After canceling strike vote, union officials ram through Michigan Medicine nurses' contract

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On July 24, the University of Michigan Professional Nurse Council (UMPNC) announced that 7,200 nurses at Michigan Medicine in Ann Arbor, Michigan, had voted by 94 percent to ratify a three-year tentative agreement negotiated by the union bureaucracy on July 10.

Both the tentative agreement and the ratification vote have been presented by the bureaucracy as "wins" and "historic gains" for nurses. Contract highlights published on July 11 stated, "Management sought concessions to our language—we fought those concessions off and won improvements."

The conditions under which the ratification took place, however, were determined by the UMPNC bureaucracy's efforts to prevent a struggle by nurses against Michigan Medicine.

Although talks began in October 2025, the union bureaucracy allowed the previous agreement to expire on March 31, 2026, and kept nurses working for more than three months without a contract. On June 25, UMPNC finally announced that a strike authorization vote would take place July 13-18.

The vote never occurred. It was canceled when the tentative agreement was announced on July 10.

The ratification vote therefore took place after the bureaucracy had already made clear that it would not organize a strike or any broader mobilization of the membership. This was an undemocratic process in which the union apparatus controlled not merely the presentation of the agreement but the entire framework within which nurses were asked to decide on it.

Nurses were given a little more than a week to review the agreement before voting from July 20-24. The UMPNC website published the articles and language that changed, which had to be read alongside the 2022-26 contract. It also noted that the 2026-29 wage scales were estimates, with final numbers to be agreed during implementation.

A review of the tentative agreement shows that, far from "historic gains," the contract fails to resolve nurses' central demands over overwork, unsafe staffing and declining real wages.

The new contract contains base wage increases of 4 percent in the first year, 4.5 percent in the second and 4.75 percent in the third, along with a $3,000 ratification bonus. This aspect of the contract has been widely reported in the corporate media. Apart from the fact that the new wage scales are described as "estimates," the increases do not make up for the erosion of compensation caused by inflation during the previous four-year contract, and nurses' wages remain exposed to further losses from inflation over the life of the agreement.

A direct comparison of the new agreement with the previous 2022-26 contract also reveals that many of the union bureaucracy's claims of "improvements" are undermined by management loopholes or the carryover of existing terms.

Contract highlights and media statements say that the agreement guarantees "no pre-scheduled patient assignments for charge RNs," and that the charge nurse role is not intended to include an assignment. But the agreement contains a critical escape clause for management. It states that the charge nurse role is not intended to include an assignment "apart from unanticipated needs that are unable to be filled through float resources, volunteerism, [or] voluntary over appointment/overtime."

The contract therefore codifies management's ability to assign patients to charge nurses under various "unanticipated" conditions which inevitably arise due to low staffing rather than eliminating the practice.

Similarly, the bureaucracy says there is "no more penalty for running out of PTO" and that it warded off management demands for a "punitive attendance policy." However, the restructured attendance policy preserves a disciplinary track through the continued use of a formalized "Problem-Solving Meeting" process for unscheduled PTO, tardiness or partial-shift absences.

While framed as intended to "promote a thorough understanding of lifestyle situations," these meetings remain the first step toward formal corrective action that "may lead to disciplinary action."

Finally, despite UMPNC claims of "improved staffing ratios" across the board, the general-care staffing ratio remains unchanged from the previous contract's guidelines at 3-4:1 during day shifts and "up to 4:1 on nights." The supposed "historic" ratio gains are therefore highly localized rather than universal.

That the agreement serves the requirements of hospital

management is reflected in the response of Michigan Medicine itself.

Julie Ishak, chief nurse and operations executive for Michigan Medicine's academic medical center, declared, "The ratification represents our shared goal and partnership in providing the highest quality care for the patients and families we serve."

Ishak, who is paid more than $680,000 per year, went on to praise the "dedicated bargaining teams who worked tirelessly to collaborate on a fair agreement that allows us to keep moving forward together to serve our community."

Michigan Medicine is the University of Michigan's academic medical center, combining University of Michigan Health's patient-care system with education and research programs at the medical school. It has 12 hospitals, hundreds of outpatient sites and operates the UM Medical Group, UM Health-West in Grand Rapids and UM Health-Sparrow in Lansing.

The hospital forecasts $9.5 billion in revenue for fiscal year 2026 and an operating margin of $181.4 million. Michigan Medicine is controlled by the University of Michigan Board of Regents, an eight-member body elected statewide and dominated by Democratic Party representatives. David C. Miller, Michigan Medicine's CEO, earns total compensation of $1.52 million.

Michigan Medicine has approximately 48,600 employees and 1,043 beds. It is the second largest hospital system in the state behind Corewell Health, which has 21 hospitals, annual revenue of $17.6 billion and approximately 5,500 beds.

The system is held up as a top workplace for health care workers in the state in terms of wages and benefits. But the terms of the contract are an indication less of superior conditions at Michigan Medicine than of the abysmal conditions throughout the health care industry as a whole.

Opposition to the contract was visible in social-media comments, where nurses and supporters noted the inadequacy of the wage increases and pointed out that the staffing language would not produce a change in daily working conditions.

The handling of the 2026 negotiations follows the pattern set in previous Michigan Medicine contract struggles.

In 2022, more than 4,000 nurses participated in a strike-authorization vote, with 96 percent voting in favor of a walkout over staffing, workloads, patient safety and pay.

The MNA-UMPNC refused to call a strike on this mandate. Instead, it held informational events and urged nurses to rely on continued bargaining and appeals to Democratic Party politicians and AFL-CIO representatives. A sellout tentative agreement was negotiated at the eleventh hour and no strike took place. The 2022 sellout repeated what had occurred in 2018, when a 94 percent strike authorization vote was also ignored.

The cancellation of the strike vote in 2026 was therefore not an isolated episode. It continued a longstanding policy of preventing nurses from using their collective strength against management while keeping control of the bargaining process in the hands of the union apparatus.

A critical task for nurses is to draw the political conclusions from these experiences. Nurses at Michigan Medicine require rank-and-file committees, democratically controlled by workers on the units and independent of the MNA-UMPNC bureaucracy. Such committees must establish communication across the hospital system and unite nurses with respiratory therapists, technicians, aides, clerical staff, maintenance workers, food-service employees, physicians in training and every other section of the workforce.

The starting point is the needs of workers and patients, not what management claims the university can afford. This means demands for enforceable nurse-to-patient ratios, immediate hiring of sufficient staff, an end to mandatory overtime and unsafe assignments, inflation-protected wage increases, full health benefits and worker control over health-and-safety conditions.

The struggle cannot remain confined to a single Michigan hospital system. The staffing and workload crisis is national and international. Michigan Medicine nurses confront the same basic issues behind the strikes and job actions by nurses and hospital workers across the country and around the world. Since 2022, there have been 91 strikes in the US by health care workers confronting under-staffing produced by cost cutting, wage reductions caused by inflation and hospital systems' systematic subordination of patient care to financial priorities.

A rank-and-file movement would unite Michigan Medicine workers with health care workers throughout the United States and internationally through the International Workers Alliance of Rank-and-File Committees. Collective actions must be organized across employers and national borders against the medical-services corporations, insurers, private-equity interests and university administrations that dominate health care.

Ultimately, the fight for safe hospitals and high-quality public health care is inseparable from the struggle against capitalism and for socialism. The present profit-driven system subordinates every social need—including the health of patients and the physical well-being of nurses—to the accumulation of wealth by a tiny corporate and financial elite. Nurses and other workers must advance a program that places the vast resources of society, including health care, under democratic public control and organizes them to meet human need rather than private profit.