With God on Our Side

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Jorge is a middle-aged Latino, tall and broad-shouldered, balding on top with a ponytail that stretches halfway down his back. From afar he looks a little intimidating, but his easy smile and childlike laugh belie his tough façade. Jorge had initially trained as a psychiatric technician and found work at a local mental health facility, but because of his size “there was only one thing they wanted me for, and that was takedowns.” He grew sick of being a “manhandler,” and transitioned to work in SRMH’s neurology department as a nursing assistant. When a phlebotomist position opened up at SRMH in 1997, he jumped at it.

In the fall of 2003, nurses at Santa Rosa Memorial Hospital—who were represented by their own independent union—had recently negotiated a two-year contract with a 14 percent annual pay raise. Other workers at the hospital were accustomed to the nurses getting higher raises than they did, but the hospital had typically given the “non-contractuals” something. Not this year. After two or three weeks without hearing anything, Jorge began speaking with other workers in the hospital’s lab, and ultimately
approached the department’s new director to request a meeting. The di-
rector refused at first but ultimately capitulated, and about twenty workers
gathered around a room as the new director defended the decision not to
give them raises. The director first argued that too much money was spent
on the nurses, and that the hospital was in tough financial shape. When
Jorge replied that the hospital had publicly boasted of its recent record-
breaking earnings, the tone of the meeting changed: “He got pissed off at
me. And [he said], ‘You aren’t going to see any part of this. The reason the
RNs got it was because they’re more educated than you and you guys are
no more than a dime a dozen. We can replace you just as fast as we lose
you. And if you don’t like that you can hit the road.’”

By this point Jorge’s own blood was boiling. “I’m the one that brings
in all the people that like to come here,” he told the director. “We the
people here in this room are the ones that have left the legacy, not people
like yourself!” As the back and forth continued, the director finally pro-
vided an opening: “There’s two reasons [the nurses] got the money that
they got. One, they’re RNs. Two, they had a contract.” A light bulb went
off. Jorge said, “That’s all I need to know! It’s over, it’s done.” And as
the meeting wound down, Jorge’s direct supervisor approached him and
said, within earshot of the director, “Jorge, you’re everything that he just
said you were if you don’t go in, right into my office right now and make
that phone call.” Jorge went into his supervisor’s office: “I walked right
into her room and I didn’t know who to call! I didn’t know what to do!
But I knew I couldn’t just back down.” He walked back out into the
hallway, grabbed the nearest telephone book, and started looking for a
union to call.

Jorge wound up calling Glenn Goldstein, the organizing director of
what was then SEIU Local 250.1 Goldstein had been organizing in the
healthcare industry for almost twenty-five years. He had been the found-
ing organizer of District 1199NW (1199 Northwest) in Washington state,2
and after coming to Local 250 in 1998 had directed Northern California
organizing efforts during the successful Catholic Healthcare West cam-
paign.3 Glenn was also married to a critical care nurse, which gave him a
deep personal understanding of the pressures facing healthcare workers.
Glenn traveled to Santa Rosa from the Oakland headquarters the next day,
and the organizing drive began soon afterward.
Exit, Voice, and Loyalty

This scene of direct confrontation between workers and managers over wages is reminiscent of union battles of old, and in some ways accurately reflects the history of Local 250, now SEIU-UHW. The union was founded in 1934 when nurses in San Francisco walked out as part of a general strike. According to several organizers, the union has had a long, militant history, in which workers and union leaders have been unafraid to do whatever it takes to win. Although the local had begun to change somewhat by the late 1990s and early 2000s, as it entered into more cooperative relationships with Kaiser-Permanente and CHW, most staffers and worker leaders in the local were still “more comfortable in head-on clashes,” according to one union leader, than they were around a boardroom table.

In the fall of 2004, many workers at Santa Rosa Memorial Hospital—especially those service workers at the lower ends of the hospital’s pay scale—were motivated to unionize by their own financial situation. One organizer involved in the campaign suggested that these workers “were getting paid way below the market level, compared to Kaiser, and it was an easy comparison to Kaiser,” since Santa Rosa’s Kaiser facility was only a few miles away.

Yet many workers approached the question of compensation ambivalently, which may help to explain their failure to mount a viable union campaign before the fall of 2004. Workers were unionized at both of the other two major hospitals in Santa Rosa, as were the nurses at Santa Rosa Memorial Hospital. All of these unions provided tangible evidence of what organizers call the “union difference.” Frank recalled how the “nurses had a union, and it was like two different countries. You were either an RN, or you were a ‘non-contractual.’” Mari knew the nurses and heard them talk about “‘My contract, my contract, my contract.’” Moreover, Sonoma County was one of the most liberal counties in the country, represented entirely by Democrats in the state Assembly, state Senate, and U.S. Congress. If Catholic hospitals stand a chance of being unionized anywhere in the country, one would think it would be here.

In the sociologist Steve Lopez’s insightful account of organizing efforts in and around Pittsburgh, Pennsylvania, he discusses how organizers had to overcome a legacy of business unionism and corruption in order to win
the trust of workers. Workers at Memorial confronted a different and more ambivalent legacy. Among these workers, it was not “do nothing” unionism but rather militant unionism that seemed to frighten them. As I stood with one political organizer at a sparsely attended rally in the fall of 2006, he contrasted the “middle class” workers at Santa Rosa Memorial Hospital with the “nursing care workers who are getting paid shit and really feel the need for the union.” Another organizer referred to nursing homes as “the sweatshops of the healthcare industry.” SRMH workers, the political organizer implied, did not feel the same urgency for representation that other workers did.

It was true that many Memorial workers tended not to be interested in the union if the union was understood as an adversary of the hospital. But this had less to do with workers being middle class than with workers’ feelings of loyalty to the hospital as a community institution. Brandon discussed just how loyal most union supporters are to the hospital in which they work: “They might hate their boss but they will defend to the death the place that they work.” As an organizer, he learned never to say, “This is a bad hospital.” He continued: “Even at hospitals where workers will say things are really messed up and patients are at risk, they’re still really proud of the work that they do and the work that their co-workers do. They clearly identify the boss as the problem.” According to him, worker leaders at Memorial were actually those most invested in improving the facility: “The window through which I look into the healthcare workforce is the people who say, ‘I want to work to make this place better,’ and I think that kind of self-selects for a group of people who just generally care a lot more about what happens at the hospital than other folks might.”

Interestingly, this meant that even a positive legacy of active unionism in other industries conveyed mixed meanings to hospital workers. Louise was encouraged to join the union campaign by her brother-in-law, who had worked for the Teamsters and “only said wonderful things about it.” Despite this encouragement, Louise still had some reservations:

[The Teamsters are] pretty radical for me, and as a nurse, coming from the place that I come from, you know, talking about walking out on my patients was like, I’d look at him and go, “What? What? I’m not walking out on my patients, are you crazy?” He said, “That’s how you get things done.” I said, “I can’t hurt somebody else. I couldn’t abandon them.”
Susan thought initially that the union was going to “ask for more.” She was not so supportive, since “I always felt like, you know, I’m not greedy.” Dan was also wary about being part of too militant an organization: “I didn’t enter this with any axe to grind. There’s not a ‘stick it to the man’ kind of feel to it.” Dan asserted that those who wanted the union didn’t “want to kill the hospital. We want to be a thriving enterprise, we really do. Because a lot of people have been there a lot of years and have a lot invested.”

Most workers who became involved in the union effort seemed to feel that the union would help them reclaim values that were central to their work—that the union would serve as a mechanism for voice. Albert Hirschman famously wrote of “exit” and “voice” as two mechanisms by which members of an organization can respond to its decline. Members can either leave, voting with their feet, or engage with the organization in an attempt to make it better.\(^5\) In Hirschman’s analysis, a key variable for understanding whether people will use exit or voice is people’s degree of loyalty to that organization. The more loyal they are, the more they will have a propensity to use voice as opposed to exit. This framework helps us understand workers’ desire for voice as a corollary to their feelings of loyalty to the hospital. And previous research has suggested that unionization increases workers’ propensity to use voice as opposed to exit.\(^6\)

Dan, a well-paid radiology technologist, said, “Interestingly enough, when you talk to employees, even though our wages are considerably lower than Kaiser, wages are not the main issue by a long shot.” Rather, he continued, the idea that united workers more strongly was that of “voice” for themselves and their patients. Mari discussed at length the relationship between her feelings of loyalty to the hospital and her desire to make things better through the union. Working at the hospital, she said, “you become attached to your co-workers, they’re your family.” Even when offered a better paying job with fewer responsibilities at another local hospital, Mari said, she “did not want to leave Memorial because I don’t believe that you can leave a place just for a better place. You don’t abandon your house just because the roof collapsed. You build it better.” She felt it would be “selfish” to leave: “Everybody in there is my community. I live here! All the people that work there are my friends, the people that are my patients, they’re people that I interact with. So I wanted to put my little help in there to make that place better instead of abandoning [it] and going where the butter was.”
A similar sentiment pervades the interviews I conducted with worker leaders of the organizing effort. According to Rebecca, those who were organizing “don’t want to destroy, they want to make things better, they want to make their jobs run smoothly, they want it to run smoother for everyone else, they want the relationships between the nurses and other people in their work groups to be good.” Louise discussed how all of the leaders of the organizing effort, herself included, “want to make our hospital a better place to give care and receive care, and we all want to be proud of what we do again.” Louise was drawn to SEIU-UHW at least in part because it had established patient care committees at the hospitals it had organized. When she spoke with unionized workers at the local Kaiser facility, they reinforced the idea that employees “work things out about the patients with the management and with the nurses.” According to Dan, a union would help people “be more emotionally invested in the institution, and they would work better for the betterment [of the hospital] if they felt their input was respected. . . . You gotta listen to the people who are actually on the ground doing the job.” George echoed this sentiment: “I think you stifle creativity when you control, I think you open up those doors when you share ideas at a table for the betterment of the patient. . . . These big guys wouldn’t be there without this whole army of staff who does a good job.” Worker leaders seemed confident that a union would allow them to live out the values that had attracted them to medical work.

A union leader pointed out that “a lot of employers will look to the market to stay competitive and keep the union out” by raising wages to the same levels as those in unionized facilities. But this strategy overlooked workers’ investment in having a say over their work. And hospital leaders did not seem open to the idea that workers might make valuable contributions if they were included in decision-making structures. At one point during the campaign at Santa Rosa Memorial Hospital, for example, administrators put a cardboard cutout of the CEO in the cafeteria along with a suggestion box as a way of soliciting worker input. Some workers took pictures of themselves next to the cutout to poke fun at this sort of superficial attempt at inclusion.

Multiple Voices

Within the unionization drive, the concept of “voice” also helped to unify a rather disparate group of hospital workers in ways that a narrower, more
material focus might not have. Workers in the hospital exemplify the extensive class differentiation within modern society: professionals and managers work alongside pink-collar nurses, white-collar bureaucrats, and service workers. Charitable and professional tropes have the potential of dividing workers from one another. Some workers making the same wages might see themselves differently because of their different proximity to patients (kitchen workers versus nursing assistants, for example), while some workers with the same proximity to patients might see themselves differently because of different salaries and different relationships to professional associations (nursing assistants versus anesthesia technicians, for example). The bargaining units at Santa Rosa Memorial Hospital that organized with UHW included nursing assistants, whose mean annual income in California was $27,450 in 2009, and nuclear medicine technologists, whose mean annual income was $86,590.

Brandon suggested that two overlapping groups were typically most interested in organizing: “The people who do the most patient care, and the workers who are the most marginalized.” These two groups are not mutually exclusive, he continued, but are more like “a Venn diagram.” Workers such as nursing assistants, laboratory assistants, and phlebotomists are both directly involved in patient care and “on the low end of the totem pole in the hospital hierarchy.” Workers such as dietary workers and housekeepers are marginalized without being in close contact with patients; and workers such as respiratory therapists, surgery technicians, and imaging technicians are involved in patient care and are relatively well compensated.

Pete, a union organizer involved in the Santa Rosa campaign, complicated this analysis in two ways. First, he suggested that there was a status hierarchy among hospital workers that mirrored pay differences, meaning that professional workers were more likely than others to be considered “leaders” by the workforce as a whole. In other words, although they made up a smaller percentage of the workforce than lower-paid workers, organizers needed to target professionals given their influence among the workforce as a whole. Second, he continued, professionals were more likely to be in favor of unionization for vocational (as opposed to financial) reasons. Whereas low-wage workers “are always going to look at the union as a protection, as an insurance, as a way to guarantee wage increases,” professionals were more likely to think about the ways that unionization might allow them to be better professionals.
Existing scholarship supports the idea that healthcare workers support unionization for a variety of economic and vocational reasons. Indeed, throughout the nonprofit sector, according to consultants Jeanne Peters and Jan Masaoka, “unionization appears to stem not only from [workers’] desire for better salaries but also from their unmet expectations about the distinction of their work culture from corporate or bureaucratic culture.” Among professional employees, support for and involvement in unionization efforts appears to be driven by a desire for professional growth and patient care more than by traditional wage and benefit concerns. Consistent with this idea, the financial benefits of unionization among hospital workers seem to be higher for low-income workers than for professionals.

It seems safe to assume, then, that among the different groups of employees at a hospital there will be quite different motivations underlying the desire for unionization. Some have argued that in this context a craft-union approach, by which a union organizes a particular occupational group across different workplaces, might be more successful than an industrial approach, by which a union organizes all workers in a particular workplace or industry. Nurses in California, through the California Nurses Association (CNA), have certainly had tremendous success as a craft union. But other than the nurses, who together made up approximately 28 percent of all hospital employees in 2008, most occupational groups in the hospital make up much smaller percentages of the workforce, meaning that their leverage as separate occupational groups would likely be quite small. Moreover, separate occupational unions would run the risk of competing with one another over wages, benefits, and voice over the organization of work. And while a craft approach may unite those workers with the most similar interests, there is reason to suspect that craft unions actually undermine the organization of less-skilled workers. In their compelling historical study, the sociologists Michael Hannan and John Freeman show that the density of craft unions had a negative impact on the survival of industrial unions, particularly in environments in which industrial unions were not common.

The debate over the relative merits of craft and industrial unionism has persisted in different forms over the last century—between the Knights of Labor and the American Federation of Labor (AFL) in the late nineteenth century; between the AFL and the Industrial Workers of the World (IWW) in the first decades of the twentieth century; and between
the AFL and the Congress of Industrial Organizations in the 1930s and 1940s. Most organizers within UHW seemed to come down firmly on the side of industrial unionism, committed to organizing workers as workers and to breaking down occupational boundaries that might otherwise have separated them. The challenge for the union, then, was to “manage this tension” between workers’ different motivations, and to make the case that these diverse groups of workers were better off standing together than standing alone. For Brandon, this was part of what he had “come to love about hospital organizing,” given that “you really are organizing across race, across income levels, across gender, language, and everything.” But he admitted that some technical workers would say things like, “Why can’t we just have a union for the radiology technicians, we don’t want the housekeepers.” Pete discussed how some technical workers “associate the word ‘union’ with the old industrial unions, autoworkers, farmworkers.” He continued, “Some respiratory therapists [say], ‘Why do I want to be in a union with housekeepers? Why are you sticking me with them? I’m a professional.’ There’s a lot of that in hospitals and healthcare. It’s very hierarchical.” Nevertheless, Brandon discussed how workers of many different stripes often came to see their common interests fairly quickly:

You overcome it by having an organizing committee that has people from all those different areas, and it’s frankly surprising to me when I think about it how quickly people see that they at least have a common interest. Because whatever the political issues are, everyone wants more of a voice, they want more control over the work that they do. I think that’s one of the realities of working in this capitalist economy. People have so little power over the eight hours a day that they spend at work and everyone wants more power and they should have it.

Brandon suggested that “voice” and “power” are nearly synonymous, and that all workers want more of both. He assured “folks with more formal education” such as the respiratory therapists that they would make the decisions on behalf of their own department: “Just like you guys wouldn’t tell the housekeepers how to clean the floor because they know how to do that better than you, they’re not going to tell you how to ventilate a patient because you know how to do that better than they do.” And he warned them, “You’re not going to be able to address your issues if it’s just you guys,
‘cause guess what? There’s just twenty of you, and there’s sixty housekeepers in this hospital, so do the math. The twenty respiratory therapists could have a union and not win anything, [and] they probably couldn’t win a union to begin with.” It is only with collective power, he argued, that winning voice is possible.

The idea that a union enhances workers’ voice is not entirely intuitive. For example, union contracts often are designed to overcome the arbitrariness of management through standardized rules and procedures, without leaving much room for discretion on either side of the labor-management relationship. Explaining why she supported the union, Betty recalled how she recently had asked her director about hospital policy and had been told, “It depends on what your supervisor says.” Betty continued, “The rules are not the same throughout the whole hospital. Rules are rules, they should be for everybody.” Similarly, Frank described a desire to have “something written in a contract saying, ‘This is what I do for x amount of money.’ And if they deviated from that box I could say, ‘Hey, you can’t do that, I can’t do that now.’” Although a contract might increase the predictability and fairness of people’s everyday work, there are ways in which it might actually reduce the amount of discretion that both managers and workers have in changing the way work is done. Labor leaders are quick to point out that the details of a labor contract are all the result of negotiations, and that there is nothing inherently rigid or inflexible about it. Nevertheless, in practice, “power” and “voice” may not always be as closely linked as Brandon and workers themselves suggest.

The concept of “voice” was also used to frame some of the more material demands by workers. Claims to higher wages and more extensive benefits were framed as being consistent with a desire for reciprocity and for being heard. For Betty these issues elided almost seamlessly: “I always just felt that we should have some rights to be able to voice our opinion and have a say-so in some of these changes and what’s going on as far as wages and retirement.” Brandon also seemed to see wages as a symbol of respect when he spoke about the interests of housekeepers and dietary staff being “more often around wages, benefits, respect.” Louise thought retirees should be offered the opportunity to stay within the hospital’s health insurance policy: “When [workers] put in x amount of time for you, made sure that your hospital was built up, got your reputation up and running, and made that commitment to you, I think [offering a retiree insurance
plan] is fair.” Interestingly, Louise contrasted this desire for retiree health insurance with a rumor from an antiunion employee:

One of the people that was against unions said to me, “Oh, it’s just that these housekeepers want to make $35 an hour.” And I said, “Where the hell did you get that from?” and she said, “Well, I heard them talking,” and I said, “Well, you know what? I think you might have heard what you wanted to hear because anybody who has absolutely no education is never going to think they’re going to make $35 an hour.”

Although low wages were seen by hospital administrators (and even some workers themselves) as an indication of the vocational nature of this work, those who supported the union seemed subtly to have shifted the meaning of certain deprivations, conceiving of them as a betrayal of the hospital’s values. Health insurance upon retirement would be “righteous” of the hospital. Giving housekeepers $35 an hour, absurd.

**Round One**

The first time I walked into the small organizing office at SEIU-UHW headquarters in Oakland, I was struck by two things. First, the place looked like an empty bomb shelter. Despite the priority that the union gave to organizing, the organizing office was windowless and spare. I would come to appreciate that this was because organizers were always out and about, working twelve-hour days in and around the hospitals they were organizing. The second thing I noticed was a picture of a network diagram on the wall, an elaborate snowflake, with workers’ names linked to each other by lines—enough to make a sociologist weep with joy. Brandon was proud of this drawing. He and Joe, another organizer, had managed to establish relationships with a huge number of Memorial workers in a matter of a few months.

Something that made the Memorial campaign unique, Brandon recalled, was “how easy” it was to generate support for the union initially: “We had one meeting with five people and just about every subsequent meeting we had came from those five people or from other existing contacts, and it was all through word of mouth, all underground.” Brandon and Joe would ask workers whether they knew of anyone else to speak
with, and almost everyone would give them new leads. Brandon compared the hospital to “a little city,” with “family connections and a lot of relationship connections.” People tended to know one another, and in ways that were not immediately apparent. Brandon continued, “I just found out about this a while ago that there’s a couple different groups of people that go bowling together at the hospital. They’re in a bowling league. I’ve been working at this place for five years, I had no idea.” In many cases, relatives set one another up with work at the hospital. Two of the earliest supporters of the union, Rebecca and Ron, were husband and wife. They and their son Tony all worked as telemetry technicians at the hospital. In other cases, workers had formed relationships on the job. And these relationships often transcended different departments, since certain positions in the hospital demanded that employees work throughout the facility. For example, Bettie, who worked in central supplies, discussed how she was “out and about all night, and I’m throughout that whole hospital all night long,” so she could talk with “everybody.” Brandon explained, “There’s a high level of interaction between all the different [departments], because everyone comes to the cafeteria so everyone knows the dietary workers, the housekeepers are on every floor, nursing assistants are on every floor, everyone interacts with everyone else.” Brandon also noticed that in general the hardest departments to organize were “groups of workers like pharmacy techs and medical records, because they’re isolated and they spend so much time with their managers.”

In Santa Rosa, the organizing campaign took off like wildfire. It was what organizers call a “hot shop.” Within five or six weeks after going public in October 2004, 68 percent of the twelve hundred eligible employees in a combined service and technical workers’ bargaining unit had signed a petition for a union election. Jorge explained that support for the union was rising, “numbers [were] popping up,” and how the organizing committee “started going by what the books said.” Brandon also described this stage of the campaign as being done somewhat by rote:

If you don’t have a public majority it’s going to be really hard to win this, there are some things that it’s just how it works. If you’re teaching someone how to drive, if the car doesn’t have gas in it, you might really not want to put gas in your car but the car’s not going to go anywhere. It’s sort of the same thing with an election. You might really want everyone to stay
underground, but you’re not going to win if you do that. If people want to win, this is what they have to do; there’s no democratic consensus to build around that.

The initial drive for the union was deceptively simple. The union filed its petition in December 2004, and a vote was scheduled by the National Labor Relations Board for early February 2005.

The hospital’s management was relatively quiet until after the holidays. When managers did speak up, however, they spoke loudly and clearly. The hospital hired an antiunion law firm in order to turn opinion against the union, and ran a textbook antiunion campaign. On several occasions, union supporters were approached by their immediate supervisors. A nuclear medicine technologist was one of these workers: “[My supervisor] said, ‘I’m disappointed in you for supporting the union.’ He made it seem as if [union supporters] had somehow hurt him by supporting the union—he made it very personal.” 18 A dietary aide recalled that workers in her department were brought together several times a week for “updates about the union,” during which time supervisors would distribute antiunion flyers. A supervisor told a patient transporter in the Imaging Department, “The union is not a good thing. Anybody who wants the union in here is an idiot.” A manager summoned Jorge to his office and questioned him about his union activity for over two hours. Mari recalled the manager of the Pathology Department telling her that she was not permitted to wear her union button. Another worker put up prounion flyers in her break room only to have them removed by the next day. This worker said, “It was easier to be against the union than to be for it. We were afraid to step out in support of the union.” Two workers reported feeling that their union activity was putting their jobs at risk. 19

Supervisors also told workers that a union might jeopardize patient care. One manager told a respiratory therapist about an incident in which a therapist at a different facility had been forced to go on strike while intubating a patient, putting the patient’s life in jeopardy. 20 Another manager told a unit secretary that any wage increase would have to be accompanied by cutbacks elsewhere, “probably patient care or they’ll have to cut your hours.” A management flyer read that “SEIU organizers have routinely ignored Hospital rules and improperly gone into units, departments and even treatment rooms to campaign.” 21
Management’s antiunion stick was accompanied by a carrot. Several years before, during an unsuccessful union drive by the Teamsters union at the same hospital, Jorge was approached by his manager and told: “You look like you’re one of the people that people respect. So if you lighten up on [the union], we’ll show our appreciation. You’re making how much, $12.50 an hour? $13.50 from this point on.” During the SEIU union drive, the message was similar if more subtle. Several employees were given unprecedented wage increases in the last two weeks before the election, or even offered supervisory positions within the hospital. During the fall of 2004 and the beginning of the new year, administrators actively sought out the advice of employees, asking them “what their ‘issues’ were,” “if there was anything they needed,” or if anything “could be improved.”

The administration articulated its message about SEIU most fully during a series of antiunion meetings in late January, during which managers showed workers carefully crafted PowerPoint presentations that made the case against the union. Forming a union meant that workers would abdicate their authority to a self-interested bureaucracy, the PowerPoint presentations suggested. A slide with the title, “Does a Local 250 Contract Really Give You a Real ‘Voice’?” read, “SEIU Local 250 is a large, bureaucratic organization. All important decisions are made by the SEIU leadership.” Rather than giving all workers a voice, the slide continued,

In reality, only a few strong [union] supporters may be rewarded by the union with a seat at the bargaining table for having “delivered” a large group of new dues-paying members. Your right to continue to work directly with management to find common-sense solutions to problems may be severely restricted.

Union leaders were painted as power-hungry upstarts bent on profiting themselves: “Who would this small group of employees be? Would they represent your interests? Do you trust these individuals to decide your future?” The slides also suggested that workers would be taken advantage of financially. One slide informed employees that Memorial workers as a whole would be paying over $600,000 a year to the union, while another told workers that a union would not guarantee “any changes in work rules” or “any increase in pay or improvement in benefits.” Indeed, workers could end up with far less: “Bargaining is a ‘give and take’
process. SEIU could trade valuable benefits you have now for things the SEIU wants.”

Although unions were once necessary, the hospital’s slideshow proclaimed, the National Labor Relations Act of 1935 (which, ironically, actually gave workers collective bargaining rights) had changed all that. According to the slides, “laws were passed to protect workers,” and employers “realized they had to compete for good workers by consistently improving pay and benefits; offering opportunities for growth and advancement; [and] providing fair and respectful treatment.” These factors explained why so few workers were currently members of unions.

In its last presentation before the scheduled vote, management used the specter of the strike to raise questions about the union’s motivations. A slide with the heading, “SEIU’s Slogan, ‘We Are Striking to Improve Patient Care,’” suggested that SEIU did not actually care about the hospital’s patients:

- SEIU always claims strikes are to improve patient care.
- This is an insult to every caregiver.
- Innocent patients and their families are the only ones who truly suffer the consequences of a hospital strike.

As a result, any healthcare strike is hard to justify.

Another slide read, “Everyone (except the union leadership) loses in a strike. Employees who strike lose. The Hospital loses. The patients, their families and our entire community lose.” Moreover, a strike would not work, since “the hospital can hire replacements for employees who strike. [Memorial] can even bring in qualified employees from other Saint Joseph Health System locations to work.” The presentation implied that the union would not have to suffer the consequences of a failed strike: “If the strike does not work, the union can just walk away and try to forget it happened. The employees must try to pick up the pieces. It can take months or even years for the damage to heal.” In sum, “SEIU does not operate hospitals, does not take care of patients and has no long-term stake in the success of [Memorial].” Moreover, another slide declared, “there are few, if any, unions who call strikes as frequently and irresponsibly as SEIU.”

The strategies used by hospital management are all standard fare among antiunion employers, and the labor scholars Kate Bronfenbrenner
and Tom Juravich have demonstrated just how effective these sorts of tactics can be. In their study, unions won approximately 85 percent of certification elections in the public sector, yet only 48 percent in the private sector. The authors demonstrated that employer opposition explained much of the variation. Employers that used many antiunion tactics in concert, as Memorial did, were able to limit union victories to less than 40 percent.

Several employees recalled management’s antiunion practices as having a chilling effect. George discussed the fear that arose for him when he began to get involved in the union: “Am I going to put my job in jeopardy? Hell, yeah.” The day after his picture appeared on a union flyer his director came to observe him work, something rare for this supervisor, and seemed quick to notice flaws in George’s work: “‘How come this patient’s head of the bed isn’t at 30 degrees?’ ‘Well, because that’s a rotating bed, it can’t go 30 degrees.’ ‘Why’s that patient almost out of pain medication?’ ‘Well, the nurse is trying to get that patient’s pain under control.’” The director then took George aside and said, “Is there something that I’ve done that’s caused you to seek out a union?” George answered, “No, Dan, it’s above and beyond you, it’s administration here and how they treat the staff. It’s not in your power.” Cynthia discussed how “getting involved at work is a really scary thing,” and how she had to overcome feeling worried that people would think badly of her: “That’s been my style, to be careful, to be able to get along with everybody. And so for me it was challenging to step outside that and to do that. And also with management who clearly was not appreciative of you wearing a button; [they] stare at your button like you’ve done something bad just ‘cause you’re wearing a button.” She remembered how the mandatory meetings made her reconsider her decision to become involved:

I remember walking out of the hospital with [a co-worker] one evening or afternoon after work and after one of these meetings and we both were thinking, “You know what? Maybe this isn’t such a good idea, this union stuff. I have to think this through.” So we were basically scared off. We thought, “This sounds scary and maybe he’s got some points, and it’s so controversial.”

Frank and Cynthia were two of the relatively well-paid workers who were interested in organizing. Frank “felt confident” he could find work
somewhere else if he was fired. Cynthia felt that her husband’s job meant that she would not be in dire straits if she were fired. But several workers did not feel so secure. Of the low-wage environmental services (janitorial) employees, Frank remembered, “They would be threatened by their supervisors [that] if they did this they would lose all their benefits, they would lose wages, they may even lose their job. And they could get away with it because they weren’t speaking English to them and no one was hearing it.”

But the antiunion campaign had effects that went well beyond making particular union leaders feel vulnerable. As the level of tension in the hospital rose, many who had thought the union would be a way to improve the hospital now wondered whether it might in fact be the adversarial force the hospital described. Brandon explained, “Any kind of rumor that goes around or anything management says has an additional layer of credibility or impact that it doesn’t normally have because people are just so afraid, or management has made it so clear how much they don’t want this to happen.” The rhetoric that the hospital used, he continued, “made it very clear that supporting the union means you’re against the hospital. That resonates with people in a big way.” Brandon recalled that people turned against the union faster than he had ever expected:

There’s this guy I met with who was like, “I’ll do whatever it takes, we gotta win this union, I’m down, you can count on me.” And then the week before the election he wouldn’t even talk to me. Just ‘cause the campaign management had run had scared the hell out of people. That stuff is surprising the first time you see it.

Brandon spoke with many members of the organizing committee who told him about “seeing co-workers on one side of the floor who they wanted to talk to, who were supporters, and they would start walking toward them and the person would go walk around the whole other side of the floor to get away from them because they wanted to avoid the whole subject.”

In the days leading up to the election Brandon and worker leaders came to the conclusion that they could not win. Support had dropped from 68 percent to less than 50 percent in a matter of a few weeks. This is also sadly typical. In her research on NLRB campaigns, Laura Cooper, a law professor, found that workers had an even chance of winning an election only
when union authorization card support reached 62.5 percent. And Cooper’s research was conducted two decades before the Memorial campaign, just as employers were developing comprehensive antiunion strategies that made an even higher level of support necessary for winning an election.

As a result of the declining support, SEIU withdrew the petition for an election at Memorial and filed unfair labor practice complaints with the National Labor Relations Board (NLRB). Four months later, in June 2005, after the NLRB documented seven violations of federal labor law, St. Joseph Health System settled with the labor board. Though the system did not admit wrongdoing, it was required to refrain from activities that were illegal under federal law and to post flyers throughout the hospital that stated:

We will not tell off-duty employees who are engaged in peaceful handbilling to leave the outside nonworking area of our property, nor will we write down the names of off-duty employees engaged in peaceful handbilling who are asked to leave such areas. We will not in any like or related manner interfere with, restrain, or coerce you in the exercise of the rights guaranteed to you by Section 7 of the [National Labor Relations] Act.

But despite this slap on the wrist, management at Santa Rosa Memorial Hospital had won round one of the campaign. Over the next four years the system would face several more sanctions by the NLRB, evidence of its persistent antiunion conduct.

Competing Local Legacies

The union’s initial defeat was due, in large part, to the aggressive and comprehensive antiunion campaign waged by hospital management and hired antiunion lawyers. This antiunion campaign was not as nasty as it might have been, however. No union leaders were fired. The hospital did not threaten to close. Rather, through their one-on-one meetings, mandatory group meetings, and literature, managers were able to elevate workers’ fears about unionization while downplaying its advantages. This persuasion worked, in part, because there was a local example of ineffectual and conflictual unionism from which management could draw: the nearby Sutter Santa Rosa Medical Center. The union, meanwhile, worked to
highlight a model of a strong labor-management partnership present at the local Kaiser Santa Rosa Medical Center, but was unable to make this argument successfully.

Sutter Medical Center of Santa Rosa and Kaiser Santa Rosa are the two other main hospitals in Santa Rosa. All three sit within three miles of one another, and at the time of the Santa Rosa Memorial Hospital campaign, both Sutter and Kaiser workers were unionized with UHW. Yet Sutter and Kaiser represented opposite poles of labor-management relations: at Sutter, the union was weak and had been embroiled in battles almost constantly since Sutter had leased the hospital from the county in 1996. Sutter had the reputation for being one of the most vehemently antunion systems in the state, and it had been engaged in a long and protracted battle with SEIU for years. At Kaiser the union was strong, both in Santa Rosa and around the state. Since 1997 the system had been engaged in an innovative labor-management partnership with SEIU and other unions. For hospital management and antiunion workers, Sutter was suggestive of what might be lost in labor struggle. For union leaders and union supporters, Kaiser was representative of the “union difference.”

For hospital management, Sutter Santa Rosa was the archetypical unionized workplace. In the midst of the early campaign at Memorial, in November 2004, both UHW and the CNA announced a one-day strike at Sutter Santa Rosa to protest what they saw as unfair practices during systemwide contract negotiations. This was part of a protracted systemwide struggle that would culminate with the strike that served as my introduction to labor organizing (see the preface).

Yet workers from Sutter Santa Rosa did not seem especially interested in the fight. Only 249 of the 525 workers even voted on whether to participate in the strike, with 206 of them voting in favor. Santa Rosa Memorial Hospital administrators seized on this news, distributing “talking points” to supervisors. One talking point explained that the Sutter facility “told employees that if they strike for one day, they will be replaced [by temporary workers] for the five day minimum period. It is properly referred to as a one day strike with a four day lockout. It is legal. Those who strike for one day will lose five days of pay.” Another talking point emphasized that the local had “been in negotiations with Sutter since July.” Most important, supervisors were to emphasize that only 30 percent of nurses and 40 percent of ancillary workers authorized the strike, demonstrating
“how a majority of employees can lose their voice to a minority with a union and have to pay dues on top of it.”

According to a labor organizer who had worked at Sutter Santa Rosa around this time, the union’s weakness at the facility was understandable. Before 1996, the hospital was a county-owned public facility known as Community Hospital. In the 1970s and 1980s, as public-sector unionism blossomed across the country, nurses and ancillary workers had established a strong and radical independent union there: “People . . . would go to meetings and there would be like sixty, a hundred people lining the walls.” Yet the union’s affiliation had changed several times in the recent past, both before and after the hospital’s privatization. It became an affiliate of SEIU public sector Local 707, which then merged with Local 1021; and ultimately, through a reorganization of SEIU’s California healthcare locals in the early 2000s, it became a member of UHW. At some point during these transitions the nurses decided to break away from the ancillary workers, first as an independent union and then as an affiliate of the California Nurses Association.

As a result of this internal tumult, there was very little enthusiasm for the union and very little in the way of worker leadership. The organizer I interviewed discussed how the union stewards with whom she worked—those workers who play a leadership role—had not been elected, but rather had responded to “a letter in the mail from SEIU [Local] 707 saying that they needed stewards and to call a number if they were interested.” The stewards, therefore, “were not leaders” so much as they were a coalition of the willing. What had once been an example of strong, public sector unionism had, by the 2000s, become something of an afterthought for the workers at the hospital and for the union itself. Wages and benefits at Sutter were slightly higher than at Memorial, but not by much.

At Kaiser Santa Rosa the story was entirely different. Workers at Kaiser tended to value the union both for the high wages and generous benefits it secured and for the culture of partnership that it made possible with management. At one point Louise was thinking of leaving Santa Rosa Memorial Hospital and toured the Kaiser facility. She asked workers about the “patient care committees” she had heard about, and they told her, “Oh yeah, we have those, and we definitely work things out about the patients with the management and with the nurses. It’s not a thing where they tell you what to do and you do it, the parent-child thing, it’s that we work as
a group.” She spoke with managers who told her they did not “have any problem with the union.” When her husband, a Kaiser member, had to be in the hospital in January 2009, Louise looked out the window of his room and saw “somebody standing in front of the nurses and they’re making them do these exercises to reduce their stress.” When she asked one of the nurses what they were doing, the nurse explained, “Well, it got really busy at the station and everybody was getting really stressed, and somebody came up and said, ‘I want you to stop now, stand away from your computers, you’re going to do some exercising and break that up.’”

Her experience at Kaiser contrasted sharply with her work at Memorial, where resources were distributed based on Taylorist time-work studies. At Kaiser, “They were more of a ‘You can ask us for it, if we have an extra person we’re going to bring them over to you, we’re not going to go by this acuity system, we’re going to give you help when you need it.’” To Louise, Kaiser’s twenty-first century labor-management partnership made possible a return to the mid-twentieth-century values she missed at Memorial.

Several other Memorial workers also discussed Kaiser favorably. Mari, who got a job at Kaiser after being laid off from Memorial, believed that at Kaiser workers “are not scared of their immediate supervisors, versus at Memorial they’re scared.” She also noticed that Kaiser “has their rules” that guide patient care, whereas work at Memorial was always more ad hoc. At Kaiser, she was asked to work only in the labor and delivery department, whereas at Memorial she was often asked to “float to postpartum to help out” when work was slow in labor and delivery. She felt that floating jeopardized the care she could give patients, since floating meant that “sometimes if there is an emergency C-section I don’t have the equipment immediately.” Furthermore, at Memorial, staffing decisions depended on patient volume. For Mari, this meant that “if I’m due to work at 7 a.m. they can come at 5 a.m. and say sorry we cancelled you.” At Kaiser, these sorts of cancellations did not happen. Frank noticed that at Kaiser there was one anesthesia technician for every four rooms; at Memorial, he was responsible for ten patients. George expressed frustration that while respiratory therapists at Memorial have significantly more responsibility than they do at Kaiser, Kaiser’s therapists still make much more.

Several Kaiser workers I interviewed corroborated what Memorial workers had told me. April, a chief steward at Kaiser, also worked
occasionally at Memorial. At Memorial, she noticed, workers did not seem to have clear roles, and the hospital “cross-train[ed] people that maybe shouldn’t be cross-trained.” At Kaiser, there were more “skilled workers for appropriate classifications.” At Kaiser, a worker knew his or her schedule, whereas at Memorial “it always changes.” But the most important difference seemed to be that at Memorial there’s “an authoritative structure, and employees are unhappy.” Given the arbitrary power that managers had, workers were “scared of retaliation . . . scared to say anything.” At Kaiser, workers discussed issues with management on the floor, but at Memorial communication from management was on “bulletin boards.” Among Memorial’s pronion workers, Kaiser represented what was possible with collective organization.

There were two types of unionism already in existence in Santa Rosa’s hospitals—models that served as reference points for both management and labor. In the first round of the Santa Rosa Memorial Hospital unionization campaign, management’s analogy prevailed. As suggested above, this was due largely to hospital leadership’s control of the debate. But it was also because hospital leadership at Memorial made it crystal clear that they viewed the union as an adversary—as power hungry, dues-driven, and ready to go on strike at a moment’s notice. In this context, it was difficult to make a convincing case that partnership would ever be possible.

**Digging In for the Long Haul**

But if the antiunion campaign in late 2004 and early 2005 effectively eroded support for the union among the hospital workers as a whole, it also deepened the resolve and commitment of a core group of leaders, who felt that the ugly face of the hospital had been unveiled. Mari told the story of an interaction she had with a manager in the dietary department. After learning that Mari had been speaking with dietary workers, the manager approached her: “She was so angry at me. [She said,] ‘How dare you talk to the employees about that union. You’re just scaring them, you know they can lose their jobs, and you can lose your job.’” Mari asked why she should not tell them what she had been hearing. The manager responded, “Well, they’re just lucky to have a job. These people are uneducated, they don’t know anything.” For Mari, “That was my
turning point. At that point I was not a hundred percent sure that I was going to get involved, but that morning I realized that I was going to be involved in the union until we get a union.” Similarly, Cynthia explained how the hospital’s antiunion campaign made her “believe more and more that it would be good for the hospital to have a counterbalance. It was obvious they were acting like a corporation.” Dan echoed this sentiment. He was upset by the “lies that they throw out there and the disinformation and the innuendos and some stories I’ve heard from other departments about the intimidation, real nasty, and the buying of the consultants and all that crap.” Dan explained that many workers in his respiratory therapy department had come on board “as they have seen the response to the campaign.”

It seems likely that the material benefits of unionization were never what primarily motivated worker leaders. As this chapter suggests, many of those who decided to organize were those motivated by a sense of injustice, and those for whom the values espoused by the hospital resonated most deeply. For this hard-core group of worker leaders, the hospital’s concerted antiunion campaign tended to deepen their resolve. Pete discussed how people’s involvement in the organizing effort tended to evolve. Although some people fought for the union out of a narrow sense of self-interest “at the beginning,” the “campaign creates” something more. And while some workers perhaps “loved going up in front of a room of people and cracking jokes,” the people who stuck with it tended to be motivated by something deeper.

As Rick Fantasia has suggested, workers’ formal union status may in some ways be less important than the way they learn to act in solidarity with one another over the course of an organizing drive. Even without a contract and its formal protections workers can start acting like a union. Rebecca spoke about how a union means “you never have to go before an abusive manager by yourself.” Louise thought that most people were involved in the organizing effort because they “want some sort of support,” want there to be “people behind you.” Yet worker leaders began to provide this support for one another even in the absence of official recognition. On one memorable occasion, José was called in for a meeting with his supervisor in the Nutrition Services Department. Two other members of the organizing committee accompanied him, helping to ensure that the supervisor would not intimidate him.
After the union withdrew its petition in early 2005, the focus of the campaign shifted from the fairly established framework of an NLRB union election to something more ambiguous. Union organizers and workers realized that they would be unable to win an election in the face of concerted management opposition, and so began to campaign for what the union called a “fair election agreement”—a set of ground rules and accountability mechanisms going beyond the National Labor Relations Act that would stave off the kind of campaign the hospital had waged the first time.

According to many labor scholars, current labor law makes it very difficult to organize a union successfully. A report by the labor scholar Gordon Lafer compares labor election law with national election standards, and argues that the secret ballot is the “only point at which current union election procedures met the standards of U.S. democracy.” Otherwise, Lafer concludes,

> there is not a single aspect of the NLRB process that does not violate the norms we hold sacred for political elections. The unequal access to voter lists; the absence of financial controls; monopoly control of both media and campaigning within the workplace; the use of economic power to force participation in political meetings; the tolerance of thinly disguised threats; the location of voting booths on partisan grounds; open-ended delays in implementing the results of an election; and the absence of meaningful enforcement mechanisms—every one of these constitutes a profound departure from the norms that have governed U.S. democracy since its inception.

As a solution to the inequalities enshrined in contemporary labor law, unions have sought “fair election agreements” with employers. Under such voluntary agreements, a union and employer typically agree to rules about what each side can say about the other, the access each side has to employees, and the enforcement of the agreed-upon rules. Oftentimes a local mediator is appointed who is able to resolve disputes more quickly than the National Labor Relations Board. Employers, however, tend to regard these agreements as submitting to unionization without a fight. In a meeting in the fall of 2005, Memorial CEO George Perez said that he would not agree to “unilateral disarmament.” In 2007, a full-page advertisement by St. Joseph Health System in newspapers up and down California suggested that the union was really lobbying for “front-end agreements that we believe give away the rights of employees to be informed by both sides
and to exercise their right to choose in a secret ballot election as outlined by the NLRB.”

**Political Struggle**

In this section I diverge slightly from the chronology of the campaign in order to examine a more standard “social movement union” response to the kind of workplace defeat described above. In their efforts to win “fair election agreements” from employers, unions often search for any conceivable source of economic or political leverage. And in January 2007, a new political opportunity presented itself to those working on the Santa Rosa Memorial Hospital campaign.

On January 8, Sutter Corporation—one of the largest not-for-profit health systems in California—announced that it was closing Sutter Santa Rosa, a hospital that Sonoma County had contracted to Sutter in 1996. The hospital, previously the county’s only public hospital, was in need of an expensive seismic retrofit, and it was deeply in the red. Sutter had taken control of the hospital without fully understanding the extent to which indigent patients relied on it. As a result of the closure, Sutter planned to transfer to Santa Rosa Memorial Hospital the “Health Care Access Agreement” it had signed with the county. Under this agreement, Sutter had committed to providing medical services to indigent patients, AIDS patients, and county jail inmates, among other provisions—responsibilities that Memorial would now assume. In turn, Memorial pledged that it would expand its inpatient capacity by eighty beds, expand its urgent care services, and double the size of its emergency department in order to accommodate the new traffic.

The transaction between Sutter and Memorial could not occur, however, without the approval of the Sonoma County Board of Supervisors—something that seemed to go unrecognized by the hospitals and, initially, by the Board of Supervisors itself. The union, however, saw an opportunity to link the fight for the future of the county’s healthcare with the organizing struggle at Santa Rosa Memorial Hospital. Specifically, the union hoped that it could prevent Memorial from doing any business with the county unless the hospital agreed to the “fair election agreement.” By leading a coalition to place conditions on the proposed transaction, moreover,
the union could capitalize on public sentiment against corporate healthcare and bring new allies into Memorial’s organizing struggle.

This strategy seemed promising at a Board of Supervisors hearing the union helped to organize on February 27, 2007. The hall was packed with hundreds of concerned community members, and many more stood in the adjacent hallway. And unlike other union events, which relied heavily on turnout charts and reminder calls, people seemed to have come to this meeting spontaneously.

Yet as the board meeting proceeded, I could see tensions that might emerge for the union. One of the primary concerns among community members concerned Memorial’s lack of women’s reproductive services. Memorial refuses to administer abortions except in cases of rape and will only perform tubal ligations (or tube-tying) if the procedure can be justified “medically.” As Memorial’s chief medical officer explained these restrictions, based on Catholic doctrine, there was an audible gasp among the gathered crowd. Yet could the union’s theological strategy described below—one premised on building alliances with the Catholic Church—continue if the union was to build alliances with advocates for reproductive services? Even more important, in several hours of audience questions for the Board of Supervisors, almost nothing was said about workers’ rights at Memorial. People expressed concerns about care for the poor, emergency room capacity, a family medicine residency program that was based at Sutter, and even helicopter traffic. Aside from five powerful minutes from Father Ray Decker, concern for the workers at either hospital seemed to get lost in the shuffle. After the hearing, a lead organizer on the Memorial campaign assured me that workers’ right to organize was the “main peripheral issue”—hardly reassurance at all.

Nevertheless, for the next several months the “healthcare coalition” became the major focus of organizing efforts in Santa Rosa. In April, two political organizers for the union began weekly meetings that brought workers together with Sonoma County healthcare advocates. Ultimately the coalition would come to include several state representatives and other political leaders. In May, the union issued a “Healthcare Justice Platform” that would become the basis of a summerlong petition drive. More than any other document, the platform demonstrated the union’s effort to weave together a concern for healthcare in the county with a concern for healthcare workers. The first plank of the platform, “Protect and Improve
Healthcare in Sonoma County,” demanded a revised “Healthcare Access Agreement” to assure that indigent services would be preserved in the county, and argued that Sutter should remain open until Memorial was able to replace all the services that would be lost. It also advocated for an expansion of primary health clinics in the county and additional funding for several small district hospitals in the county. The second plank, “Be Fair to Those Who Care,” advocated on behalf of healthcare workers as well as doctors. It emphasized the need for a plan to ensure smooth job transitions for those being moved from Sutter to Memorial, and made the transaction between Sutter and Memorial contingent on Memorial adopting “fair election” ground rules for its workers interested in unionizing. It also discussed the importance of a vibrant family medicine residency program. Finally, the third plank, “A Community Voice for Healthcare,” asked the county to convene a “Citizens healthcare committee” to oversee the planned changes. During the spring and summer, the union spearheaded an effort to gather more than five thousand signatures on the petition. Memorial workers and community advocates collected signatures at grocery stores and farmers’ markets. The union also hired a canvassing company to complement the volunteer effort.

And while the political organizers directing the community campaign had initiated it for strategic reasons, according to one leader it “became a mission,” a “David versus Goliath fight that we were very proud to be in.” These organizers began attending healthcare policy meetings in the county, doing “detective work” and “pounding the pavements.” As a result of the information they gleaned, they became informal advisers to the county, and developed personal relationships with several of the county supervisors.

But partly as a result of organizers’ missionary zeal, according to one political organizer, the union “lost sight of strategy” in the local fight. It wound up “doing more work in the interests of the community [than] a union should be doing,” with little benefit for the Memorial campaign itself. On March 11, 2008, the Santa Rosa Press Democrat reported that Sutter, in the face of public pressure, had decided to keep the hospital open. The announcement was tangible proof of the union’s political influence, yet a Pyrrhic victory, since the announcement stripped the union of political leverage with Santa Rosa Memorial Hospital. I remember a meeting on the Memorial campaign in late 2008 in which the room seemed filled
with local politicians and their aides. One of the community supporters I
had worked with turned to me with a look of confusion: “I’ve never seen
so much political support for a local issue. Why can’t they do something?”
But political influence did not translate into union success—like trying to
turn a screw with a hammer.

In narrow political terms, the union’s strategy regarding the Sutter-
Memorial transaction was unsuccessful. In this political campaign, like the
unions in the sociologist Paul Johnston’s *Success While Others Fail*, the union
sought to frame its claims as “public needs.”

In his study, Johnston rightly
argues that public sector unions operate in a different context than private
sector unions: public sector unions are most successful when they make use
of “political-organizational resources” and frame their demands in public
policy terms, while private sector unions—even at their most creative—
tend to use market and political resources to “buttress their market posi-
tion.” This explanation may go some way toward explaining the union’s
failure to leverage political power in the Santa Rosa Memorial Hospital cam-
paign. The union was able to win political power, but it was unable to trans-
late that political power into recognition for the union in the private sector.

Although Johnston’s analysis is astute, it fails to make sense of the ideo-
logical character of the leadership at Santa Rosa Memorial Hospital. In
Johnston’s analysis the motivations and strategies of “capital” are assumed
away—“the boss is the boss”—and understood as a relatively static “po-
litical opportunity structure” to be discerned and taken advantage of.

Indeed, the union actually was able to translate political pressure into eco-
nomic pressure over the course of the Sutter campaign, costing Memo-
rial Hospital millions in unnecessary and unfinished construction. But if
the union’s political campaign “succeeded” to the extent that it prevented
the closure of the indigent hospital, cost Santa Rosa Memorial Hospital
financially, and likely played a role in the resignation of Memorial’s CEO,
this economic leverage was not enough to bring Memorial to the nego-
tiating table. As a lead organizer for the union explained, the Sisters of
St. Joseph of Orange were not motivated solely by economic interests.
When the union leveraged its political power to defeat the planned merger,
it likely reinforced the view among the Sisters that the union was an instru-
mental actor willing to use almost any means to reach its desired ends.

From a broader perspective, however, the union’s work to intervene in
the Sutter-Memorial deal, which inadvertently helped lead to its collapse,
can be understood as a strategic success. The two political organizers who led the healthcare coalition became trusted colleagues of and advisers to important actors in the local healthcare community. Week after week over the summer of 2007, workers joined with other community members to gather signatures on behalf of the healthcare platform. All of these efforts helped to establish long-term relationships among union leaders, community leaders, and important political actors—and they helped to establish the union as being aligned with the good of the community as a whole. In other places, such as Stamford, Connecticut, labor-community coalitions have successfully blurred the distinction between worker interests and community interests. What may have failed according to the union’s narrowest strategic interests may have succeeded in securing the union’s long-term reputation within the community and even among workers themselves.

This second interpretation of the campaign against the Sutter-Memorial transaction, however, demands an appreciation of the idea that labor must connect its narrower strategic interests with a broader conception of the public good. It is to this ideological terrain that I now turn. Ultimately it would not be market position but moral position that would influence St. Joseph Health System.