

Nurses' union announces ratification of sellout contract at Michigan Medicine

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On Sunday morning, the Michigan Nurses Association (MNA), the parent union of the University of Michigan Professional Nurse Council (UMPNC), which represents 6,200 nurses at Michigan Medicine, announced the ratification of the tentative agreement reached late last month between union negotiators and negotiators for the University of Michigan-based hospital system.

The union claimed that 95 percent of nurses who cast ballots voted to ratify the agreement. However, as of this writing, it has not provided vote totals.

Michigan Medicine is the hospital system affiliated with the University of Michigan, the largest public university system in the state, with 30,000 total employees, a \$2.1 billion endowment, and \$5.5 billion in annual revenue. Notwithstanding its status as a non-profit health care system, Michigan Medicine had an operating margin of \$233 million in its most recent fiscal year.

On September 22, the MNA-UMPNC announced that a tentative agreement had been reached. It then proceeded to push through the deal by means of a completely undemocratic process. Union officials declared the agreement a “victory” and claimed it met the nurses’ basic demands for mandatory staffing ratios to end unsafe under-staffing and an end to mandatory overtime.

The impossible working conditions for nurses have been intensified since the outbreak of the COVID pandemic, with the hospital system eliminating hundreds of positions and driving other nurses to leave due to overwork and “burnout.”

The union released only its contract “highlights,” which sought to present the agreement in the best possible light, but in fact demonstrated that the deal failed to meet any of the nurses’ demands. Union officials only posted the actual 167-page contract on Tuesday night, September 27, having scheduled ratification meetings to being the next day, Wednesday, September 28.

Rank-and-file nurses were given no time to study the agreement, which will largely dictate their work lives for the next four years, or prepare questions to be addressed by union officials at the ratification meetings.

These anti-democratic procedures were consciously implemented by the union to dissipate the militant determination of the nurses to fight for decent staffing levels and working conditions, as well as wage increases to meet soaring inflation. That militancy was expressed in a 96 percent vote by nurses to authorize a strike at the beginning of September, already two months after the expiration of the previous contract. The strike vote was part of a wave of struggles by nurses and health care

workers across the country and internationally, including strikes in northern California and Minnesota and a strike vote by nurses in western New York State.

A reading of the agreement demonstrates that none of the issues of concern to nurses have been resolved.

Most significantly, nurses had insisted that they could not provide adequate patient care and their own safety was impacted by the untenable ratio of patients to nurses. The intransigence of hospital management on this point—insisting that such ratios were its prerogative and that it was not legal to even bargain over them—led to the UMPNC filing a charge of “unfair labor practices” with the Michigan Employment Relations Commission (MERC) in August. The negotiator for hospital management claimed that the ratios of patients to nurses in various departments constituted “non-mandatory and illegal subjects of bargaining.”

The tentative agreement does, in fact, list ratios of patients to nurses for various departments, but makes abundantly clear that such ratios are only “guidelines,” and that “[t]he parties agree that a process to determine staffing levels to provide nursing care for the projected nursing workload in the patient care units is necessary.”

What is this process to be?

First, it should be noted that the sentences immediately preceding the call for a “process” state that “staffing levels *should* permit the delivery of safe transformative patient care” (emphasis added). Then the document abruptly indicates that “The University will maintain current levels of staffing.”

These are the levels, however, that have led to overwork, burnout and resignations throughout the hospital system. In these passages, management is making clear that it has no intention of hiring a significant number of nurses to establish the proper ratio of patients to nurses.

Furthermore, management retains the right to make significant changes to the “staffing model” and is required only to notify the union. The union may object, but this merely triggers a “Workload Review Committee” to call a meeting with the associate chief nursing officer and chief nursing officer.

Matters unsettled there can be escalated to the chief nurse executive and a “Joint Implementation Team.” Should any complaint about staffing miraculously survive this nightmarish, bureaucratic process, it is then sent to arbitration and mediation, where the odds are stacked in management’s favor.

There is a similar Byzantine process to handle disputes

concerning “compliance” with the already compromised “staffing model.” Complaints about compliance differ, however, in that they end up going before a “Tripartite Panel” (comprising a representative of the union, a representative of hospital management, and an arbitrator jointly selected by the union and management). The “Tripartite Panel” is empowered to award \$200 to each nurse “during the period of the shift that is in dispute.”

Even were such damages to be awarded, in a break with the current experience of nurses, who have found their “Assignment Despite Objection” grievances overwhelmingly shelved, there is no requirement for the hospital to hire more nurses.

As for the issue of mandatory overtime, the Michigan Nurses Association says that it is ended by the new agreement... “except in select emergency situations.” Just what are these situations and what does the contract say on the subject?

The agreement states (P. 37) that overtime assignments “should be filled by volunteers.” Two pages later, it explicitly states, “The parties agree that in the operation of a tertiary care medical care facility some Overtime/Over-Appointment is unavoidable.”

Management is required only to “provide an explanation for OT/OA greater than 5 percent of all hours worked in that pay period.” If OT/OA is greater than 7.5 percent for “three consecutive four-week periods,” then a penalty is paid of \$100 per nurse on a unit, up to a maximum of \$7,500.

Rather than being used to hire more staff, the “penalty” money is to be used for “educational, professional, or patient care-related unit needs.” It is far from clear how this supposed “penalty” redresses the staffing shortage, or how it differs from spending management may already be planning.

Notwithstanding these passages, the agreement argues that “The University and the Association agree to eliminate mandatory overtime except in cases of Emergency Situations.”

Among possible examples enumerated is “a hospital emergency which is unforeseen and could not have been prudently planned for or anticipated by the hospital, and that substantially affects the delivery of medical care or increases the need for health care services.” Perhaps concerned that this definition is so vague as to permit nearly any set of events being designated an Emergency Situation, the paragraph says that holidays and typical levels of absenteeism do not constitute such an Emergency.

But what about COVID-19? Monkeypox? The next pandemic? From the definition provided above, any of these would be considered Emergency Situations.

Thus, the supposed prohibition on mandatory overtime is little more than window-dressing to conceal the continued ability and intention of management to impose overtime on nurses as it sees fit, based on considerations of profit, not the safety of either nurses or patients.

As for pay increases, the 7.5 percent increase in the first year, and 6 percent, 5 percent and 4 percent in the following three years, fall well below the current rate of inflation and will mean a cut in real pay and purchasing power. The lump sum bonuses, \$5,000 this year and \$2,000 to those still employed in 2026, are intended to coerce a vote for the agreement from nurses with immediate and pressing financial needs, including student debt among the newest hires (median debt is more than \$40,000 for nurses beginning their

careers today).

The Michigan Medicine nurses’ contract dispute marked a critical element of a broader wave of militancy among health care workers in the US and internationally and throughout the global working class. Of particular note:

- 15,000 nurses carried out a three-day strike in Minnesota last month.

- 2,000 mental health workers remain on strike in Northern California against Kaiser Permanente.

- Nurses at Chris O’Brien Lifehouse, a hospital in New South Wales in Australia, have just rejected a contract that offered a mere 3 percent pay-increase (a massive cut, in real terms).

- Nurses at Henderson Hospital in Nevada refused to clock in on August 28 due to under-staffing.

The determination of the nurses at Michigan Medicine to fight, coming so close to the midterm Congressional and gubernatorial elections, frightened the union officials and spurred the hurried announcement of a tentative agreement that varied little in fundamentals from the previous positions of hospital management going back to expiration of the contract on July 1.

The *World Socialist Web Site* called on nurses to reject the agreement based on the previously released “highlights.”

The ratification of the agreement does not signify the end of the struggle by nurses at Michigan Medicine. It will, on the contrary, set the stage for an intensification of attacks by hospital management under conditions of falling stock prices, rising interest rates and imminent recession.

It makes all the more urgent the construction of a rank-and-file committee of nurses and other health care workers in the hospital system, independent of the pro-corporate union, to enforce staffing and safety standards and link their struggles with those of other health care workers across the US and around the world fighting for high-quality care for all and an end to for-profit medicine.



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