of the strike on those for whom they would otherwise be responsible.31 In order to feel comfortable challenging power relationships within the hospital, then, workers need to embrace the mobilized heart—they need to feel that supporting the union is consistent with the hospital’s
larger mission of patient care. As a lead organizer at Santa Rosa Memorial Hospital put the point, “You have to organize people to a vision of good.”

Scholars have long recognized the limits of adversarial politics within the healthcare industry and service sector more generally. It is no surprise, then, that a theme of almost every antiunion campaign—in healthcare as well as in other helping services—is that unions represent interests opposed to the well-being of patients or clients. In an emblematic article, the medical scholars Christopher Bryan-Brown and Kathleen Dracup write that unions “tend to destroy the ideals of professionalism because they are not patient centered. Unions generally look askance at altruistic behavior and at the professional who wishes to go the extra mile for a patient.” The article argues that healthcare workers often operate in environments of resource scarcity: “Making the best we can with what we have is a more certain professional approach than trying to get a better deal through a trade union.” In what has become an almost classic confusion, the authors here conflate professionalism and sacrifice, and assume that workers’ interests are identical with the interests of the health systems for which they work. Unions and workers do not protest going the “extra mile for patients,” but rather resist running workplace marathons for large employers on behalf of these corporations’ bottom lines. Moreover, preliminary studies of the relationship between unionization and patient outcomes demonstrate positive effects of a unionized workforce on patient care. For example, mortality rates of cardiac patients have been found to be lower in unionized hospitals than in their nonunion counterparts. Presumably, unionized workers were better able to point out patient care problems without fear of reprisal.

The perception that unions are enemies of altruism is at least in part a product of the narrowness of American labor law (about which authors like Bryan-Brown and Dracup often seem woefully ignorant), which limits the scope of mandatory bargaining to wages, hours, and working conditions. In the United States, antiunion ideology has become so pervasive that authors like Bryan-Brown and Dracup see negative effects even in such patient safety initiatives as staffing ratios that have been promoted by unions. They claim that staffing ratios are actually harmful to patients as a whole, since these ratios are incompatible with “a worldwide shortfall in the number of nurses needed to maintain the ratios.” This analysis overlooks that the pay and conditions of healthcare work are important
causes of staff shortages, and that these conditions are exactly what unions help to ameliorate. Yet the popular conception of unions as narrowly interested, self-serving, and undermining of vocational values is hard to shake—even among some workers themselves.

The Union and the Hospital: The Struggle over Catholic Teaching

In the face of their initial setback, union organizers and worker leaders regrouped and decided to wage a public, community campaign for what it called a “fair election agreement”: a set of ground rules and accountability mechanisms that would limit the hospital’s antiunion campaign and create an environment in which workers could “freely” choose whether they wanted a union. As unions across the country have struggled against concerted management opposition and a weak labor law, these sorts of longer-term campaigns—campaigns over the process by which workers choose—have become more common. And as it sought to pressure the employer to agree to such ground rules, the union engaged in strategies typical of “social movement unionism,” finding sources of leverage in the political arena, in the media, and among religious leaders and community coalitions.

Ultimately, however, the union campaign at Santa Rosa Memorial Hospital became a struggle over the meaning and implications of Catholic teaching. According to the union and its supporters, the religious values on which the hospital was founded had been corroded by the healthcare market. The hospital system’s espousal of Catholic values was hypocritical, corporate mumbo-jumbo. Indeed, since the 1970s, the “values-driven” approach to management has become increasingly common among corporations of all stripes. For example, Starbucks advertises that “Working at Starbucks is a lot like working with your friends.” Walmart has a slogan, “A career at Walmart is more than a job. It’s a way to ignite your spark.” Even earlier in the twentieth century, personnel departments had been aware of the ways in which promoting company values could inspire loyalty, discourage collective action, and—to paraphrase the title of a book by the antiunion industrial psychologist Charles L. Hughes—make unions feel unnecessary. For supporters of the union, St. Joseph Health System was merely using its religious legacy to rationalize worker exploitation and subjugation.
Even though the Sisters of St. Joseph of Orange had long since turned over hospital management to laypeople, the Sisters still controlled the governing board of the system, and had asserted on numerous occasions that they were the primary decision makers. According to the union and their allies, then, the Sisters were risking their legacy by sanctioning aggressive antiunion tactics, since Catholic social teaching required that the hospital be supportive of unionization.

The Sisters and their hired ethicist agreed with the union about the importance of a dignified workplace but argued that unions were only one way of achieving it. Moreover, they suggested, a union would undermine the hospitals’ “Biblical community.” And just as the union regarded the system as hiding behind theological rhetoric, the Sisters saw the union’s invocation of Catholic teaching as part of a strategic “corporate campaign” that assaulted the image of the hospital system, manipulating workers and community allies alike to join the union’s cause. The union’s use of theology was purely instrumental, hospital leaders claimed, one weapon in an arsenal that was designed to bring about what the antiunion political scientist Jarol Manheim characterized as a death of a thousand cuts. 42

Although the union drew on a rich tradition of Catholic social teaching on the rights of workers to organize, the hospital leadership had important sources of cultural power as well. The Sisters of St. Joseph of Orange were not only owners of the hospital but also traditionally had been the hospital’s moral leaders, embodying and supporting employees’ vocational commitment to care. As nuns, they represented an ethic of subordinated femininity—a life of self-sacrifice and religious identification. Even without evangelizing their religious beliefs among the workforce, they fostered among workers a similar ethic of selflessness and self-sacrifice. These Sisters were acting with precedent. In the 1930s and 1940s, the Catholic Health Association struck an alliance with the American Hospital Association over the status of hospital workers in the recently minted National Labor Relations Act. Together these groups sought exemption from the act on the grounds that “low pay was a virtue, since it attracted staff who were motivated by the ‘right values.’” 43 The role of Catholic hospitals was essential to this argument because “it extended, by analogy, the dedicated service of Roman Catholic nuns to the jobs of all hospital workers.” 44
For the union to win an election agreement with St. Joseph Health System it would have to engage the Sisters on the ethical terrain the Sisters saw as central to their ministry. And given the Sisters’ moral commitments, they reacted to economic and political pressure in unexpected ways. A lead organizer in the campaign to organize Santa Rosa Memorial Hospital explained that organizing in the for-profit hospital industry was simpler than organizing most Catholic hospitals. He said that for-profit companies “have a clear objective, they want to make as much money as possible,” and would capitulate if the union caused them to lose enough money. Catholic systems, however, “have an ethic,” and the sisters who own these hospitals believe that they are “good advocates” for their workers. Sisters understand unionization as an indictment of their leadership, he suggested, and so are ideologically opposed to unionization even when it makes economic sense to settle.

The union’s success on this terrain was due, in large part, to its capacity to combine a concern with power with a concern for values; to combine collective action with dialogue and deep relationships; and to combine workers’ involvement and workers’ voices with dialogue and debate among Catholic leaders at the national level. The Sisters of St. Joseph of Orange had natural theological legitimacy as women who had dedicated their lives to religious practice and care giving. And while many union leaders rooted their work in religious traditions as well, the union was more vulnerable to having its relationship to theological teaching be dismissed as instrumental. For the union’s theological position to be taken seriously within the religious community, then, union leaders had to navigate the tension between their moral commitments and their organizational goals—between authenticity and instrumentality.45

Despite the diversity in the literature on contemporary labor unions, no existing scholarship adequately explains this cultural terrain on which the labor struggle ultimately was fought. This is because the literature is limited by materialist assumptions, and tends to paint employers as one-dimensional market actors motivated by the bottom line alone. Even for those who articulate most powerfully the importance of moral or cultural resources to union drives, the dominant narrative has been one of leveraging moral arguments against market forces, be they agribusiness companies or multinational hotels.46 Religious and cultural traditions are
understood as tools that help motivate workers and their allies fight back against an impersonal capitalist adversary.

Although labor scholars have tended, with some notable exceptions, to underestimate the role of culture in contemporary labor struggles, social movement scholarship has engaged with the question of culture through the concept of “framing.” Frames are “action-oriented sets of beliefs and meanings that inspire and legitimate the activities and campaigns of a social movement organization,” and thus “mediate between structural parameters and . . . social actors.” Recently, the sociologist Marc Steinberg has pushed this line of analysis even further by suggesting that we understand framing as taking place in a “discursive field” within which multiple sides work to legitimate their interpretation of these symbols to a broader audience. The goal of a social movement organization is not so much to create an oppositional culture as to win legitimacy over the symbols at stake.

This theoretical orientation allows us to investigate the process by which the union engaged in ideological struggle with St. Joseph Health System. Importantly, each side argued that it represented a vision of Catholic teaching in the face of impersonal market forces embodied by the other, and each side struggled with the inconsistencies and contradictions in its orientation. For the union, the immorality of the market was reflected in the unequal power relationships the market tended to create; Catholic teaching has long asserted the rights of workers to organize for exactly this reason. For the Sisters, the immorality of the market was reflected in its tendency to depersonalize and commodify social relationships; Catholic teaching asserted the dignity of the worker, which—hospital leaders argued—under some circumstances actually might be undermined by a bureaucratic and impersonal union structure. In this way each subscribed to a view of the market as fundamentally immoral, yet each side identified the immorality of the market in the other. The conflict took on the qualities of a Rubin’s vase, with each side seeing the market in the other without seeing it in itself.

Cultural Struggle

The workers’ relationship to the union and the union’s cultural struggle with St. Joseph Health System may be analytically distinct, but they are deeply
intertwined. The moral legitimacy of the Sisters within the Catholic hospital helped to instill among workers the *martyred heart*. One oft-repeated story among union supporters in the Santa Rosa Memorial Hospital campaign was how a nun had approached a pro-union worker and told her she was “greedy” for wanting a union. Although the message was rarely so explicit, workers were consistently reminded of the vocational nature of their work and urged to mirror the Sisters’ own selflessness. The theological campaign over the rights of workers to organize simultaneously helped workers feel that their involvement with the union was consistent with the hospital’s mission.

Values became an important terrain of struggle, then, not only because of the hospital’s religious legacy and religious leadership but also because these religious values resonated with workers’ sense of the noneconomic dimension to the care they provided. The organizing work undertaken by the union thus had an impact both on the context within which the election was to take place and on the beliefs and understandings of the workers who would ultimately choose whether to unionize. What began as a battle over positional power in the organization became one over the values underlying it.

This is not to say that unions should abandon bread-and-butter concerns—far from it. Rather, in a context in which the meaning of work matters, both for workers themselves and within the wider political context of struggle, unions must think carefully about how to weave together economic and cultural power. This endeavor must go beyond discursive processes of “framing” to infuse union practice as well. As a simple example, in the context of health care, unions must make clear how workers’ interests are in keeping with patients’ interests as well. One organizer described with a pained look on her face a decision made several years ago by the union to picket the opening of an acute-care clinic at a union-busting hospital system.

This vision for U.S. unionism is quite consistent with the theory articulated by Antonio Gramsci in his *Prison Notebooks*. For Gramsci, revolutionary change was contingent on workers and intellectuals putting forward a vision of the social world in which workers’ interests were in the interests of the entire society. Workers had to move from solidarity based on similar work, and even from solidarity based on class position, to an “intellectual and moral unity” that would make working-class power consistent with a broader vision of the social good. There are echoes of
Gramsci in the way that Eileen Purcell, a union leader in the St. Joseph Health System campaign, described her own vision for the labor movement: “I’m about building unions that are knitting together relationships that start with the workers, that link to the community in which workers live, and have a larger than life vision around a social justice community that we’re trying to build.” Ross, Purcell, and countless others had joined SEIU in order to turn this vision into a reality.\textsuperscript{54}

**Labor at the Cross (Roads)**

Fifteen years after John Sweeney assumed the presidency of the AFL-CIO on a platform emphasizing new organizing, and five years after SEIU president Andy Stern led a breakaway coalition from the AFL-CIO on the premise of bringing millions of new members into unions, the rate of private-sector union membership in the United States in 2010 was a meager 6.9 percent, the lowest rate since the early 1930s.\textsuperscript{55} Among those scholars committed to union renewal, a vibrant debate has taken place about the relative merits of “top-down” versus “bottom-up” approaches to union expansion. Some scholars have emphasized the importance of union outsiders and centralized leadership to organizational reform and organizing success;\textsuperscript{56} others have seen these same activities as undermining union democracy and rank-and-file leadership.\textsuperscript{57}

These scholarly debates have taken on increasing significance in light of recent internecine labor struggles.\textsuperscript{58} In the middle of the campaign at Santa Rosa Memorial Hospital, for example, the international SEIU union put the local union in trusteeship, effectively firing most of its staff (see chapter 5). Around the same time, SEIU became embroiled in a dispute with one of its longstanding allies, UNITE HERE (Union of Needletrades, Industrial and Textile Employees, Hotel Employees and Restaurant Employees), for which SEIU drew condemnation from virtually every corner of the labor movement.\textsuperscript{59} Although many different accusations flew among the various sides in these fights, underneath the invective were real differences in the ways that these unions understood how to achieve power for workers and for the working class.

The campaign at Santa Rosa Memorial Hospital, and the broader strategy of organizing Catholic hospitals of which it was a part, blurs some of
the distinctions between bottom-up and top-down unionism, while introducing new tensions and contradictions. The Memorial campaign relied on the commitment of a dedicated group of worker leaders, yet combined this grassroots commitment with top-down strategies such as national roundtable discussions among union leaders, bishops, and Catholic healthcare leaders (sponsored by the United States Conference of Catholic Bishops); alliances with Catholic scholars; and ongoing communication with system executives.

More generally, for cultural struggle to be effective, leaders must conduct intensive education and training among workers—both helping them appreciate a larger vision of unionism and working with them to become symbolic actors on a broader stage. But preparing workers for effective bottom-up participation is itself something of a top-down endeavor. Cultural struggle must center on the experiences of workers themselves, but work on multiple levels—through insiders and outsiders, workers and intellectuals—to cast workers’ interests as being in the common interest.

But if the campaign at Santa Rosa Memorial Hospital helped to reconcile competing conceptions of union power, at least to some extent, reconciling these competing conceptions is insufficient to create an effective cultural strategy. A union debate that focuses on the best strategy to win power for workers misses the importance of meaning for these workers. And while increases in workers’ control over wages and working conditions can be experienced as liberation, the hospital context demonstrates the ways in which this control—narrowly conceived—neglects important dimensions of workers’ emotional lives.

Discussing her vision for labor unions, one leader in the Memorial campaign contrasted her own position with those in the mainstream of the labor movement today. Many unions had “placed their hats on ‘let’s build power, political power, and then we’ll take it forward from there.’” But for her the ends were as important as the means: “For me it was always about building a community predicated on love, power, and justice. So I want to build power, but I want that power to be linked to a vision of something that’s greater than my self-interest.” She was frustrated that union leaders would talk about how to “get more power” in a manner “delinked from justice and love.” The irony, for her, was that her own vision of unionism was “very consistent with what these Sisters are trying to build. They’re trying to build their kingdom of God on this earth.” The labor movement,
this leader implied, needed to be more self-reflective about the world it was hoping to achieve.

This vision is particularly well suited for an industry like healthcare, in which many workers are motivated by more than narrow self-interest, and in which corporations are particularly influenced by and enmeshed with cultural values. The task for the labor movement, then, is to develop what Antonio Gramsci calls a “concrete phantasy,” a vision for the healthcare industry—and beyond—that connects workers’ interests with the interests of all.\(^63\)

### An Outline of the Book

Throughout this book I suggest that labor scholarship has focused on how unions have been able to achieve economic power for their members without fully appreciating the implications of workers’ emotional investment in their work or the ideological power of capital.

I first examine the history of Santa Rosa Memorial Hospital and workers’ early attempts to organize a union with SEIU United Healthcare Workers West in 2004–05. Chapter 1 reviews the historical legacy of the Sisters of St. Joseph of Orange, and explores how the values on which the hospital was founded continue to find expression in the understandings and practices of workers in the hospital. The religious nature of the hospital is not only a historical legacy but also an important symbolic recognition of the social nature of hospital care, which infuses all work in the hospital, from the direct provision of care to the work that goes on far away from the bedside. This chapter also elaborates what happened as the Sisters gave up sole administrative control of the hospital, and the frustration workers experienced as the hospital administration instituted a more secular and more corporate regime—as it moved from the martyred heart to the managed, or \textit{mismanaged}, heart.

In chapter 2 I recount workers’ early organizing efforts in the hospital between 2004 and 2005, and the relationship between workers’ desire for voice in the hospital and their emotional investment in their work. I demonstrate how the union campaign initially engaged workers’ frustration over a lack of power more than it did workers’ emotional commitment to hospital work. By engaging in a textbook antiunion campaign, the hospital was able to marginalize prounion worker leaders, intimidate
union supporters, and undermine union strategy. As important, however, the hospital was able to frame the union as having interests that were opposed to the well-being of patients, the hospital, and the community. The divisive campaign was portrayed as being the fault of an external, “third party” union that would put the heart of the hospital—the direct care for patients—at risk.

At the end of chapter 2 I present the story of the union’s political strategy as it moved from the workplace to the broader community. In so doing I diverge slightly from the chronology of the campaign, since the theological campaign (discussed in later chapters) began before and continued after this political campaign. Over the course of 2007, the union sought to intervene in a deal between a struggling local hospital and SRMH, in order to make the deal contingent on Memorial’s willingness to negotiate “fair election” ground rules. This strategy was emblematic of the standard union “comprehensive campaign” or “corporate campaign,” which uses economic and political leverage to win concessions from employers. This analysis helps to highlight what distinguished the ideological struggle from the strategies of more standard social movement unionism. The strategy was unsuccessful in its narrow political goals, but it was successful as one component of the broader ideological project.

I then examine the union’s shift to a cultural strategy: from workers’ positional power in the hospital to workers’ relationship to the hospital’s soul; from a focus on the workplace to a focus on the religious community and beyond. In chapter 3 I explain how SRMH fit into a larger “Catholic” strategy to organize Catholic hospitals within the national SEIU. That the union could wage a battle over the hospital’s moral standing was made possible because of a unique cohort of leaders within the international SEIU; because of St. Joseph Health System’s strong financial position, which made it unbeatable in the economic realm alone; and because of the clear contradictions between what the system asserted about its values and what it did in practice. In this chapter I also elaborate the terrain of the theological debate that would come to dominate the campaign—the theological arguments that the hospital and union came to make about the relationship between Catholic teaching and labor unions.

In chapter 4 I illustrate how the union successfully expanded the scope of conflict beyond the workplace, engaging broader religious and political communities in a campaign for a “fair election agreement” between
2005 and 2009. By building a coalition of Catholic religious leaders who became spokespeople for Catholic social teaching on the rights of workers, the union was able to challenge the St. Joseph Health System’s monopoly on moral authority in the hospital. This chapter explores the creative ways the union built and made use of this coalition, and the tensions involved in these sorts of labor-community alliances. It also discusses how the role of workers changed as the campaign’s focus shifted from workplace to altar.

At almost the very moment the union won its campaign for a “fair election” agreement, however, the international SEIU placed the UHW in trusteeship, firing its top staff and bringing the St. Joseph Health System campaign to an abrupt halt. Tensions had been brewing between the local and international for years, in part because of a personal clash between the local and international leader, in part because of real differences in how each conceived of union strategy. As workers at Santa Rosa Memorial Hospital reeled from the news, they began to regroup with a newly formed National Union of Healthcare Workers (NUHW) composed of a volunteer staff of former UHW employees. The staff dedicated to the hospital campaign dropped from five paid staff to one lone volunteer. SEIU sought to undermine the campaign to prevent NUHW from gaining a toehold at any hospital in California.

In chapter 5 I explore the internecine struggle between NUHW and SEIU as workers fought a third and final round for their union. Through this lens, I enter the contemporary debate on union democracy and union revitalization, particularly as it relates to the struggle at Santa Rosa Memorial Hospital. In this chapter I also explore how the trusteeship forced workers at Memorial to take ownership of the campaign in ways they had not been asked to before, and came together with almost no resources to take on a well-funded hospital system and a powerful union, who were now united in their opposition to the grassroots workers’ drive to unionize hospital workers.

Finally, in the conclusion, I explore the implications of this study for the labor movement as a whole. I argue that while unions must continue to advocate for the material advancement of their members, they must see themselves less as interest-based organizations and more as values-based organizations. Unions must combine their instrumental focus on power with a narrative focus on meaning.