STRIKES BY NURSING PERSONNEL:

A CHALLENGE FOR NURSE MANAGERS IN

KWAZULU- NATAL PROVINCE

BY

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DEDICATION

This work is dedicated to the following:-

(i) My colleagues in the nursing profession who provide nursing care to patients/clients.

(ii) My students of Nursing Administration who inspire me to continuously seek more knowledge.

(iii) My children S'busiso, Gugulethu, Fikile and Dumisani.

(iv) My late parents Philemon and Nessie Biyela for instilling in me the love of education.

(v) My late husband Obed Artwell Kunene for his love, encouragement and sustained support through all my studies.

DECLARATION

I declare that:-

STRIKES BY NURSING PERSONNEL: A CHALLENGE FOR NURSE MANAGERS IN KWAZULU-NATAL PROVINCE is my own work and all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

P.J. KUNENE

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ABSTRACT

The main aim of this study was to investigate the problem of strike action by nursing personnel as well as the challenges this poses to nurse managers. This study also aimed at detecting views of nurse managers and nursing personnel on nurses' strikes especially with regard to the effect of these on standards of patient care.

The study was done in four hospitals in the KwaZulu-Natal province. A descriptive survey was conducted. Two sets of questionnaires were designed, one for nurse managers and another for nursing personnel. The total sample comprised one hundred and fifty five (155) nursing personnel and one hundred and nine (109) nurse managers.

Many factors were identified as causing strikes, but the majority of respondents identified dissatisfaction with salaries and unsatisfactory working conditions as the main causes of strikes.

The study revealed that both nurse managers and nursing personnel were divide in their opinions on the nurses' right to strike. However the undesirability of nurses' striking was indicated since very few benefits of strike action were identified while numerous adverse consequences were highlighted. These views are supportede by literature which makes reference to contradictory views of various authors on strikes.

Two out of the four(4) hospitals from which data was collected had experienced nurses' strikes in the early 1990's. The findings revealed that many nurses participated in the strikes unwillingly. Patient suffering in spite of contingency plans for patient care was expressed as a concern by many respondents.

Recmmendations made highlighted the need for participation of both providers and consumers of nursing care in minimising or preventing nurses' strikes.

ABSTRAK

Die belangrikste doel van hierdie studeer was om die probleem van staak aksie van verpleegpersoneel en ook die uitdagings dit oor die verpleegbestuurders te ondersoek het. Die' studeer was ook bedoel om die verpleegbestuurders en verpleegpersoneel se uitsigte te ontdek oor verpleeg staking met belangrikheid oor die standaard van pasiënt versorging.

Die studeer was in vier hospitale in die KwaZulu-Natal Provinsie gedoen word. 'n Omskrywende besgtiging was gedirigeer. Twee stelle van vraestel word ontwerp, een vir die verpleegbestuurders en die ander vir verpleegpersoneel. Die totaal voorbeelde was een hondred vyf en vyftig verpleegpersoneel en een hondred -en-nege verpleegbestuurders.

Baie oorsake was gesien as staakprobleme, maar baie verweerders gelyksel ontevredenheid met salaris en sleg werktoestande as die belangrikste aanleiding van staak aksie.

Die studie het uitgebring dat die' twee, verpleegbestuurders en verpleegpersoneel was geskei in hulle opinee oor die reg van verpleegsters om te staak. Ewewel die ongewens van verpleegsters was gesien omdat baie min voordele van staak aksie was geidentifiseer hoewel baie teenstelling gevolgstrekkings was bewys. Hierdie opinee was gesteun by letterkunde en maak die teenstellings van die dader.

Twee van die vier hospitale waarvan die data versamel is, het verpleegstaking in die vroee 1990's ondergevind. Die berindinge het uitgebring dat baie verpleegsters aan die stakings ongewillig deelgeneem het. Pasiënt boete ondanks die toevaligheid planne vir pasiënt versorging is deur baie verweerders as 'n saak uitgedruk.

Die aanbevelinge het nadruk gelê op die behoefte vir die deelneming van albei verskaffers en verbruikers van verpleeg versorging om verpleegstakings te verklein of verhinder.

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CHAPTER ONE

OUTLINE OF THE STUDY

1.1 INTRODUCTION

Strike action by nursing personnel has in the past two decades become a serious problem in South Africa , escalating remarkably in the 1990's. Questions have been raised about the nurses' right to strike. Because of the implications it has for quality patient care. As an employee the nurse has certain basic rights. Gerber, Nel and van Dyk (1992) refer to six categories of internationally recognised workers' rights namely:

- the right to work
- the right to freedom of association
- the right to collective bargaining
- the right to strike
- the right to protection
- the right to training

These rights need consideration in management of nursing personnel. Finnemore and van der Merwe (1992:78) highlight the rights of employees which are specified by the International Labour Organisation as 'the right of freedom of association' and 'the right to organise and bargain collectively'. He states that employees who feel that their rights have been violated by the employer may resort to strike action to force the latter to take note of their grievances and react promptly to them. However conflicts arise when such strikes occur in the patient care environment because it would appear that the patient becomes a bargaining unit and suffers more than the employer. Medlen (1994:2) expresses concern over nurses' decision to resort to strikes at critical times such as during violence and political upheavals when hospitals are flooded with major trauma victims. This highlights the challenge to management to protect the rights of nursing personnel so as to minimise or prevent the need to strike.

1.2 BACKGROUND TO THE PROBLEM

History by Searle (1965) indicates that in South Africa nurses came under strong influence of the Trades and Labour Council Propaganda Committee to organise the nursing profession into a trade union in 1942. The committee made nurses aware of their exploitation by their employer who took advantage of their high sense of vocation. In spite of this, nurses took a united stand against joining trade unions. They realised that trade unions lacked understanding of the nurses' ethical responsibility and obligation to respect patients' right to care at all times. The result was the formation of the South African Nursing Association in 1944 under the first Nursing act (Act 45 of 1944). This was a professional association formed to represent nurses and protect their interests, thus making it illegal for nurses to strike (Searle 1965:248 -250).

Trade Unions and professional associations are not mutually exclusive. They both represent worker's interests. Searle (1987:279), in comparing trade unions and professional associations, states that the former is concerned solely with the socio-economic affairs of its members while the latter is concerned with all aspects of development of the professional. Stern (1982:12) suggests that trade unions sometimes attracted nurses' interest and attention by emphasizing a potential increase in job satisfaction and reduced anxiety from job related tensions.

It must be noted that nursing is not practised in a vacuum. Nurses are affected by changes in societal norms, values and practices. South Africa is going through rapid social and political changes which have led to instability in the general population. Nurses have been affected by these. They like other employees, insist on using collective bargaining to have their needs met and their rights respected. Uys (1992:34) maintains that it is simplistic to demand health workers, including nurses, not to strike when they feel that their employers do not honour their contracts with them. They are aware that other employees who resort to strike action manage to have some of their demands met by employers.

Nevertheless Some nurses have shown their commitment to patient care by not joining strikes or stayaways. The general public has been divided on the issue of nurses' strikes. Some

people supported and praised nurses for not joining strikes and continuing to render essential patient care. Others have condemned them for being aloof to community concerns and accused them of supporting the status quo and being traitors or selling out their fellow citizens.

1.3 STATEMENT OF THE PROBLEM

Trade unionism presently has a great impact on the labour market in South Africa. Health care services have been similarly affected by unionism. Groups of health workers, including nurses, have joined trade unions, especially the National Education, Health and Allied Workers' Union (NEHAWU) which was launched in 1987.

Trade unions advocate the withholding of labour as one of the basic rights of democracy. They therefore use strikes as a weapon against management or employers. Strikes by nursing personnel are a threat to patient care in that they put patients' lives at risk: failure to provide needed emergency and total care may result in unnecessary deaths, temporary or permanent suffering or disablement and loss of trust in the nursing profession. Such a situation is a challenge for nurse managers at various management levels since they are responsible for facilitating provision of continuous quality patient care. Searle, quoted by Everste (1991:35) confirms this when she states that 'the main role of the nurse administrator, whatever level at which she functions, is to manage the nursing service in such a way that quality nursing care is ensured'.

The first-line manager or nurse-in-charge of a unit is the critical element in labour relations in nursing. Her expertise in handling complaints and grievances at unit level is crucial to minimising serious grievances which might result in job dissatisfaction and a felt need to strike.

Nurse managers at middle and top management levels have to be sensitive to personnel's needs and problems. They need to attend to grievances referred to them promptly, following well defined grievance procedures. For this reason nurse managers need knowledge of legal procedures concerning labour relations and personnel management principles that have a significant impact on labour relations (Young and Hayne 1988:366).

Nurse managers also need knowledge about the dynamics of strike action and strike handling. They should continually take proactive measures to prevent nurses' strikes by implementing preventive management. Quick and Quick (1984:145) define preventive management as 'an organisational philosophy and set of principles which employ specific methods for promoting individual and organisational health while preventing individual and organisational distress.' This approach to management emphasizes the principle of interdependency of individual and organisational health, expressed as 'person-organisation fit'. Individuals who are mentally, socially and physically healthy contribute to maintenance of a healthy organisation.

Where it has become impossible to prevent a strike, nurse managers need to develop skills of proper management or handling strikes so that there is only minimal disruption of patient care. Antagonists of strikes by nursing personnel emphasize that it is wrong for a patient to be denied his right to care even for a brief period as this might be crucial for his survival. Van Tonder (1992:30) maintains that human life is so valuable that the death of even one patient due to neglect while nurses are on strike challenges the nurse manager to be committed to finding ways of preventing strikes by nursing personnel.

Appropriate contingency plans for continuity of effective patient care in the event of nurses' strikes is an important responsibility of management. According to Marriner Tomey (1988:320) more special and elaborate notification procedures and plans are necessary for strikes occurring in the health field than for those occuring in industry. Alternate plans must be made to ensure acceptable standards of nursing care during strikes, for example, the transfer patients to those hospitals not involved in the strikes.

1.4 MOTIVATION FOR THE STUDY

The researcher has observed that nurses in various health services in South Africa got involved in strike action with increasing frequency in the early 1990's and that this resulted in major disruption of patient care. An urgent need to investigate awareness of potential strike activity amongst nurses, its implications for patient care and the challenges it poses for the nurse manager has been identified.

1.5 SIGNIFICANCE OF THE STUDY

The study was intended to make nurse managers aware of issues and problems that have a potential of resulting in strikesin the nursing profession and health services. It was also intended to make nurse managers aware of personnel management approaches which are more likely to result in healthy labour relations and thus minimise the need for strikes. The study would identify strategies that can be adopted for maintenance of acceptable standards of patient care in the event of nurses' strikes. It was also envisaged that the study would fill a gap in research studies pertaining to the challenges that strikes by nursing personnel pose to nursing management.

1.6 OBJECTIVES OF THE STUDY

The study aimed at achieving the following objectives:-

- to identify reasons for nurses' involvement in strikes.
- to detect nurse manager's views on strikes by nursing personnel.
- to detect nurse manager's views on effects of strikes.
- to identify the role of the nurse manager in minimising the need to strike.
- to determine the degree of preparedness for continuation of patient care during strikes by nursing personnel.

1.7 ASSUMPTIONS

The study is based on four basic assumptions. It is assumed that:-

- nurses in South Africa are increasingly getting involved in strike action, particularly in the 1990's.
- the majority of nurses in South Africa are against strikes but are forced to adopt the strike strategy because of employer and management policies which they perceive as unfair.
- the standards of nursing care are lowered by the proliferation of strikes in health care services.
- nurse managers lack the ability to handle strike action and fail to make adequate

alternative plans for the provision of safe nursing care during strikes.

1.8 DEFINITION OF TERMS

Conceptual and operational definitions are given in this section. They include the concepts nursing personnel, nurse manager, challenge, industrial relations, trade unions, industrial action including strikes and lock-outs. Operational definitions are used to define the terms as they are used in the study.

1.8.1 NURSING PERSONNEL

For purposes of this study nursing personnel means nurses of all categories below the level of first-line management. It includes senior professional nurses and professional nurses not in charge of wards, enrolled nurses and enrolled nursing auxillary. Students and pupil nurses were not included in the definition of nursing personnel for this study. The concept 'nursing personnel' is used interchangeably with the term 'nurses' by referring to either 'strikes by nursing personnel' or 'nurse's strikes.'

1.8.2 NURSE MANAGER

In this study, nurse manager refers to a professional nurse who has been allocated, appointed or promoted to a charge-ship or supervisory position to manage and co-ordinate the work of groups of nursing personnel under her control, as well as other categories of health care workers. The various levels of management in most nursing services hierarchies in South Africa are as follows :

First-level, first-line or lower-level managers direct, oversee and co-ordinate the efforts of nursing personnel at functional or unit levels. They are also responsible for co-ordinating activities of other categories who work as a team in the unit to contribute to total patient care, for example domestic workers, ward clerks, messengers or porters, paramedical and medical staff, nursing and medical students practising in their units. They form a bridge of communication and a vital link between the subordinates and higher authority at middle and

top level management. They are more in touch with the needs, complaints and problems of nursing personnel. They are also involved in direct patient care activities.

Middle-level managers comprise Chief Professional nurses or clinical nursing managers of areas or zones comprising a number of units, sometimes called area or zonal managers or supervisors. Such areas could be a medical section, a surgical section, a paediatric section, an obstetric section, an outpatient departments and others. The extent of each area supervised is determined by the size of the hospital. The Senior Professional nurses or Professional nurses in charge of units report directly to the area managers.

Top-level managers are at the top of the nursing service hierarchy and include the ranks of Nursing Service Managers, Senior or Principal Nursing Service Managers and Chief Nursing Service Managers. Small, less complex hospitals are usually under the control of Nursing Service Managers while the large, more complex ones are under the control of either Senior or Chief Nursing Services managers. In the latter case, Senior or Nursing Services Managers are given specific areas of responsibility, for example, being in charge of patient care matters or personnel matters. The nurse manager in charge of the nursing service is directly answerable to the Medical superintendent with whom she enjoys a collegial relationship. She also works in close co-operation with the Hospital Administrator especially on personnel matters, for instance, recruitment and selection, as well as conditions of service. She forms a vital link between the various categories of nursing personnel and the employing authority.

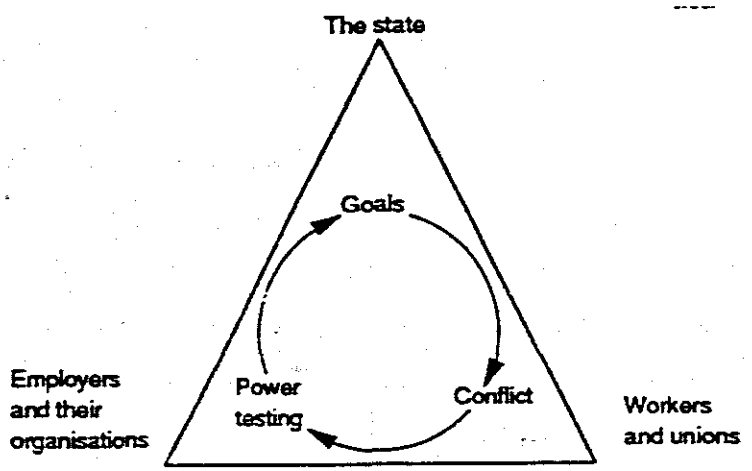
1.8.3 CHALLENGE

In the context of this study, challenge refers to those phenomena which demand special skills of management and problem-solving because they can adversely affect patient care and stable industrial relations if not skilfully managed.

1.8.4 INDUSTRIAL RELATIONS

This term is used synonymously with 'Labour Relations.' Finnemore and van der Merwe (1992:1) define industrial relations as a stable on-going activity at any work place. It is a broad concept which encompasses all aspects of the employment relations, that is, employer/employee relations (individual or groups), employee/employee relations, relations between formalised or institutionalised groups, for example management or employer associations and trade unions. A tripartite relationship that exists in the industrial relations system in South Africa is depicted in figure 1.2.

FIGURE 1.2 PARTICIPANTS IN INDUSTRIAL RELATIONS



Source: (Finnemore and van der Merwe, 1992:13)

The three participants relate interdependently as follows:

- employees sell their labour to the employers. They may be organised into trade unions or remain unorganised.
- employers are responsible for ensuring attainment of organisational goals through effective utilisation of scarce human and material resources.
- the state is both master and servant of the two. It holds legislative power that prevents exploitation of one by the other and thereby protects the interests of both parties (Gerber, Nel and van Dyk 1992:376) (Finnemore and van der Merwe, 1992)

1.8.5 TRADE UNIONS

In this study trade unions refer to associations of groups of workers formed for the purpose of maintaining or improving the conditions of their working lives. Research shows that workers join trade unions for various reasons such as economic and social reasons, job security and self-regulation, self-fulfilment and political reasons. Political reasons are important for workers deprived of political rights who then join unions for the upliftment of the oppressed fellow workers (Finnemore and van der Merwe, 1992:56). This explains the increase in trade unionism among Blacks in apartheid South Africa. Because Blacks were excluded from the governmental machinery, they joined trade unions which formed alliances with anti-governmental political parties, for example, the Congress of South African Trade Unions, African National Congress and South African Communist Party (COSATU, ANC, SACP) alliance.

1.8.6 INDUSTRIAL ACTION

According to Finnemore and van der Merwe (1992:191) industrial action refers to 'any suspension of normal working arrangements which is initiated unilaterally by either employees (whether through their union or not) or management, with the objective of exerting pressure within the collective bargaining relationship.' Industrial action is usually perceived as an employee or union tactic. Its most visible form is organised strikes. Management or employers use lock-outs as an important form of retaliatory industrial action.

Employees undertake industrial action as a collective strategy to resolve dissatisfactions which are no longer perceived as individual but group concerns. Forms of industrial action include:

- **Work to rule:** workers intentionally slow down their work and meticulously adhere to their job description or contracts of employment thus reducing production.
- **Go-slow:** workers continually fulfil their duties but work at a pace that considerably reduces output.

- **Sit-in:** workers occupy the workplace, possibly continuing to work but effectively denying the employer control and access to work processes. Sit-ins also aim at preventing scab labour from taking jobs of strikers and promote solidarity amongst workers.
- **Picketing or boycotts:** marching and placard-carrying is a technique by which workers engaged in an industrial dispute attempt to persuade others to take their side and join them while preventing others from taking their jobs. This technique also helps them communicate their grievances to the public, disrupt customers or consumers of the service and deliveries from entering the workplace. (Finnemore and van der Merwe, 1992:192) (Rycroft and Jordaan 1990:219-221)

1.8.7 STRIKES

Strikes are a form of industrial action, but they will be defined separately from the above concepts since they are the problem being investigated in this study. Finnemore and van der Merwe (1992:194) quote Flippo (1976) who defines strikes as 'a concerted and temporary withholding of employee services from the employer for the purpose of extracting greater concessions in the employment relationship than the employer is willing to grant at the bargaining table'. It is the ultimate weapon that the workers, through their union, can use against management and the employer. Strikes make it difficult or impossible for management to provide the expected quality of service. This accounts for the concern about nursing personnel involvement in strike action.

The following types of strikes need to be explained:-

- **The lawful strike:** a strike which is embarked upon after using statutory - resolution procedures defined by the Labour Relations Act or recognition agreements.
- **The illegal strike:** a strike which is embarked upon contrary to workplace or

Industrial Council agreements nor provisions of the Labour Relations Act. These are the so called 'wildcat strikes ' and there is no legal protection of strikers in this case.

- **Secondary or sympathy strikes:**

  employees who are not party to the original dispute may join the strike in solidarity and support of the strikers; employees of other categories such as nurses might join strikes of domestic workers out of choice, not through coercion. Employees of other organisations or consumers of the service might also do this. In such cases the aim is to put more pressure on management to provide a quick settlement.

1.8.8 LOCK-OUTS

A lock-out is a form of industrial action used by employers as the ultimate economic weapon. In such a case the employers withdraw the opportunity for workers to work by locking them out of the premises. The aim is to force employees to accept an offer made by management for fear of loss of the employment contract. Conditions for lawful and unlawful strikes also apply to lock-outs (Finnemore and van der Merwe 1992:191-196) (Rycroft and Jordaan, 1990:206-221)

1.9 ORGANISING THE REPORT

The report of this study is organised in chapters as follows:

Chapter one gives an outline of the study. The discussion gives background to the study and statement of the problem, objectives to be achieved, conceptual and operational definitions of terms used in the study.

Chapter two presents an overview of literature reviewed for the study. It includes previous research done on strikes in general and in the nursing profession in particular. The chapter includes other available literature on strikes by nursing personnel. Professional associations

and trade unionism in nursing are also discussed.

Chapter three presents challenges facing nurse managers in respect of strike action. These include management's responsibility for minimising nurses' strikes and the disruption of patient care.

Chapter four presents a theoretical framework on which the study is based , namely Roy's Adaptation Theory of Nursing Administration.

Chapter five presents a description of the research methodology. It includes explanation of research design, sample and sampling methods, research instruments and ethical implications.

Chapter six presents analysis and interpretation of data collected from nursing personnel. Data is presented in the form of tables and graphs followed by the necessary explanations or interpretations.

Chapter seven presents analysis and interpretation of data collected from nurse managers and follows the same approach as used in chapter six.

Chapter eight presents a summary of the research, conclusions drawn from the findings, limitations and recommendations made for practice and for future research.

CHAPTER TWO

OVERVIEW OF NURSES STRIKES, PROFESSIONALISM AND TRADE UNIONISM IN SOUTH AFRICA

2.1 INTRODUCTION

This chapter presents a critical review of literature pertaining to strikes by employees, particularly nurses. Nurses are an employee group and therefore exhibit many of the characteristics and behaviours of other employees. They seek avenues of communication to express work-related discontent. Professional Associations exist in the nursing profession to protect nurses' interests whilst ensuring adherence to professional ethical codes. The ethical code makes it obligatory for the nurse to honour her contract with the employer by providing continuous and safe patient or client care in nursing services. Professional Associations have a tendency to concentrate more on professionalism than on conditions of employment.

Trade unionism in nursing is also discussed. Present day South African society puts emphasis on freedom of association and freedom of expression which are hallmarks of a democratic country. Nurses are part of the wider society and are therefore influenced by forces operating therein. The increase of strikes by nursing personnel in South Africa can be related to nurses increasingly joining trade unions which often use the strike weapon to force management to succumb to employees' demands.

2.2 STRIKES BY EMPLOYEES, INCLUDING NURSES

White (1985:107) agrees with Finnemore and van der Merwe (1992:1) that strikes are an inherent feature of workers where they sell their labour. The ability to withhold labour brings the employers and employees to the negotiating table. Both parties can pose sufficient threat by withholding 'something'.

Contrary to popular belief, strikes are not the only way in which industrial conflict finds expression. They are however the most perceptible expression of organised conflict (Nel and van Rooyen, 1991:201). White (1985) agrees with this view when she states that strikes are the most visible demonstration of differences between staff and management. She highlights that strikes are relatively infrequent in the United States of America (USA) compared to the amount of collective bargaining which is negotiated without resorting to strike action. She states that in 1984 ninety eight percent (98%) of collective bargaining was negotiated successfully without resorting to strikes.

White (1985) in the USA identifies the media as the reason for the misconception about the high incidence of strikes. The media sees strikes as a more newsworthy event in comparison to the collective bargaining that is successfully negotiated without resorting to strikes. This belief about the media exists also in South Africa.

Ngwenya(1993) agrees with Finnemore and van der Merwe (1992:51) that unions are portrayed in negative light, described as part of the total onslaught against South Africa. Television coverage with its need for action focuses mainly on strikes and picket lines rather than negotiations where agreements are patiently hammered out. Kotze (1992:6) also points out that the media gives much publicity to striking workers in health services and very little acknowledgement to nurses who "faithfully carry out their duties under very difficult circumstances".

This was also noted during the strikes of the 1970's , for example, the South African Labour Bulletin (1974:28) warned about 'the misconception brought about by irresponsible reporting' which indicates that 'workers long to down tools on the slightest pretext and bring society to the edge of chaos' Shane and Farnham (1985:15) agree with the view that strikes are a much publicised and emotive aspect of industrial relations.

2.3 ANALYSIS OF THE DEFINITION OF STRIKES

In defining strikes Griffiths and Jones (1980), as quoted by Nel and van Rooyen (1991:202-203), highlight four important elements, namely:-

"A strike is a temporary stoppage of work" The strikers plan to resume their work at the end of the strike. This is in contrast with most employers' perceptions who see striking employees as having cancelled their contract and may therefore hire a completely new workforce.

This dichotomy of views and perceptions reflects a need for extensive education of managers and employers to see strikers as committed workers demanding attention to those issues which interfere with their achievement of goals. Colvin (1987:46) and Keene(1992:16) share this view when they state that it is the deep sense of responsibility for present and future patients which leads nurses to resort to strike action when all else fails.

Griffiths et al (1980) further state that:-
'A strike is a stoppage of work.' This implies that it is a last resort that is not easily used because it can mean deprivation and loss for the strikers and their families.

'A strike is carried out by a group of workers', as opposed to resignation by individual employees.

'A strike is a collective action' to express a grievance which has been ignored by management. A lesson to be learnt by management is that individual employee complaints must be attended to and prevented from becoming grievances and escalating to an extent of necessitating collective action.

According to Shane and Farnham (1985:15) strikes can be interpreted as:-

- a reflection of the country's industrial relations in general
- a visible aspect of industrial relations

- an event occurring at a point in time
- a part of a process, culmination of which is the strike
- a breakdown in employer/employee relationships
- a part of the negotiating process
- a reflection of trust in so far as the striking employees expect a continuation of employment after negotiation or strike action
- a display of power at the level of the organisation or society
- an alternative to other forms of protest such as quitting, sabotage, material wastage or restricting output.

Finnemore and van der Merwe (1990: 194-195) state that three factors must be present for individual action to be defined as a strike:-

- stoppage, retardation or interruption of work or breach of contract
- a common purpose between the employees undertaking the stoppage
- the purpose must be to induce or compel the employer to comply with any demand or proposal.

Therefore 'strikes are both a reaction against frustrating situations and an instrument of positive action', according to Welliz and Hyman (1984) quoted by Finnemore and van der Merwe (1992)

2.4 ARE STRIKES NECESSARY ?

Peel (1988:58) sees strikes as not inevitable, man-made phenomena which are avoidable if proper steps , based on common sense and mutual trust are taken on time. He emphasizes the need for good communication and quick action by management on what may appear to be trivial issues because it is the sum-total of worker dissatisfaction which stimulates anti-management activities, including strikes.

Peel (1988:60-61) further states that good communication helps to develop the mood for co-operation to the point where strikes become irrelevant and unnecessary. The author highlights contradictory views of employers on the effects of open and free communication

in organisations. Some employers see information disclosure as something which can erode the managerial prerogative with no matching compensation. Other employers believe that more information disclosure will moderate trade union demands, prevent rumours and increase workers' sense of identification with the organisation. Trade unionists believe that information disclosure will correct the power imbalance and help them to bargain with management as equals. Peel however warns that it should not be assumed that information disclosure can bridge the gap between goals of management and those of the union.

According to Stern (1987:46) and Keene (1992:16) nurses believe that they possess the ethical right to strike when no other means are available to resolve problems. They acknowledge however that this may adverslely affect the quality of patient care.

Fisher (1988:22) argued that the Manchester nurses' strike in the United Kingdom in 1982 was justified because the nurses were fed up with staff shortages, closure of wards and being underpaid. They believed that the public and the government had ignored and underestimated their real concern for their patients and for the National Health Service for too long. They had tried other means of industrial action such as lobbies, petitions, candle-lit vigils, occupations or sit-ins, road blocking with no effect. It was only after the strike that the government gave some concessions to their demands. Fisher(1988) gave the assurance that nurses would never have taken the decision to strike lightly. They felt it was better to withdraw their labour for about 24 hours while providing 'emergency cover' rather than withdraw their labour permanently, for example, through resignations.

Rycroft and Jordaan (1990:206) refer to the right to strike as an essential element in collective bargaining because it is the threat of strikes which ensures that the employer will bargain more fairly. This right has been endorsed by the human rights charters, for example, the European Social charter. These authors differentiate between the 'right' and the 'freedom' to strike. They prefer to refer to the 'freedom' to strike because of the coercive nature of strikes whereby other people are forced to strike against their will. Such coercion has consequences of harm to other individuals. Satisfaction of one's right should never violate the rights of others.

Finnemore and van der Merwe (1990:196) highlighted that, according to the pluralistic framework of industrial relations, it is essential that workers are granted the right to strike so as to balance the power between the employer and employee and prevent it from being biased in favour of the employer.

An article written by the Health Workers Organisation in Natal (1988:25-26) highlighted some contradictions and some factors that affect nurses' lives. Nurses suffer the same plight as other workers such as '...long working hours, shift work, staff shortages, lack of maternity benefits and creches, rudeness from those situated in the hierarchy above them...' The article therefore advocates that nurses should be involved in the broader worker and community struggles. This view is supported by the protagonists of the Health Worker Concept which is increasingly being suggested for health services in South Africa in the 1990's to unite all health workers, including nurses. Nurses are divided on this issue which is seen by others as conflicting with their professional values and ethics. Sosne (1992:14), shared with South African nurses a belief that the right to strike must remain an option to nurses in case all attempts at conflict resolution fail.

2.5 THE UNDESIRABILITY OF STRIKES

Strikes are an undesirable weapon, therefore both the unions and management should take responsibility for avoiding them. The undesirability of strikes was highlighted by Rycroft and Jordaan (1990:206) who stated that few workers welcome a strike even though their power rests on the right to strike. They consider the harm it brings to individual workers. Strikes mean some personal deprivation for workers, for example, loss of income or loss of employment and may harm the workers more than the employer. In the cases of nurses' strikers, the consumers of nursing care, that is, patients or clients are harmed more than the employer who is responsible for the policies and practices that bring discontent (van Tonder, 1992:30). Uys (1992:33) poses ethical arguments for and against strikes. She makes reference to Glick (1986) who stated that strikes inflict damage to third parties who are innocent of the decision- making process. Many nurses claim that they participate through coercion, intimidation and a threat to their lives and property.

Trade union officials dread strikes because they are a financial drain. If a strike is lost it weakens the union. It is therefore important that the threat of strikes should be avoided in employer-employee negotiations.

Ngwenya (1993:58) conducted a study on Black trade unionism in South Africa from 1970 to 1991. In this study it was indicated that adversary relationships exist between management and trade unions in some organisations. He highlighted that in most South African companies trade unions were labelled as a disruptive force, their leaders were sometimes called 'communists, terrorists or agitators.' This author warned that the trade unions could expect to be accused of disruption even after the post-apartheid era. On the contrary it is sometimes the trade unions which express concern about elements with ulterior motives who want to undermine or weaken the government, as reported in the Natal Mercury (August 29, 1994:6)

Chaska (1983:52) highlighted that nurses have two sets of contrasting values, those of employees and those of professional. Employees attempt to control their working conditions through strikes, boycotts and demonstrations. Professionals are reluctant to use these strategies because of their commitment to the service motive. Nurses prefer representative structures controlled by other nurses who will understand their value system.
Thembela (1993:33) supported this view when he emphasized the need for nurses to continue their commitment to the ethical responsibility of protecting human lives.

2.6 PROFESSIONAL ASSOCIATIONS, TRADE UNIONS AND STRIKES BY NURSING PERSONNEL IN SOUTH AFRICA

Searle (1965) gave a historical background to the South African nurses' opposition to trade unionism in 1942. A study done by Searle in the early sixties indicated that nurses rejected trade unions for the following reasons:-

- trade unions were politically inclined and that was believed to be contrary to the spirit of nursing.

- trade unions used strikes as a bargaining weapon and that was contrary to the nurses' ethical foundation.
- trade unions stipulated rigid staffing patterns and workload agreements with no consideration for the unpredictability of patient and community needs.
- trade unions associated nurses' work with that of a factory operator and that was strongly resented by nurses. (Searle, 1965:248-252)

It can therefore be deduced that there was a great commitment of nurses to their calling to render safe nursing care at all times.

Opposition to trade unionism in nursing led to the challenge of establishment of a professional association. The aim was to prevent discontented nurses from joining trade unions which used strikes as a powerful bargaining tool thus disrupting patient care. The South African Nursing Association (SANA) was then formed through the first Nursing Act(Act 45 of 1944).

This Association was formed to represent all categories of nurses of South Africa, not only trained nurses as in the previous South Africa Trained Nurses' Association (SATNA). Membership to SANA was compulsory. The subprofessional nursing categories were included as associate members. However they still felt inadequately represented because the association was dominated by senior nursing personnel, most of whom were in authority positions in the nursing services from were the grievances arose. This stifled freedom of expression, leading to unsettled grievances and a move to seek association and representation in other organisation which did not necessarily value nursing and its ethical responsibilities. A move by nurses to join trade unions was noted to increase from the 1980's. This showed a deviation from the previous stand of opposition to trade unionism taken in 1942. Nurses also expressed dissatisfaction with the compulsory membership of SANA which was still stipulated in the succeeding Nursing Acts (Act 69 of 1957) and (Act 50 of 1978) as amended.

Some nurses employed in the public sector voluntarily become members of organisations that deal with issues that affect all public servants. An example of this in KwaZulu-Natal is the Natal Public Sector Workers Union (NPSWU) formerly known as Natal Provincial Staff Association (NPSA).

Pillay (1994:1-2), editor of the NPSWU newsletter, observed that public servants had bottled their grievances to a point where the slightest perceived threat to their job security could lead to an explosion. She highlighted that public servants 'have the right to fair labour practices, to form and join unions, to organise and bargain collectively.' She also gave a reminder that these rights should be restrained to protect the rights of citizens as consumers of essential services, including nursing. She stressed a need for a legal framework that ensures consistent, predictable, accessible and efficient methods of resolving public sector conflicts.

The new Government of South Africa continues to show commitment to addressing workers' needs. Following on the Public Service Relations Act (105 of 1994) a Labour Bill, called the 'Cheadle Bill' has been drafted in 1995 and published for comment. It seeks self-regulation of workers rather than state regulation, as well as mediation and arbitration rather than costly litigation and confrontation. To be in line with the democratic principle of freedom of expression it calls for workplace forums to enable solving problems at the functional units where they arise. It entrenches collective bargaining rights as well as the right to strike and lock-out with certain limitations, for example, 'no strikes in essential services'. It forbids dismissal of strikers who adhere to stipulated strike procedures for example, before expiry of a 30 day period of a dispute remaining unresolved or if a 48 hour notice was given (Davie, 1995:1 and 8 in Business Times February 5)

In 1980, in keeping with the apartheid policy of separate development, there were moves to amend the Nursing Act (50 of 1978) to exclude nurses practising in the homelands and self-governing states from membership of SANA.

Nurses in the independent homelands or the TBVC states, (Transkei, Bophuthaswana, Venda and Ciskei) were to form their own nursing councils and professional associations. Nurses in the self-governing territories continued to function under the South African Nursing Council but had to form their own representative associations or organisations after being forced out of SANA, for example, KwaZulu Nurses Organisation (KNO) in KwaZulu. A brief historical background of this organisation is given here since this research was done in the KwaZulu-Natal province.

Zuma (1986:1-12), the then organising secretary of KNO, reported that in a meeting held at Ulundi in November 1980 most nurses of KwaZulu expressed opposition to the exclusion from SANA. They even sought legal assistance and advice on what steps to take. They agreed that while negotiations for retaining SANA membership were going on they should form an organisation of KwaZulu nurses to cater for the professional interests of nurses and their service benefits. The organisation was called KwaZulu Nurses Organisation (KNO)

All efforts to retain SANA membership failed. KwaZulu nurses and those of other self-governing territories were legally excluded from SANA through an Act of Parliament, the Nursing Amendment Act (70 of 1982) clause (1)(a) After lengthy deliberations the constitution of KNO was formally adopted in September 1984.

That KwaZulu nurses did not choose but were forced to withdraw their SANA membership was emphasized by Dlomo (1986:13), the then Chief Nursing Officer in KwaZulu, in a keynote address to the KNO constitutional congress when she said 'We are here today as nurses of KwaZulu at a congress of our own without the other nurses of the rest of the Republic not by our own choice but because of the decisions of the White nurses who served on the Board of the South African Nursing Association who requested the South African Government to pass legislation excluding us from membership of the South African Nursing Association.'

After adoption of the constitution of KNO a KwaZulu Nursing Bill was proposed. It was adopted by the KwaZulu Legislative Assembly and promulgated into an Act in 1985, the KwaZulu Nurses Act (15 of 1985). There was no clause of compulsory KNO membership in this Act.

Strikes by nursing personnel were forbidden according to the Nursing Act (50 of 1978) section 40 (2) (a)(b)(c) as well as KwaZulu Nurses Act (15 of 1985) Section 35 (2)(a)(b)(c), which ruled that:-

(a) No person shall instigate a strike or go-slow strike by persons registered or enrolled in terms of this Act or incite such persons to take part in or to continue such a strike or go-slow strike or in the continuation of such a strike or go-slow strike.

(b) For purposes of this subsection 'strike' and 'go-slow strike' shall include any action by which the services rendered by persons registered or enrolled in terms of this Act are disrupted or are likely to be disrupted.

(c) Any person who contravenes any provision of this subsection shall be guilty of an offence.'

Nurses strikes occurred in spite of the provisions of these Acts. Nurses who were involved in the strikes faced disciplinary measures by the South African Nursing Council (SANC) accused of neglecting patients. There was pressure and threat on health services when nurses went on strike against the 'no strike' clause. As a result of a motivation from a South African Nursing Council meeting held in Kimberly in 1991, Parliament deleted the 'no strike' clause from the Nursing Act (50 of 1978) by Nursing Amendment Act (21 of 1992). This gave the impression that nurses were free to strike with no fear of sanctions. Kotze (1991:17) President of SANC, explained that this was a total misconception. SANC still holds held the view that any form of patient neglect is unprofessional. Nurses would continue to be disciplined, **not for striking, but for neglecting the patients entrusted to their care.** This is a controversial issue which is opposed by some nurses who feel that SANC ignores the nurses' rights which are violated when issues leading to the strikes are not addressed.

It was stated in chapter 1 that South Africa is currently in a stage of transition marked by rapid socii-political changes. A new government of national unity was elected in April 1994. This officially put an end to all forms of segregation of people, including nurses, on racial basis. In keeping with these changes the various professional associations and organisations in South Africa (about seventeen including the previous homelands and self-governing states), are undergoing drastic changes aimed at transformation of nursing statutory bodies, SANA and SANC, by formation of a new democratic organisation for all nurses of South Africa.

South African nurses, concerned with unity, stability and democracy within the nursing profession, formed nursing forums which have worked tirelessly before and after the 1994 government elections for formation of the new structure. In 1993 the Concerned Nurses of

South Africa (CONSA) organised the First National Consultative Conference based on the theme 'South African Nurses facing new challenges' to address various issues of concern to nurses and to plan the way forward. Resolutions were taken on strategies to unify nurses and to deal with nurses' concerns through representative organisations elected by and acceptable to all nurses.

Another important move was formation of a Provisional Steering Committee of Nurses Planning for the Future (NPPF) which organised the First National Convention Workshop of Nurses in South Africa. This convention was held in January 1994. It was attended by over 600 delegates. The aim was to restructure and unify the nursing profession. Key resolutions at this convention were:-

- formation of a nursing organisation with professional and trade union functions
- transformation of SANC in consultation with nurses to create an acceptable body with proper representation of the people it serves.

The outcome of the convention was formation of a new structure called the Transitional Nurses Committee (TNC). The name laid emphasis on its temporary nature. It had a proposed life span of one year. Nzimande (1994:4), then facilitator of NPPF and later elected as chairperson of the TNC, in an opening address at the convention, emphasised the need for a temporary management structure during the transition period. Its responsibilities were to monitor, plan and direct activities to avoid instability and chaos. She also highlighted the need for credibility, wisdom, creativity, flexibility and ability of previously divided nurses to work together.

One of the objectives of the TNC was to draft a constitution for a new nurses organisation. Based on inputs from nurses all over South Africa a draft constitution was prepared through extensive consultation. It made provision for three models of the new proposed organisation from which one model would be chosen by a popular vote. These were:-

MODEL ONE: A LABOUR UNION

This would deal only with socio-economic or labour issues. The whole organisation would register as a labour union.

MODEL TWO: A COMBINED MODEL

The organisation would have a labour union section and a non-labour union section but the two would work together. Membership would be voluntary and not all members would need to belong to the labour union section.

MODEL THREE: THE PROFESSIONAL ORGANISATION

Members in this organisation would be seen only as professional people with no attention to their needs as workers or employees. Members would have to join other organisations to get their employment needs addressed, or would negotiate for themselves.

The whole of 1994 was spent through consultations with nurses at grassroots level. A third draft was finally produced in December 1994. This led to a first National Constitutional Nurses' convention, the aim of which was to debate and adopt the constitution. The convention was held on 26,27 and 28 January 1995. On the 28th of January the constitution was adopted. The name of the organisation is Democratic Nursing Organisation of South Africa (DENOSA).

The model chosen was a nursing organisation with both professional and union functions. This was in keeping with the current legislation and aspirations of the majority of nurses that the time had come for nurses to bargain freely for their rights. Of most importance with this constitution is that it is open to all nurses of South Africa and has no colour or racial elements.

At the time of writing this research reports nurses in the nine(9) provinces were preparing for election of three (3) members from each province, a total of 27, who would constitute an Interim National Board (INB) to take the process of transformation forward and prepare

for elections of National, Provincial and District Boards of DENOSA. It is hoped that this organisation (DENOSA) will represent nursing and nurses locally, nationally and internationally. It is interesting to note that nurses in the same land where there was so much opposition to unionism have decided to form a nursing organisation with union and nursing functions within itself.

2.7 PUBLIC OPINION ON NURSES' STRIKES

Public opinion is an important factor in a union's decision to call a strike. If viewed by the public as justified a strike is more likely to achieve its aim. For this reason both the union and management seek to win favourable public opinion before and during the strike. The mass media plays an important role in increasing the bargaining power of one of the parties thus influencing the sympathies and opinions of the public in favour or against employer/management or union/employees (White, 1985:106) (Kniveton 1989:108)

Cole (1988:19) reports on findings of a market research opinion poll conducted in the United Kingdom which revealed that nurses have a firm backing from the public on strike action in that country. The reasons for strikes which are most supported include:-

- striking for more pay
- protesting at the state of the National Health Service

The poll revealed that people realised that nurses are grossly underpaid and undervalued. Cole maintains that the striking nurses were just as concerned not to harm patients as were the non strikers. A spokesman for the Royal College of Nursing, commenting on the result of the poll, felt that the results would change radically if most nurses were to walk out and leave patients unattended, then the public would not support the nurses' strikes.

van Tonder (1992:29) in South Africa quoted media reports which highlighted negative perceptions of the public who described striking nurses as 'essentially irresponsible and totally immoral, who try to further their own interests at the cost of patients in their care.'

Further examples of media reports in South Africa giving the viewpoint of patients and the public on nurses' strikes in one hospital are reflected in the following reports which appeared in the Sunday Times newspaper:-

'I do not want to go back to X Hospital - they do not know how to take care of us' said one of 900 patients who were transferred to another hospital when Hospital X was on strike. A patient treated in the spinal unit of Hospital X said he was very disappointed that nurses had left people in severe pain just to 'toyi-toyi' outside the hospital. He thought the decision by the medical superintendent to close the hospital was a good one because he was thinking about his patients first and there was nothing he could do without nurses. The patient stated 'I am not against nurses fighting for their rights but they are not working in factories. They are dealing with people, whose lives are in their hands.' (Kobue, 1994:2).

White in the USA (1985:106-107) maintains that the media is responsible for influencing peoples' opinions and perceptions on strikes. It highlights the negative impact of strikes and downplays the positive gains.

2.8 THE 1994 STRIKE WAVE IN SOUTH AFRICA WITH PARTICULAR REFERENCE TO KWAZULU-NATAL

von Holdt (1994:14) in the South African Labour Bulletin questions the reality of the current strike wave in South Africa when he asks'..Is there a strike wave or a wave of media hysteria..?' 'Is it really the workers who have unrealistic expectations-or is it employers, economists, journalists and politicians who have become almost hysterical about the current strike wave in South Africa ? ' He explains that the number of strikes is not dramatically different from the pre-election era. It is the tone of the strikes which is different. Poof wages and weak leadership have been cited and these also apply in nurses' strikes. von Holdt maintains that the main problem is the crisis of relations in the apartheid workplace marked by inequalities of power, wealth and skills along racial lines, and highly authoritarian management practices. Workers want changes in the workplace that will match the political changes in the country, with special emphasis on equality and democracy.

In the KwaZulu-Natal province the media reports on a wave of wildcat strikes, for example, hospital strikes, blockades by striking truckers, a month long motor industry strike, food workers' strikes and sporadic teachers' strikes. This has left employers, the government and trade unions concerned about ultra-left-wing extremists using labour forces to stir up revolution. Industry was hit by loss of billions of rand in turnover and health services were concerned with threats to patients' lives (Tribune reporters, 1994:1)

Bonnin, Gwagwa, Isaacs and Sitas, from the Centre for Industrial and Labour studies at the University of Natal, reported on strikes in KwaZulu-Natal in 1994. They estimated that approximately 48000 workers had been involved in strikes between May and September 1994. These authors related the strikes to clashes between employee expectations and employer priorities. Employers expect worker discipline and wage restraint for economic growth whilst employees expect 'their government to rally around their grievances.'

Bonnin et al (1994) reported that 17 hospitals were involved in some form of industrial action in less than six months, citing reasons of long term discontent, for example, low salaries, corruption, nepotism, lack of affirmative action eg in top management posts, poor communication between management and workers, and others.

In one large hospital about 2000 workers, including nurses, were involved in the strikes. Some strikes were short lived while others lasted up to 2 months. Health services came to a standstill as the strikes escalated from hospital to hospital. Central Workers Forums were formed, initially welcomed by management, but later rejected, resulting in a breakdown in negotiations. Trade unions eg Nehawu, were accused of working with management against workers. Concern of the government for stability in health services was demonstrated through protracted intervention of the MEC for Health in Natal, Dr Z. Mkhize, in addressing worker grievances during the strike wave (Bonnin et al 1994:3)

2.9 EFFECTS OF STRIKES BY NURSING PERSONNEL

2.9.1 Effects on patients and the community

Rumbold (1986) quoted by van Tonder (1992:31) maintains that when a nurse strikes she not only disregards the rights of the patient but also exposes the patient to risks. Patients are turned away to other hospitals, there are delays in diagnosis and a decline in the quality of nursing. van Tonder (1992) emphasised that it is unacceptable for nurses to leave suffering patients to their own fate for reasons of the nurses' own interests. It is not only individual patients but the community as a whole whose rights to health care are violated during nurses' strikes.

A report by White (1985:128) on the Minnesota nurses' strike in the USA in 1984 reveals that different perceptions existed between the hospital authorities and nursing personnel on effects of the strike. Hospital authorities claimed that the quality of patient care remained satisfactory in spite of the strike. The nurses argued against this, highlighting that some patients booked for elective surgery were severely inconvenienced by the delay or cancellation, especially if they were in pain.

The hospital brought in temporary nurses regardless of whether they had satisfied the Minnesota continuing education requirements or not. This resulted in substandard nursing care. White (1985:117) agrees with van Tonder (1992:31) when she states that strikes in the hospital setting essentially mean a human cost of suffering or loss of life resulting from inability to restore essential bodily functions.

Fottler, Hermandez, and Joiner (1988:393-394) advise on the need to forecast the impact of strikes. These authors support the view that the real losers in strikes in health care institutions are patients and their families, as well as prospective patients. Patients may be deprived of services, may need to be moved from a hospital affected by the strikes, thus putting their relatives under a lot of stress as they try to trace and follow up their patients. Some patients may be discharged prematurely with no pre-arrangements for continuity of care. Limited beds may remain available, operations delayed and outpatient care

discontinued.

The views of the above authors are supported by the following media reports on nurses' strikes in South Africa in 1994:-

- many gunshot, stab wound and heart attack victims were waiting up to six hours before receiving treatment. Patients requiring emergency surgery, including caesarian sections, were waiting up to twenty four hours before reaching theatre. Some patients who died waited for hours in the ward before being removed to mortuary (Jackman, Daily News August 26:2 & August 27, 1994:5)
- a picture of a 'frightened' patient who had undergone major abdominal surgery and was reported to be worried about his future since the nurses had gone on strike (Woodroof, Natal on Saturday August 27,1994:1)
- ambulances lined up as paramedics waited for a minimum of twenty minutes before patients could be accepted for emergency treatment. Some seriously ill patients died or had to wait long for transfer to other hospitals to get emergency treatment (Govender and MacMillan, The Natal Mercury, August 29,1994:1)

Colter (1988:23) in the United Kingdom, expressed negative views on the effects of strikes by stating that strikes are self-defeating and distract from the issue causing the discontent. Like Searle (1965) in South Africa, Colter emphasised that the hospital is not a factory where workers can strike if they feel they are not getting a fair share of the profits. In nursing, if the complaint is understaffing the hospital runs with even fewer nurses if a strike occurs and this is self-defeating.

2.9.2 Effects on nursing personnel and the nursing profession

Strikes by nursing personnel have an impact on the rights of nurses themselves. van Tonder (1992:30) states that striking nurses disregard their own priveledge to care for patients and their own right to ensure safe nursing care for their patients. Nurses strikes violate the nurses right to status, respect and courtesy. They are no longer entitled to the trust, support and respect of the community or their colleagues.

Medlen (1992:2) stated that disruption of patient care discredits the nursing profession. In an editorial article she reflected negative views of various nurse leaders internationally, which are in line with those of most nurse leaders in South Africa, for example:-

- Baly (1984), in the USA, expressed the belief that decisions should be made at a conference table and not in the streets. She warned that patients who suffer avoidable harm while nurses are on strike might sue the nurses or the hospital and public trust would be lost.
- Storey (1979) in the United Kingdom, emphasized that the issue is not about the nurses' right to strike, industrial action or trade union activity. 'It is about the health, safety and welfare of patients and the particular responsibility the qualified nurse holds in not placing patients at risk'

In view of the observation that nurses' strikes have been noted mainly in the previously Black hospitals researcher saw a need to get views of people who had been in leadership positions in these nursing services. Informal discussions were held with some retired Black senior members of the nursing profession. The majority expressed negative views, as reflected in the two examples of statements they made:- (They requested to remain anonymous) 'It is very sad to see the image of nursing getting tarnished by nurses who show no commitment to patient care! What angers me is that some uncaring people prevented me from going to help in the hospital where I had been working when I wanted to offer my services voluntarily during strikes.' 'I am ashamed to be called a nurse when nurses are busy 'pulling down' the name of the profession to the level of any occupation with no emphasis on the service motive.'

A contrasting view was expressed by one who said she was against the oppressive policies in health services. 'It is time nurses fought for their rights. Let those in power know that today's nurses are not prepared to tolerate injustices like us. It is a pity that patients suffer, but in the long run they will benefit.'

These statements confirm concerns that exist in regard to nurses' strikes while also showing that conflicting views exist among nursing professionals.

A few examples of media reports on nurses strikes in various hospitals in South Africa in 1994 support the apparent negative consequences on nursing personnel:-

- reports of supreme court interdicts restraining strikers from continuing with wildcat or illegal strikes followed by mass dismissals in one hospital. Conflict arose between striking nurses and the union when the union was accused of siding with management (Daily News reporters August 30:1) (Govender The Natal Mercury, August 29:1) (Smith and Ismail, Sunday Tribune August 28:1) (Miller, Daily News August 31:2)
- nurses left as skeleton staff were overworked or manhandled by strikers who forcibly removed them from the working situation (Miller, Daily News August 31:2)

- the image of nursing was tarnished when volunteers had to take over their patient care responsibilities, for example, the Red Cross, St John's Ambulance volunteers, school children, relatives of patients, doctors and soldiers from the defence force (Daily News reporters August 26:2)

Positive effects reported on included the commitment of government or employing authorities and management to look into nurses' grievances as speedily as possible while urging them to return to work, setting up commissions of enquiry or granting some of their requests, for example, salary adjustments (Jackman, Daily News August 26:2)

White (1985:109) states that 'nurses have certain professional obligations which are above and beyond those of the commercial worker. The methods of the commercial worker cannot be resorted to without lowering the whole status of the nursing body engaged in life and death problems'.

Makunga (1991:9) expressed her views on peoples' feelings after involvement in strikes. Some of the effects highlighted include:-

- loneliness, feeling unloved and uncared for
- loss of self-esteem
- insecurity, sadness, grief and disappointment

- anger, suspicion and fear
- guilt that one has hurt and disappointed another, has said too much, has exposed oneself completely, and has broken a social rule and moral law.

Hibberd and Norris (1992:487-495) conducted a study on the experiences of nurses working in a hospital which served as a centre for emergencies during a 19-day strike in 98 hospitals in Alberta, Canada. The findings revealed that nurses worked under great stress due to increased workloads, unfamiliar service leading to anxiety about the potential for error and harm to patients, insufficient instruction on patients records or no time to read instructions and stress of working with strangers.

In the beginning they felt they were managing but as time went on they felt demoralised. The nurses' experiences were summarised under three main aspects:-

- striving for safety, that is, maximum patient safety
- assessing competence, since most supplementary nurses brought to augment the service were from other fields such as teaching, research and management.
- preserving integrity -they committed themselves to service at the expense of their personal lives. They had an obsession about being at work, worked long hours and felt guilty if they took a day off.

2.10 CONCLUSION

In this chapter an overview of strikes was given. Contradicting views on nurses' strikes were highlighted. Some authors acknowledge justification for nurses' strikes when all other means of negotiations have failed, while other authors emphasize the undesirability of strikes. Professionalism and trade unionism was also explored in this chapter.

CHAPTER THREE

MANAGEMENT OF CHANGE VERSUS CONFLICT

DURING THE TRANSITION PERIOD

3.1 INTRODUCTION

Discussions in the previous chapter have shown that, in spite of some justification for nurses' strikes, they are generally undesirable and have more negative than positive consequences. Nurse managers are challenged to adopt management approaches that will minimise the need for nurses to resort to strike action. They are also challenged to devise means of providing an acceptable quality of nursing care where it has not been possible to prevent a nurses' strike.

Supporters of legalising strikes maintain that strikes occur whether they are legal or not. The government and employers will be able to plan for and cope with them if there is a law which allows for their occurrence while providing impasse regulations to avoid them. There is no evidence that anti-strike laws have any effects on the number of strikes nor that legalising strikes increases their incidence (Moore 1989:248).

3.2 THE CHALLENGE OF PREVENTING OR MINIMISING STRIKES BY NURSING PERSONNEL

Mason and Talbott (1985:25) warn that if strikes are seen as a weapon used by employees to express gross dissatisfaction, it becomes an important responsibility of nurse managers to be alert to such dissatisfaction, attend to complaints promptly and prevent them from escalating into serious grievances which, if not attended to , will end in strikes. Nurse managers are given a reminder that human behaviour in organisations is unpredictable because it stems from deep seated needs and different value systems.

The quality of life at work is a concern of both nurse managers and the nurses that they manage. Mason and Talbott (1985:256) report on a study done by Wandelt, Pierce and Widdowson (1981) in the USA which confirmed the familiar nurses' complaints of short-staffing, too much over-time, inadequate continuing education opportunities, poor salaries, too much paper work, absence of collegiality among health professionals, lack of childcare facilities or too much shift work. These researchers noted that dissatisfaction stems from the work setting rather than nursing practice. These complaints are noted amongst South African nurses too. It therefore poses a challenge to management to improve the work setting and thus avert dissatisfaction.

3.2.1 DEALING WITH CONFLICT

A substantial amount of conflict exists in health care organisations because there are many members who engage in numerous and varied interdependent relationships. Douglass (1992:169) agrees with Mason and Talbott (1985:115) that conflict is an inevitable by-product of interpersonal dealings. It is a high priority issue for nurse managers. The nurse manager must identify sources of conflict.

Stern (1982:14) in the USA identified the following sources of conflict which have a great impact on nurses:-

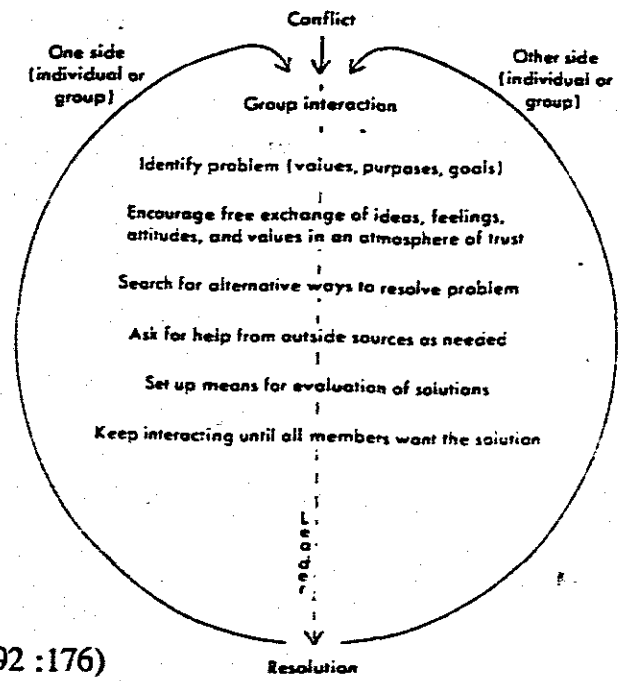
- dissatisfaction and false expectations
- inability to control their career or their jobs
- management imposing business techniques on nursing care functions
- dehumanised, impersonal treatment of professionals in large complex organisations, the notion that one is just a number and receives no recognition for a job well done
- external economic considerations, for example salaries.

Different beliefs exist about conflict. Douglass (1992:170) and Mason and Talbott (1985:115) refer to beliefs of traditional bureaucratic or conservative managers that conflict is unnecessary, harmful and reflects failure of planning and control. These managers

establish a repressive disapproving climate and use win-lose approaches. These authors also refer to human relationist and interactionist theorists who adopt a liberal approach to conflict and see it as both a functional and dysfunctional normal occurrence which occurs because human beings have needs that clash. They maintain that conflict is desirable and must be present in an organisation to maintain a dynamic state, therefore it must be stimulated and resolved. The search for solutions may lead to greater effectiveness. Nurse managers are therefore challenged not to suppress conflict but manage it so as to minimise its harmful aspects and maximise its benefits.

In considering the importance of proper management of conflict so as to avoid the need to strike the collaborative approach to conflict resolution, described by Douglass (1992:175) appears to have merit for use by most managers in managing conflict. It emphasizes active involvement and interaction of both conflicting parties throughout the problem-solving process so that solutions reached are acceptable to all. The model in figure 3.1 represents steps of the collaborative problem-solving approach.

FIGURE 3.1 MODEL FOR CONFLICT RESOLUTION



Source: Douglass (1992 :176)

Heath (1992:4) supports the collaborative approach to conflict resolution. She warns against the danger of supervisors or managers wanting to 'tell' people what to do and hardly listening

to what the people have to say. She advises that giving personnel a time to talk allows them to take ownership of the problem and thus get involved in decision making to find satisfactory and acceptable solutions. This is a basic human right.

Owen and Glennester (1990:33) in the United Kingdom observed that internal tensions occur because registered nurses distance themselves form other categories of nurses. The division between professional associations which are joined more by the professional categories and trade unions which are joined more by the lower categories has prevented nurses speaking with one voice and is a source of inherent conflict. Sosne (1992:14) advised nurses to use their power through their unions to advance their professionalism instead of choosing between the two. She warned that management uses the dichotomy between the two to divide nurses.

3.2.2 DEALING WITH CHANGE

Findlay (1992:5) advised nurse managers to be attentive to change not only as it occurs in health services but also changes occurring in the wider community. These changes influence the values, hopes, strengths and limitations of people. The importance of this was emphasized in comments made in 1991 by the then State President of South Africa, Mr F.W. de Klerk, in an opening address at the centenary celebrations of nurses' registration in South Africa. He challenged nurses, especially nurse managers, to ask themselves whether or not they were keeping pace with changes, to examine existing norms and policies so as to adapt them to existing community needs. Nurse managers were urged to project an image of stability and dedicated service to all during the transitional period of major political and social changes in the country (de Klerk, 1991:10)

Megginson (1981:81) notes that nurse managers are faced with the challenges of managing a new type of employees in the nursing field. These employees are:-

- younger, more affluent, better educated
- a very diverse group, multi-cultural, more males
- have more leisure time and a more demanding social life
- more mobile with greater opportunities for job change
- more independent

- motivated differently
- seek jobs that satisfy high needs of creativity, achievement, prestige and self expression
- want rewards 'now', demand economic incentives
- challenge authority, raise questions on 'why' certain things are done or not done

Megginson (1981) advised nurse managers to adopt a more humanistic approach when dealing with these types of employees. White (1985:109) also noted that the younger nurse lacks the professional responsibility of her calling and is more in favour of strikes.

Nzimande (1994:2) quoted Willman (1983) who observed the emergence of a new generation of nurses in the USA. Willman described these nurses as 'creative rather than conforming, initiating rather than reacting, assertive rather than passive, change agents, not retardants, political activists, not victims, and independent, not dependent.' Nurses in South Africa today, especially the younger generation, exhibit these characteristics. The older nurse manager sometimes finds it difficult to deal with this kind of nurse who is no more passive and submissive but constantly questions the status quo. Nurse managers are challenged to accommodate these changes by adopting modern management approaches for example management by objectives (MBO), which will prevent conflicts that lead to proneness to strikes.

An important change addressed by Wade, in Tjallings (1989) is the issue of the advent of trade unions in South African hospitals. She identified many challenges facing nurse managers in this regard. These include:-

- The issue of shop stewards: nurse managers have to learn to negotiate with personnel of lower categories, even non-nurses, as equals when they have been elected to represent employees. Nurse managers are challenged to be able and willing to explain and debate why certain things are done or not done, to shake off the practice of speaking to people as subordinates who can merely be told what to do.
- Management has learned more about the concerns, attitudes and reactions of staff and has realised that unions gained an upperhand on addressing personnel problems and

these ended up as serious grievances.

- Management is challenged to treat both union and non-union employees alike on matters relating to employee status.
- Equipping supervisory staff with skills to build rapport with lower categories, to guide and support them without being emotional, to teach problem solving and group dynamics.
- Equipping the staff with the necessary skills of both leadership and followership (Tjallings, 1989:156-160)

Managers can benefit from noting factors which influence change positively in organisations. Veninga (1982:261) reported on findings of a study done by Greiner (1982) which revealed that organisational change is successful:-

- Where top management is under considerable pressure to change, especially pressure from outside.
- If management makes a serious effort to find creative solutions to problems identified rather than blame others.
- If management utilises a change agent from outside so as to bring new perspectives to organisational problems and help the organisation improve its diagnosing and problem - solving abilities.
- If the proposed solutions are tested on a pilot basis to determine their effectiveness before initiating system-wide changes.

3.2.2.1 MANAGING CHANGE IN INTERGRADED HEALTH SERVICES

In chapter two reference was made to major political changes in South Africa which have resulted in the election of a new democratic government of national unity in April 1994, elected by majority vote of all the citizens of South Africa. This was a major move away from the previous apartheid system in which the majority of South Africans, the Blacks, had no vote nor access to government structures. Implications of this for nursing management is integration of health services previously segregated on grounds of race and run by different employing authorities. Managers should be prepared to adapt their management approaches

to accommodate diverse changes in health service policies and management practices.

Broome (1990:41) quotes the phrase 'No pain, no gain' as he notes that 'changes are rarely achieved without pain.' He challenges managers to utilise their skills to use that 'pain' to drive the changes. They must help personnel anticipate and accommodate the pain of change. Management must be aware of and utilise the driving forces that facilitate change and overcome restraining forces that impede or inhibit change. They must anticipate and acknowledge people's reaction to change. It is important to use systematic planned change, described by Lewin as consisting of three steps, namely unfreezing, changing and re-freezing (Lancaster and Lancaster, 1982:7-8).

The new government in South Africa addresses industrial relations issues in the Reconstruction and Development Programmes (RDP) which is its policy framework. It states that the Public Service Commission must be established in terms of the Interim Constitution to monitor a code of conduct for the public service which will incorporate principles of the new democratic South Africa. The ethos or code of conduct should be professional and internalise the concept of service to all citizen alike.

The RDP document highlights the need for a sound labour relations philosophy, policy and practice which prevents and deals systematically with corruption, mismanagement and victimisation in public institutions. This is important because these issues have been mentioned as some causes of strikes. The RDP also 'requires a system of collective bargaining at national , industrial and workplace level, giving workers a key say in decision-making and ensuring that unions are fully involved in designing and overseeing changes at workplace and industry levels.'

Industrial bargaining forums and Industrial Councils will play an important role in implementation of the RDP. Workplace empowerment emphasizes the employer's obligation to negotiate substantial changes with workers and unions, and to recognise the rights of shop stewards to attend union meetings, training, and addressing workers without loss of pay (RDP, 1994:114 and 126-127). Nurse managers need extensive education and guidance on these issues, as highlighted by Wade in Tjallings (1989:156-160)

3.2.3 DEALING WITH THE POWER DIMENSION IN EMPLOYER-EMPLOYEE RELATIONSHIPS

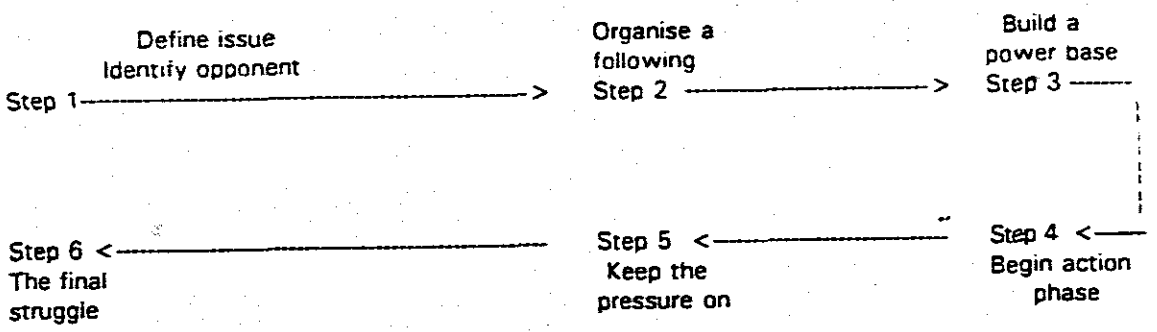
Sullivan and Decker (1988:417) note that the employer operates from a position of strength because he has power, authority and control over resources. The individual employee operates from a position of weakness with fear of loss of employment. Employees try to equalise the employer / employee relationship by unionisation which poses a threat should the employer try to exploit employees. These authors have observed that collective rather than individual bargaining increases the strength of the employee and minimises chances of victimisation.

Employees can negotiate collectively against arbitrary rules and regulations of the employer. They can collectively pose the threat of withholding their labour if no acceptable agreement is reached. This demonstrates to management and the employer that workers do have power and are able to use it.

Mason (1992:19) in the United Kingdom, found that abuse of management authority was the commonest reason for nurses found guilty of misconduct. The abuse involved harassing, bullying and overworking staff or deliberately ignoring staff complaints. Such managers hold the view that they have to be authoritarian so that staff are frightened into submission. These types of managers have also been noted among South African nurse managers. Mason (1992) quotes Latiff, an advisor in nurse management and leadership, who highlighted that nurse managers are ill-prepared for management. She emphasized that they need training and development to deal positively with the frustration of management rather than 'taking it out on the next person down the line.'

Use of power by the powerless or 'have-nots' against those with power or the 'haves' has been aptly demonstrated in Alinsky and Haley's Power-Coercive Model described by Tappen (1983:311-317) It is a win-lose strategy which is some type of force used by employees to apply pressure on management to succumb to their demands. Figure 3.2 represents the six steps of this model.

FIGURE 3.2 CONCEPTUAL FRAMEWORK OF STEPS OF ALINSKY AND HALEY'S POWER-COERCIVE MODEL



Adapted from Tappen (1983:311-317)

In the steps depicted in the model the following happens:-

Step 1 - Employees define the issue or the grievance. They identify their opponent, that is management or employer.

Step 2 - They organise a following in the belief of the concept 'strength in numbers.' The other employees must understand and own the issue or grievance and indicate clearly their opposition, for example, sign petitions or carry placards to gain more support.

Step 3 - They build a power base by capitalising on the opponents' weakness, for example, threaten to reveal corruption in management.

Step 4 - They begin action phase whereby they put into action planned strategies.

Step 5 - They keep the pressure on by developing different strategies. They sustain the action so as to weaken the opponent.

Step 6 - The final struggle represents a win or lose situation whereby either the employer/management loses and employee benefits or vice versa.

3.3 PREVENTION OR MINIMISING DISRUPTION OF PATIENT CARE DURING STRIKES

Nel and van Rooyen (1991:207) acknowledge the need for proper strike handling and contingency planning so that the service continues operating while the strike is on. Plans must be developed:-

- To identify key areas in which service must continue during the strike
- To delegate tasks to members of staff not affected by the strike
- To decide the kind of additional manpower needed and at what stages of the strike
- To train staff in services that they will be required to provide if these are different to those of their normal posts.

The key to successful strike handling is planning, organising, leadership and control. This is even more important in nursing where the lives of patients are at stake.

Marriner-Tomey (1988:320) emphasizes the need for more elaborate notification procedures and plans for strikes occurring in the health field than in industry in general. These are necessary so as:-

- To allow for delays of new admissions
- To transfer hospitalised patients to agencies not affected by the strike
- To make alternative plans for ambulatory patients
- To reschedule supervisory personnel not involved in the strike to render complete care to the remaining patients

The importance of maintaining safe patient care in the event of strikes cannot be over-emphasized.

White (1985:126) reporting on the Twin Cities hospitals' strikes in the USA, reports on contingency plans that were made. These included:-

- Driving or flying critically ill babies to outside hospitals

- Transferring less acutely ill patients to nursing homes
- placing bans on elective surgery
- laying off non-nursing personnel and advertising for more nursing personnel
- gearing for a reduced activity of 30-50 %

Nurses who were involved in the strike disagreed with management when it said that hospitals were functioning effectively in spite of the strike. The nurses stressed that some patients or would-be patients were denied their right to health care and that could not be interpreted as effective functioning in the USA.

Mason and Talbott (1985:279) maintain that many nurses are uncomfortable with the idea of striking and thus abandoning their patients because it runs counter to their service ideal. These authors stress that it is important for nurses who contemplate striking to discuss plans for patient care with nurses who have previously been involved in strikes. A 10-day notice of the intent to strike is required according to the National Labour Relations Act of America. The 10-day period is used to reduce the patient load and to halt admissions and surgery. The nurses' strike committee develops schedules for emergency coverage. The nurses providing emergency coverage are paid from the funds raised to support the striking nurses.

According to Mason and Talbott (1985) another measure taken to diminish the impact of strikes by registered nurses is reshuffling the levels of nursing administration to increase the numbers of nurse managers, for example, the charge nurses are moved to middle management level. This ensures that more management level personnel become available to give nursing care in case of a strike by nursing personnel, including registered nurses.

Uys (1992:33) argued that 'death and suffering is not so much an inherent result of health workers taking strike action, but more the result of bad strike organisation.' She emphasized the need for adequate coverage for emergency services during nurses'strikes. Uys (1992) supported by Mason and Talbott (1985) urges that responsible professionals should go out of their way to limit harm to patients if they plan to go on strike. They can do this by giving adequate notice of the strike as required by the law or recognition agreement so as to enable management to make alternative arrangements for patient care.

In South Africa this is regulated by the Public Service Labour Relations Act (Act 105 of 1994) which stipulates that a written strike notice of at least 10 days must be given to the employer about the results of a strike ballot and the date of the commencement of a strike (clause 19 (4) (b)(1). It is important to investigate whether this stipulation of the Act is observed. However it must be noted that under this Act nursing service is classified as an essential service. Employees of essential services are excluded from the right to strike (clause 19(1)) Essential services are defined in the Act as 'services the interruption of which could cause hardship to the whole or part of the community or could endanger the life, safety or health of some of the members of the community (clause 20(1)).

3.4 CONCLUSION

Challenges facing the nurse manager in respect of preventing or minimising the need to strike has been discussed in this chapter. The issue of dealing with change, conflict and the power dimension was highlighted. The importance of organising effectively to ensure minimum disruption of patient care cannot be overemphasized.

CHAPTER FOUR

THEORETICAL FRAMEWORK

4.1 INTRODUCTION

In this chapter the theoretical framework on which the study is based will be explained. Nurse managers should not use intuition, habit or tradition as a basis for making personnel management decisions. Use of specific nursing and nursing administration/management theories enables prediction, gives clues to possible outcomes of decisions made and implemented, and minimises chances of unexpected or undesirable responses or behaviours. This is important because nursing and nursing management is performed in situations that are influenced by changes in the external and internal environment. They must continually adapt so as to cope with the changes. An example of these changes is strikes by nursing personnel, a phenomenon which was rarely observed in South Africa before the 1980's.

The study is based on Roy's Adaptation theory as applied to nursing management.

4.2 DEVELOPMENT OF ROY'S ADAPTATION THEORY

The theory was developed by sister Callista Roy at the University of California in 1964. It was developed to serve as a framework for nursing practice, nursing education and research. The model comprises five elements of nursing, namely, the person, the goal of nursing, nursing activities, health and environment (George, 1985:300).

In applying the theory to nursing management Dilario, in Henry, Arndt, Di Vincenti and Marriner-Tomey (1989:78) emphasizes elements that are applicable to groups and modifies those that focus only on the individual. The theory is a useful framework for managing nursing personnel and patient-care.

4.3 BASIC ASSUMPTIONS OF THE ROY ADAPTATION MODEL

The assumptions underlying Roy's adaptation model are based on the concept of the person and the process of adaptation. Riehl and Roy (1980:180-182) identify eight assumptions which are as follows:-

ASSUMPTION:-

1: the person is a bio-psycho-social being.

2: the person is in constant interaction with a changing environment.

3: to cope with a changing world the person uses both innate and acquired mechanisms which are biological, psychological and social in origin

4: health and illness are one inevitable-dimension of the person's life.

5: to respond positively to environmental changes the person must adapt.

6: the person's adaptation is a function of the stimulus he is exposed to and his adaptation level.

7: the person's adaptation level is such that it comprises a zone indicating the range of stimulation that will lead to a positive response.

8: the person is conceptualised as having four modes of adaptation: physiologic mode, self-concept, role function and interdependence relations.

4.4 ADAPTATION

Adaptation refers to the person's response to the environment. It is aimed at maintaining integrity and promoting achievement of goals. It includes the process of coping with stressors and the end-state produced by this process. It is a dynamic rather than a static state of equilibrium. This dynamism occurs because stimuli in the environment are continually changing and acting as mediating forces to determine the person's adaptive level (Roy and Roberts, 1981:57)

Adaptive behaviour is possible when the person can:-

- keep securing adequate information about the environment.
- Maintain satisfactory internal conditions for action and for processing information.
- maintain his autonomy or freedom of movement.

In nursing management this can be possible if nurse managers lay emphasis on open lines of communication and use participative management so that nursing personnel will be kept informed, have freedom of expression and be involved in decision making.

White (1974) cited by Roy and Roberts (1981:57) sees adaptation not as a total triumph over the environment nor a total surrender to it, rather a striving towards an acceptable compromise.

Strikes are aimed at forcing management to change from existing management practices and find new ways of coping with the demands of personnel. Strike action occurs regardless of the negative impact it will have on the persons needing care, that is, patients or clients.

Adaptive actions carried over time may become ineffective. In the context of this study strikes are generally believed to follow numerous efforts at achieving a desirable state and may be resorted to when adaptive actions are seen to be ineffective. This poses a challenge for nurse managers to understand and minimise those factors which lead to stress in the nursing care environment and go beyond the adaptation levels of nursing personnel.

Adaptive responses reflect the person's ability to cope with stressors in the internal and external environment. Kenton (1994:12-19) argues against the notion that stress is all bad. He maintains that it can be a spice of life, the exhilaration of challenge and excitement. Forces which seem to be stressors working against the person can be channelled to positive energies that define ones' strength and help one to express his creativity. Kenton suggests that it is not the external effects of stressors but the way one responds to them which is important.

Some people handle stress better than others. They are referred to as 'stress-hardy' people by some psychologists who describe them as having three characteristics, namely:-

- they like challenges
- they embrace commitment
- they are in control of their lives

These characteristics can benefit nurse managers who face the challenge of nurses' strikes to remain committed to quality patient care and to remain in control of their decisions and actions.

4.5 COPING

The concept coping is very significant in Roy's Adaptation Model. Murphy (1962) cited by Roy and Roberts (1981:56) defines coping as 'any attempt to master a new situation that can be potentially threatening, frustrating, challenging or gratifying.' This definition has relevance for this study if one accepts that nursing personnel are committed to rendering quality patient care at all times and would resort to strike only when they feel so threatened and frustrated that they see no other way to master the situation. Nurse managers are therefore challenged to devise coping mechanisms when the important responsibility of effective utilisation of personnel to provide effective patient care is threatened by strikes.

Some authors describe coping to include both the routine patterns of behaviours utilised to deal with daily situations and the new patterns of behaviour adopted to deal with drastic changes and unfamiliar situations. Other authors use the term to refer only to patterns of behaviours utilised in extremely difficult situations. Some coping mechanisms are inherited while others are learnt. In presenting a holistic or unified view of physiological and psychological adaptation, the person is conceptualised as having two major coping mechanisms, namely, the regulator and the cognator subsystems (Roy and Roberts, 1981:56).

According to Fawcett (1989:312) quoting Roy (1984), the regulator subsystem 'receives input from the external environment and from changes in the person's internal state. It then

processes the changes through neural-chemical-endocrine channels to produce responses.' 'The cognator subsystem also receives input from external and internal stimulus that involve psychological, social, physical and physiological factors, including regulator subsystem outputs.

These stimuli are then processed through cognitive-emotive pathways for perceptual and information processing. The person's perception of the situation will influence his response to it. Cultural and social factors act as mediating factors to the behaviour, for example, when South African nurses were strongly influenced by the 'no-strike' clause of the Nursing Act (Act 50 of 1978) they responded differently to potentially threatening and frustrating situations. On the other hand the frequency with which strikes occur in the other spheres of employment is believed to influence nurses towards the tendency to be involved in strikes.

Henry et al (1989:79) refer to the stabilizer and the innovator in organisational adaptation which parallel the regulator and cognator subsystems in the person respectively.

4.5.1 THE STABILIZER

The stabilizer refers to those structures and processes which function together for system maintenance and equilibrium throughout the organisation, that is patient care in nursing services. The challenge for the nurse manager is to maintain the stabilizer subsystem intact in order to prevent disruption of patient care. (Henry et al 1989:79)

4.5.2 THE INNOVATOR

The innovator includes all structures and processes for change which is necessary for growth of the organisation.

If the innovator subsystem is intact the organisation operates well and is ready for new goals which lead to mastery of new situations (Henry et al 1989:80). The nurse manager must be involved in strategic planning for change.

To be successful she must ensure that information systems are such that personnel are kept informed of changes planned and are given freedom of expression about the acceptability of

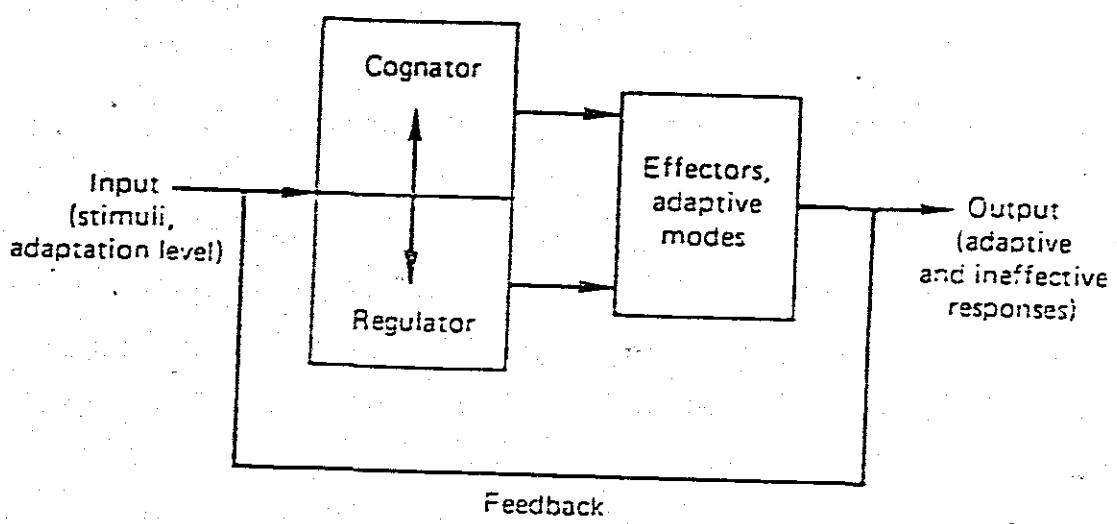
change so as to prevent ineffective adaptive behaviour such as strikes.

4.6 THE ELEMENTS OF NURSING DESCRIBED IN ROY'S ADAPTATION MODEL

4.6.1 THE PERSON

In this model the person is described as an adaptive system. The person is considered at the individual and group levels. The nurse manager interacts with nursing personnel at both these levels. Two concepts are central to the person as an adaptive system, that is, system and adaptation. Figure 4.1 presents the person as an adaptive system.

FIGURE 4.1 THE PERSON AS AN ADAPTIVE SYSTEM



(SOURCE: ROY AND ROBERTS, 1981:58)

In nursing management the organisation is parallel to the person in the nursing system. It is composed of interrelated departments which function interdependently to maintain integrity, productivity, growth and achievement of organisational goals. Organised groups of personnel are viewed as the adaptive system in constant interaction with a changing environment (Henry et al 1989:90)

4.6.2 THE GOAL OF NURSING AND NURSING MANAGEMENT

The goal of nursing is promotion of adaptive responses in relation to the four adaptive modes referred to in Assumption 8. Adaptive responses positively affect the person's physical, psychological and social well being and thus serve to maintain his integrity. Ineffective responses do not contribute to maintenance of one's integrity and state of equilibrium.

The goal of nursing management is to ensure provision of the most effective nursing care service to patients/clients. Adaptive changes in response to environmental influences are necessary to promote survival of the organisation. Adaptive behaviours promote achievement of organisational goals while ineffective organisational behaviours block goal achievement. This calls on nurse managers to be alert to, and minimise internal and external environmental influences that have a negative impact on nursing personnel and thus block goal achievement (Henry et al 1989:78)

George (1985:306) cites Helson (1964) who relates adaptation to the holistic qualities of the person. This supports the assumption of the person as a bio-psycho-social being (Assumption 1 of the theory). Adaptation to change is dependent upon the stimuli which act as input and on the person's adaptation level which is the degree to which one is able to cope with specific stimuli. This determines whether or not an adaptive or maladaptive response will be elicited. The goal of the nurse manager is to contain stimuli within the organisations' adaptation level.

In this model three types of stimuli are identified, namely:-

- Focal stimuli: those immediately confronting the person and representing the degree of change which precipitates adaptive behaviour.
- Contextual stimuli: all other stimuli in the person's internal and external environment for example, factors that cause job dissatisfaction.
- Residual stimuli: the person's characteristics, beliefs, attitudes and traits. These will influence how the person will respond in any given situation.

The strength of the three types of stimuli together forms the person's adaptation level. If the stimuli fall beyond the person's adaptation level, maladaptive responses occur. It is believed that strikes by nursing personnel occur when factors causing dissatisfaction go beyond the nurses' adaptation level. The challenge facing nurse managers is to be sensitive to these factors and be prepared to take proactive steps to minimise them before nursing personnel are convinced that they can no longer adapt and the only bargaining tool left to them is going on strike.

4.6.3 HEALTH

Helson's view of the person as a bio-psycho-social being supports the World Health Organisation's definition of health as 'a state of physical, mental and social well-being.' The core of Roy's definition of health is integrity whereby the person is maintained as a integrated whole, functioning optimally to achieve the goals of survival, growth, reproduction and mastery (Roy and Roberts,1981:53)

Health of managerial systems is also viewed in terms of integrity whereby organisational goals of survival, growth, productivity and mastery are met so that the organisation develops to its full potential. Failure to adapt to stimuli may result in ill-health of the organisation or loss of integrity which manifests itself by disruption among personnel as represented by undesirable behaviours like absenteeism, low productivity, or high staff turnover (Henry et al 1989:78) Staff resort to strikes when they feel that their rights have been violated to the extent that they can no longer continue rendering the expected quality of patient care. Wade (1992:150) supports this when she states that the strike and lock out are ulimate weapons not to be used except when there is no other remedy. Even then they must be used with circumpection and responsibilty.

This further emphasizes the need for effective listening and sensitivity to personnel grievances on the part of nursing management.

4.6.4 THE ENVIRONMENT

In this theory environment is defined as 'all conditions, circumstances and influences surrounding and affecting the behaviour of individuals and groups' (George 1985:309). It is the internal and external stimuli that impinge on the person. In the context of Roy's Adaptation Model of Administration environment refers to internal and external conditions which influence nursing care in the organisation. These conditions impact on the nursing personnel either positively or negatively thus eliciting adaptive or ineffective responses respectively (Henry et al 1989:78)

As people interact with the environment there is interchange of information, matter and energy. In this interchange people can make the following decisions in an effort to maintain integrity and balance in a changing environment:-

- alter the self
- alter the environment
- withdraw from the environment and
- alter the desirable state (Roy and Roberts 1981:52)

Strikes by nursing personnel can be viewed as the decision to withdraw from the environment when negotiations have failed to alter the environment. The decision to alter the desirable state is questionable because one would expect personnel to alter the undesirable state to a desirable one.

4.6.5 NURSING AND NURSING MANAGEMENT ACTIVITIES

In the case of patients or clients nursing activities are described in steps of the nursing process which are assessment, planning, implementation and evaluation. Goal setting is based on the patient's adaptive status. Nursing interventions are aimed at managing stimuli to enhance the patients adaptive behaviours (Henry et al 1989:79)

In management the activities involved are planning, organising,staffing, leading and controlling, as identified by Fayol (Henry et al 1989:79). Goal setting is a key concept in

management. For this reason it is important that nurse managers give priority attention to factors which facilitate achievement of organisational goals by personnel, for example, job satisfaction.

5. POTENTIAL STRESSORS IN THE PATIENT CARE ENVIRONMENT

Figures 4.2 and 4.3 respectively represent external and internal factors in health care which serve as a dynamic source of stimuli to which nursing personnel and nurse managers must constantly adapt by using coping mechanisms.

FIGURE 4.2 CONCEPTUAL FRAMEWORK OF EXTERNAL ENVIRONMENTAL FACTORS WHICH IMPACT ON NURSING CARE BASED ON LITERATURE REVIEW

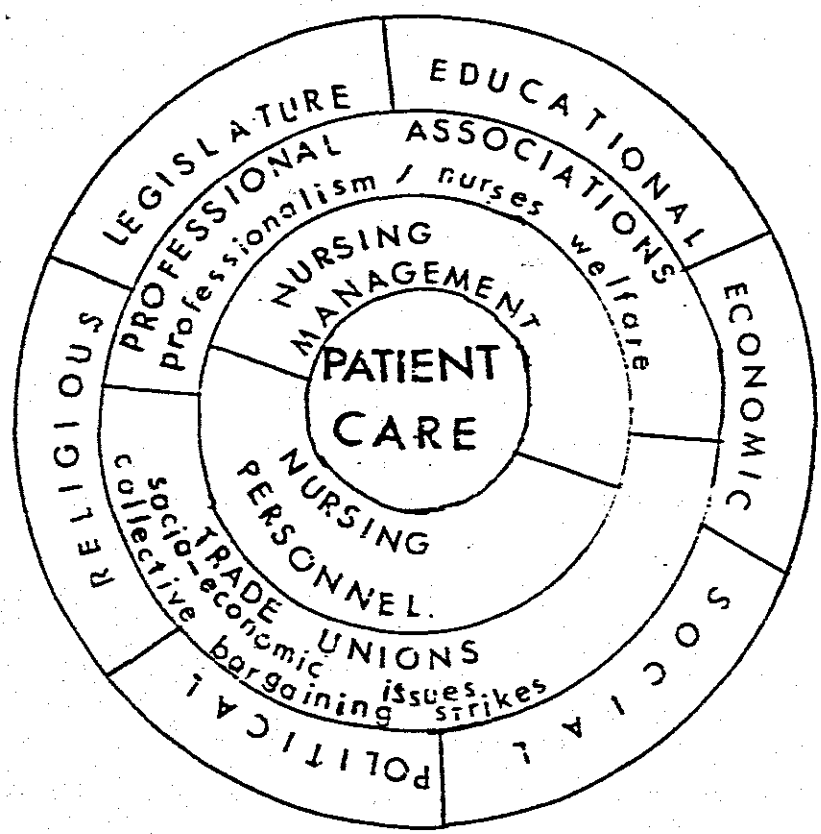
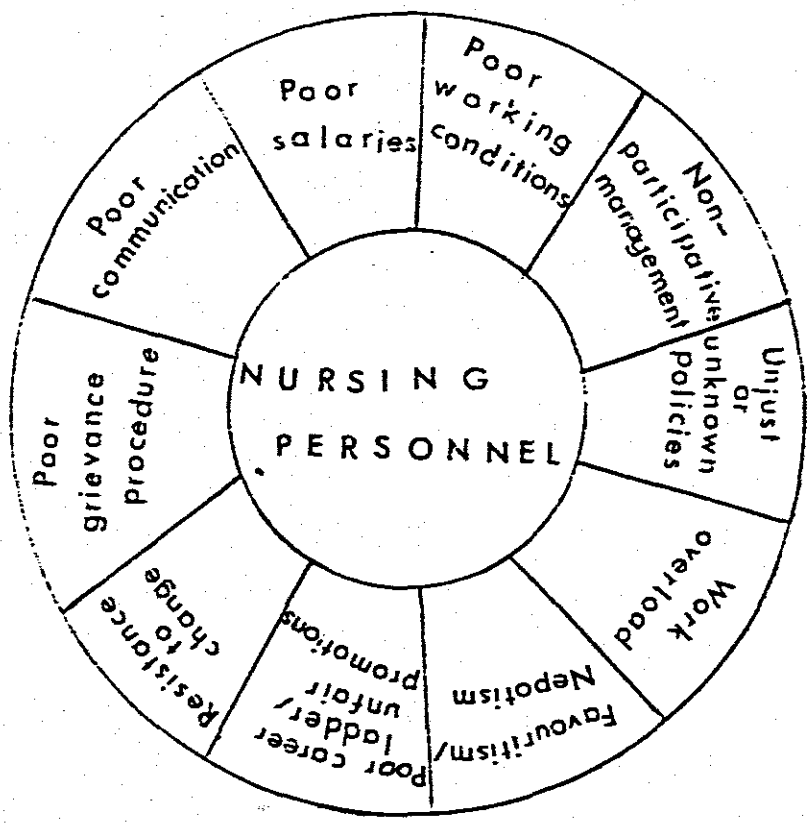


FIG 4.3. CONCEPTUAL FRAMEWORK OF INTERNAL ENVIRONMENTAL FACTORS THAT MAY LEAD TO STRIKES BY NURSING PERSONNEL BASED ON LITERATURE REVIEW



Factors represented in the models in Figure 4.2 and 4.3 are repeatedly mentioned in various sources of literature as potential stressors and job dissatisfiers if not managed proactively to enhance healthy labour relations and thus prevent or minimise the need to strike.

6. CONCLUSION

Roy's Adaptation Model of nursing care and nursing administration has been discussed in this chapter. The rationale for its use in the study has been highlighted. Adaptation was discussed in relation to the person and the organisation as adaptive systems. The importance of effective adaptive responses of nursing personnel to cope with potentially frustrating and threatening situations, and of nurse managers in preventing or minimising strikes by nursing personnel has been emphasized.

CHAPTER FIVE
RESEARCH METHODOLOGY

5.1 INTRODUCTION

This chapter deals with description of methods and procedures used in this study. It describes the research design, the population, sample and sampling methods as well as the instrument used for data collection.

5.2 RESEARCH DESIGN

A descriptive survey was undertaken. Descriptive studies are of considerable value in social research. They can be used to investigate people's behaviours and attitudes. Their purpose is to observe, describe and document relevant aspects of a phenomenon. They do not focus on explanation of relationships among variables (Polit Hungler 1991:175).

A descriptive study is useful when investigating new and emerging phenomena and thus helps to lay a sound foundation for future research. In this study strikes by nursing personnel in South Africa can be described as an emerging phenomenon which needs to be investigated to determine its impact and implications for nursing care.

Treece and Treece (1986:176) maintain that descriptive surveys can be used to provide accurate quantitative description of phenomena through the use of large samples which have a high degree of representativeness.

5.3 DELIMITATION OF THE STUDY

The study was limited to strikes by nursing personnel of all categories, excluding students, in the KwaZulu Natal province. Strikes refer to temporary work stoppage. They pose numerous challenges for nurse managers who are charged with the responsibility of providing continuous safe patient care of high quality under any prevailing circumstances.
Any work stoppage by nurses, however brief, means withholding or disruption of continuous

service to patients. It therefore needs to be examined closely to determine its causes, its consequences, proactive steps that can be taken to prevent or minimise it and strategies which can be implemented to provide safe patient care when strikes occur.

The study was limited to hospitals which have a bed state of 500 beds and more, in the KwaZulu Natal province. Only hospitals which have been categorised as 'Black' hospitals before the integration of health services were selected for the study because they are the ones which had been and continued to be involved in, or to be at high risk of involvement in strikes by nursing personnel. Non-institutional health services, for example clinics, were not included in this study.

5.4 ETHICAL CONSIDERATIONS

5.4.1 Permission for the study

Permission to conduct the study was sought from employing authorities of the public sector hospitals in Natal and KwaZulu. At the time of seeking permission health services were not yet integrated. Permission was obtained from one employing authority subject to obtaining permission from the individual hospitals selected for the study. The proposal giving an outline of the study and samples of questionnaires accompanied all letters of requests for permission. The study was conducted only in hospitals which granted permission.

5.4.2 Informed consent

Informed consent was obtained from the respondents after explanation of purpose of the study. Polit and Hungler (1991:36) explain informed consent as ensuring that 'subjects have adequate information regarding the research, are capable of comprehending the information, have the power of free choice enabling them to voluntarily consent to participate in the research or decline participation.

The issue of ability to comprehend the information, was given adequate consideration in view of the variations in levels of knowledge between the various categories of nurses. In view

of the sensitivity of the problem of study the issue of voluntary participation was emphasized to management and to the subjects selected for the sample.

5.4.3 Anonymity and confidentiality

It was emphasized that respondents should not indicate their names or names of their institutions anywhere in the questionnaire. In this way, there would be no way of linking their responses to them or to their institutions. If institutions needed to be identified anywhere in the report only codes would be used. Some respondents who had expressed concern about victimisation if their responses highlighted negative aspects in the nursing service were willing to participate when assured of anonymity and confidentiality.

5.5 POPULATION

The target population for this study was nurse managers, which includes Senior Professional nurses and Professional nurses in charge of wards, Chief Professional nurses at middle management level, Chief/Senior or Nursing Service Managers at top management levels. The target population also included the various categories of nurses involved with direct patient care at functional levels. This includes Senior Professional nurses or Professional nurses not in charge of wards, Enrolled nurses and Enrolled Nursing Auxilliaries. Student nurses and pupil nurses were excluded from this study.

5.6 SAMPLE AND SAMPLING METHOD

Stratified random sampling method was used. The variable used as a basis for stratification was nursing category. This was done to ensure that all the categories of nurses were represented. There is marked variation in the numbers of the different categories of nurses. For this reason, it is not advisable to use proportional stratified sampling design where the subjects are selected in proportion to the size of the stratum in the population. Subjects from the stratum with the least numbers would be so few that the information would provide insufficient base for making comparisons. In consideration of this fact researcher used the disproportional stratified sampling design to enable meaningful inter-stratum comparison

between strata of greatly unequal numbers (Polit and Hungler 1991:263) Figure 4.1 is an example of proportional versus disproportional stratified sample from institution X.

TABLE 5.1 PROPORTIONAL VERSUS DISPROPORTIONAL SAMPLE

Population and sample	NSM & CPN	SPN & PN in charge	SPN & PN not in charge	EN	ENA	TOTAL
Population	11	35	95	103	44	288
Proportional Sample -20%	2	7	19	21	9	55
Disproportional Sample	100% 11	30% 11	20% 19	20% 21	30% 13	75

Key : NSM= Nursing Service Manager
CPN= Chief Professional Nurse
SPN= Senior Professional Nurse
PN= Professional Nurse
EN= Enrolled Nurse
ENA= Enrolled Nursing Auxilliary

After division of the population into strata subjects were selected from personnel available on day duty. Those who were on leave, night duty or day off on the day of collecting data were omitted from the study. Researcher visited the nurse manager's offices and nursing units to select subjects.

For the sample of nurse managers all those who were available and who agreed to participate were given the questionnaires to complete. This was done because they are few in number and they the are people who face most challenges when strikes by nursing personnel occur.

For the sample of nursing personnel random sampling was done. To get a fair representation of the various levels of seniority, researcher selected the first and every fourth nurse on the off-duty roster, starting at the top of the list in the first ward and starting at the bottom of the list in the next ward, until a total of three(3) subjects was obtained from each unit. This system of alternating points of starting the selection was continued until all units had been covered. If a subject selected indicated unwillingness to participate the next subject on the list was selected.

The sizes of samples in the different institutions varied from 65 to 100 because of the differences in numbers and variations in numbers between the various nursing categories. Determining size of sample was guided by the principle that the larger the sample the more representative of the population it is likely to be and sampling error is reduced (Pilot and Hungler 1991:265)

5.7 THE RESEARCH INSTRUMENT

Questionnaires were used for data collection. Treece and Treece (1986:277) describe the questionnaire as a document containing a series of questions that must be responded to by all participants in the sample. It is the most common research instrument.

Use of questionnaires in this study was based on consideration of the following advantages:-

- It is a useful tool for collecting data from a largely widely dispersed population as cheaply rapidly, and efficiently as possible.
- It offers the possibility of complete anonymity which is not possible in face to face interviews.
- It has a high degree of ability to handle sensitive personal information involving socially unacceptable behaviour. Many people are not only willing but also happy to have the opportunity to express their views more frankly in questionnaires.
- It gives the respondent time to contemplate his or her response to questions. This is important when investigating sensitive problems like strikes.
- Measurement is enhanced because respondents respond to the same questions.

- Impersonal wording of questions can reduce the embarrassment or guilt and encourage honesty.
- Bias introduced by the presence of the researcher, which results in respondent selecting responses thought to be acceptable to the researcher, is avoided.

5.7.1 Designing the questionnaire

A short letter was included at the beginning of the questionnaire to give a brief explanation of the research and its purpose, assure anonymity and confidentiality and give directions for completion of the questionnaire.

Two sets of questionnaires were formulated, one for the nurse managers and the other one for the various categories of nursing personnel.

The rationale for separation of questionnaires was the varying degrees of responsibility for patient care which means that strikes should be perceived differently. It is ideal that nurses at managerial levels remain outside the bargaining unit and continually devise contingency plans to make patient care available if the other categories go on strike.

5.7.1.1 Types of questions

Formulation of the questions was guided by the objectives of the study, observations, informal discussions and available literature on strikes.

Open-ended and close-ended questions were used. Close ended questions were included because respondents are known to complete more close-ended questions which necessitate simply checking off the appropriate alternative than open-ended questions which require the respondent to formulate his/her own response. Some respondents lack the will and skill to do this (Polit and Hungler, 1991:283)

Open-ended questions were included because they enable more in-depth probing into the superficial information obtained through close-ended questionnaires. Some respondents

object to being forced into choosing from alternatives which do not reflect their precise opinions. They therefore tend to omit those questions. A combination of the two types of questions is therefore recommended because it offsets the weaknesses of each type (Poli and Hungler 1991:283)

5.7.1.2 Questionnaire for nurse managers

This was divided into three sections as follows:-

SECTION 1: PERSONAL PARTICULARS

This section highlighted the educational preparation and experience that the nurse manager had for her management or supervisory role.

SECTION 2: AWARENESS OF STRIKES

Inclusion of this section was based on the need for every person at management level to be aware of the occurrence of strikes by nursing personnel and their consequences even if they have not occurred in his/her service.

SECTION 3: PERSONAL EXPERIENCE OF STRIKES

This section was included for the following purposes:-

- To identify the nursing categories more prone to strikes.
- To recall reasons given for the strikes.
- To determine the impact that the strikes had on the manager's role and on patient care.
- To identify contingency plans for the continuation of patient care during strikes.
- To identify proactive measures which might have been implemented to prevent the strikes.

5.7.1.2 Questionnaire for nursing personnel

This was divided into two sections as follows:-

SECTION 1: PERSONAL PARTICULARS

The main aim of this section was to identify the various categories to be able to make comparisons or their views on strikes.

SECTION 2: EXPERIENCE OF STRIKES

Nursing personnel who had experienced strikes were expected to:-

- recall reasons given for the strikes.
- indicate participation or non-participation and reasons for it.
- highlight benefits or adverse effects of the strikes.
- indicate feelings after involvement in the strikes.
- indicate strategies they would adopt in future if circumstances which led to the strikes were repeated.

5.7.2 Validity of the instrument

Treece and Treece (1986 :253) and Dane (1990:257) describe validity as the ability of the instrument to measure what it is actually meant to measure. It is important to test all newly constructed instruments for validity. The instrument was tested for face and content validity.

Face validity refers to consensus or agreement that a measure represents a particular concept based on validation by experts. It is based on the notion that a good measure should look like or appear to be a good measure. This procedure has a high degree of subjectivity but it is least time consuming. Content validity refers to the extent to which the instrument samples the factors or situations under study. Experts must judge if the content is appropriate eg. in this study the content must be specific to strikes by nursing personnel (Treece and Treece, 1986:262) (Dane, 1990:257)

The instrument was presented to and discussed separately with three nurse managers of different hospitals not included in the study, two industrial relations experts and two research experts. Several modifications were made before the instrument was subjected to pretesting.

5.7.3 Pre-testing the instrument

The questionnaire was pre-tested on 15 nurse managers and 30 nursing personnel of the various categories not in charge of units. The purpose was to further change or re-word unclear, sensitive or unnecessary questions and to determine the time it takes to complete the questionnaire. The purposes were clearly explained to the pre-test group and they were requested to make any necessary comments about the instrument. The questionnaires were further modified according to their comments. The questionnaire for nurse managers took 20 to 25 minutes to complete and the one for nursing personnel took 10 to 15 minutes. They were again referred to the experts before finalisation and distribution to the respondents.

5.7.4 Distribution of the questionnaire

The questionnaires were handed directly to selected respondents by the researcher. Direct distribution is preferred where feasible because it ensures a high return rate and enables the researcher to meet deadlines. The prevailing circumstances in the different hospitals determined how soon they could be completed. Where they could be completed on the same day a high return rate was realised. In other hospitals which were very busy respondents were given a week to complete the questionnaires. This yielded a lower return rate as indicated in tables 5.2 and 5.3.

TABLE 5.2 RETURN RATE OF QUESTIONNAIRES FOR NURSING PERSONNEL

Hospital	A	B	C	D	TOTAL
No. Handed out	60	40	60	60	220
No. returned	51	35	38	48	172
No. Discarded	5	2	1	9	17
No. analysed	46	33	37	39	155
Percentage of Total Handed Out	76%	83%	62%	65%	70%

Table 5.2 reflects that a total of 220 questionnaires were handed out to nursing personnel, 172 (78%) were returned, of which 17(8%) were found to be unsuitable for analysis and were therefore discarded. 155 questionnaires were suitable for analysis representing 70% of total sample selected.

TABLE 5.3 RETURN RATE OF QUESTIONNAIRES FOR NURSE MANAGERS

Hospital	A	B	C	D	Total
No. Handed Out	40	25	40	40	145
No. Returned	36	22	28	34	120
No. Discarded	1	3	2	5	10
No. Analysed	35	19	26	29	109
Percentage of Total Handed out	86%	76%	65%	73%	75%

Table 5.3 reflects that a total of 145 questionnaires were handed out to nurse managers. 120(83%) were returned, of which 10(7%) were found to be unsuitable for analysis and therefore discarded. 109 questionnaires were suitable for analysis, representing 75% of total sample originally selected.

5.8 CONCLUSION

This chapter dealt with details of the research methodology. A descriptive survey was used. Subjects were selected by using a disproportional stratified random sampling design. Questionnaires were used for data collection and they contained both open-ended and close-ended questions. Direct distribution of the questionnaires was done. Data is analysed and interpreted in the next chapter.

CHAPTER SIX

DATA ANALYSIS AND INTERPRETATION OF FINDINGS FROM NURSING PERSONNEL.

6.1 INTRODUCTION

In this chapter analysis of data obtained from nursing personnel is presented. Questionnaires completed by nurse managers are analyzed and presented in chapter seven. The questionnaires from the different hospitals are not being separated for purposes of analysis except where specific points need to be highlighted.

Data is presented in the form of tables and graphs. Responses to open-ended questions are summarised and categorised into appropriate classifications through the process of content analysis (Polit and Hungler, 1991:513)

6.2 SECTION 1: PERSONAL PARTICULARS

ITEM 1: GENDER

TABLE 6.1 GENDER DISTRIBUTION

GENDER	FREQUENCY	PERCENTAGE
FEMALE	133	85.8
MALE	22	14.2
TOTAL	155	100

According to table 6.1 the majority of respondents, 85.8% (133) were females. Males were 14.2% (22) of total sample. This is in line with nursing being a predominantly female

profession. South African Nursing Council (SANC) statistics reflect that male nursing personnel formed only 6.39% of the total nursing population in South Africa in 1993, excluding students (SANC records, 1993). The sample was therefore biased in favour of females.

ITEM 2: **AGES OF RESPONDENTS**

TABLE 6.1 AGE DISTRIBUTION

N= 155

AGE GROUP IN YEARS	FREQUENCY	PERCENTAGE
16 - 25	15	9.7
26 - 35	58	37.4
36 - 45	39	25.2
46 - 55	37	23.9
56 - 65	6	3.8
TOTAL	155	100

The majority of nursing personnel 37.4% (58) were in the 26-35 age group followed by 25.2% (39) in the 36-45 age group and 23.9% (37) in the 46-55 age group. Few respondents 9.7% (15) were in the 16-25 age group.

Very few respondents 3.8% (6) were in the 56-65 age group. Over 65 years of age was excluded because the maximum age of retirement in South Africa is 65 years.

ITEM 3: NURSING CATEGORY

This variable was included because it is these various categories of nurses who work together in the nursing units to render patient care. They undergo different programmes in their

preparation for nursing which could result in differences in their opinions or views on strikes. They also carry different degrees of responsibility regarding patient care. Table 6.3 presents nursing category in comparison with age group.

TABLE 6.3 NURSING CATEGORY AND AGE DISTRIBUTION

Age group in years	Nursing Category									
N=155	Senior Prof. Nurse		Prof. Nurse		Enrolled Nurse		Enrolled Nursing Auxilliary		Total in Age Group	Age Group % of Total
	F	%	F	%	F	%	F	%	F	%
16 - 25	0	0	5	3.2	9	5.8	1	0.6	15	9.7
26 - 35	3	1.9	15	9.7	25	16.1	15	9.7	58	37.4
36 - 45	8	5.2	10	6.5	8	5.2	13	8.4	39	25.2
46 - 55	9	5.8	15	9.7	10	6.5	3	1.9	37	23.9
56 - 65	2	1.3	0	0	3	1.9	1	0.6	6	3.8
Total	22	14.2	45	29.1	55	35.5	33	21.2	155	100

The majority of Senior Professional nurses 11% (17) were in the 36-55 year age group. The majority of Professional Nurses 25% (40) enrolled nurses 27% (43) and enrolled nursing auxilliaries 19% (31) were in the 26-55 year age group. All categories had the lest numbers in the 56-65 age group.

ITEM 4 **LENGTH OF SERVICE**

This variable was included to determine the degree of staff stability or turnover among the various categories. It is believed that personnel who have been in the service for a longer period display more commitment to its survival and goal attainment, that is quality patient care in nursing services, in comparison with personnel who have been in the service for a shorter time.

TABLE 6.4 LENGTH OF SERVICE ACCORDING TO NURSING CATEGORY

N = 155	Length of Service in Years								Total In Category	
Nursing Category	1 - 10		11 - 20		21 - 30		31 - 40			
	F	%	F	%	F	%	F	%	F	%
Senior Prof. Nurse	1	0.6	12	7.7	8	5.2	1	0.6	22	14
Professional Nurse	30	19.4	8	5.2	7	4.5	0	0	45	29
Enrolled Nurse	25	16.1	21	13.5	9	5.8	0	0	55	36
Enrolled Nursing Auxilliary	22	14.2	9	5.8	1	0.6	1	0.6	33	21
Total	78	50.3	50	32.2	25	1.2	2	1.2	155	100

The majority of respondents 50.3% (78) were in the 1-10 year service range followed by 32.1% (50) in the 11-20 year service range. 16.1% (25) were in the 21-30 year service range. This indicates stability in the services. Only 1.2% (2) were in the 31-40 year service range.

According to category the majority of Professional Nurses 19.4% (30), enrolled nurses 16.1% (25) and enrolled nursing auxilliaries 14.2% (22) were in the 1-10 year service range. The majority os senior professional nurses were in the 11-20 year service range.

6.3 SECTION 2: EXPERIENCE OF STRIKES

ITEM 5 OCCURRENCE OF STRIKES IN THE HOSPITALS

Out of the four(4) hospitals from which the sample was drawn personnel from two(2) hospitals had experienced nurses' strikes. Respondents who worked in the other two(2) hospitals which had not experienced strikes could not complete items 6 to 19 of the questionnaire since it was based on the personal experience of strikes. In analyzing these items the sample will therefore comprise thirty seven (37) respondents from one hospital (hospital C) which had the strikes and thirty nine (39) respondents from the other hospitals (hospital D) This is a total of 76 respondents which is 49% of the total sample of 155.

ITEM 6 PERIOD(s) WHEN THE STRIKE(s) OCCURRED

In hospital C 49% (37) referred to strikes which occurred in 1990, 1993 and 1994 while 16% (6) referred to strikes which occurred in 1994 only. In hospital D 82% (62) referred to strikes which occurred in 1990 and 1994 while 18% (7) referred to strikes which occurred in 1994 only. It was noted that the respondents who referred to the 1994 strikes only were in the 1-10 year service range.

On the basis of these findings it may be said that strikes in health services in KwaZulu-Natal province were a problem in the 1990's.

This could be related to the level of political intolerance which had an influence on nursing personnel. Due to a state of violence in the province there was an increase in the number of patients admitted in hospitals and thus pressure of work on nursing personnel increased, aggravating the situation.

ITEM 7 DURATION OF THE STRIKE(s)

The majority of respondents 93% (71) indicated how long the strike(s) lasted while 7% (5) did not know. The majority 86.8% (66) indicated the same period of duration of the strike(s) as appearing in table 6.5.

TABLE 6.5. DURATION OF STRIKE(s)

HOSPITAL	YEAR	DURATION IN WEEKS
HOSPITAL C	1990	2
	1993	3
	1994	9
HOSPITAL D	1990	1
	1994	6

A few respondents in the enrolled nurse 2.6% (2) and enrolled nursing assistant category 3.9% (3) indicated different durations as appearing in table 6.6.

TABLE 6.6 VARYING PERIODS OF DURATION OF STRIKES

HOSPITAL	YEAR	DURATION IN WEEKS
HOSPITAL C	1990	1
	1993	4
	1994	12
HOSPITAL D	1990	1.5
	1994	12

These responses demonstrate that the minority 7% (5) lack awareness of what actually constitutes a strike.

The 6-day strike by nursing personnel is long enough to cause disruption to patient care unless adequate contingency plans have been made. Implications of strikes that lasted for 2 weeks up to 2.5 months pose serious challenges for the nurse manager who is held responsible for provision of effective patient care in spite of the strikes (Mellish & Lock 1992:317). Kniveton (1989:106) suggested that effective strikes should be short and highly disruptive. 'Short' means that losses to the employees are minimal but in the case

of patient care it still poses serious implications to lives of people. In nursing the idea of highly disruptive strikes cannot be condoned because it is the patient who suffers most in loss of production aimed at hurting the employer.

ITEM 8 NURSING CATEGORIES INVOLVED IN THE STRIKES

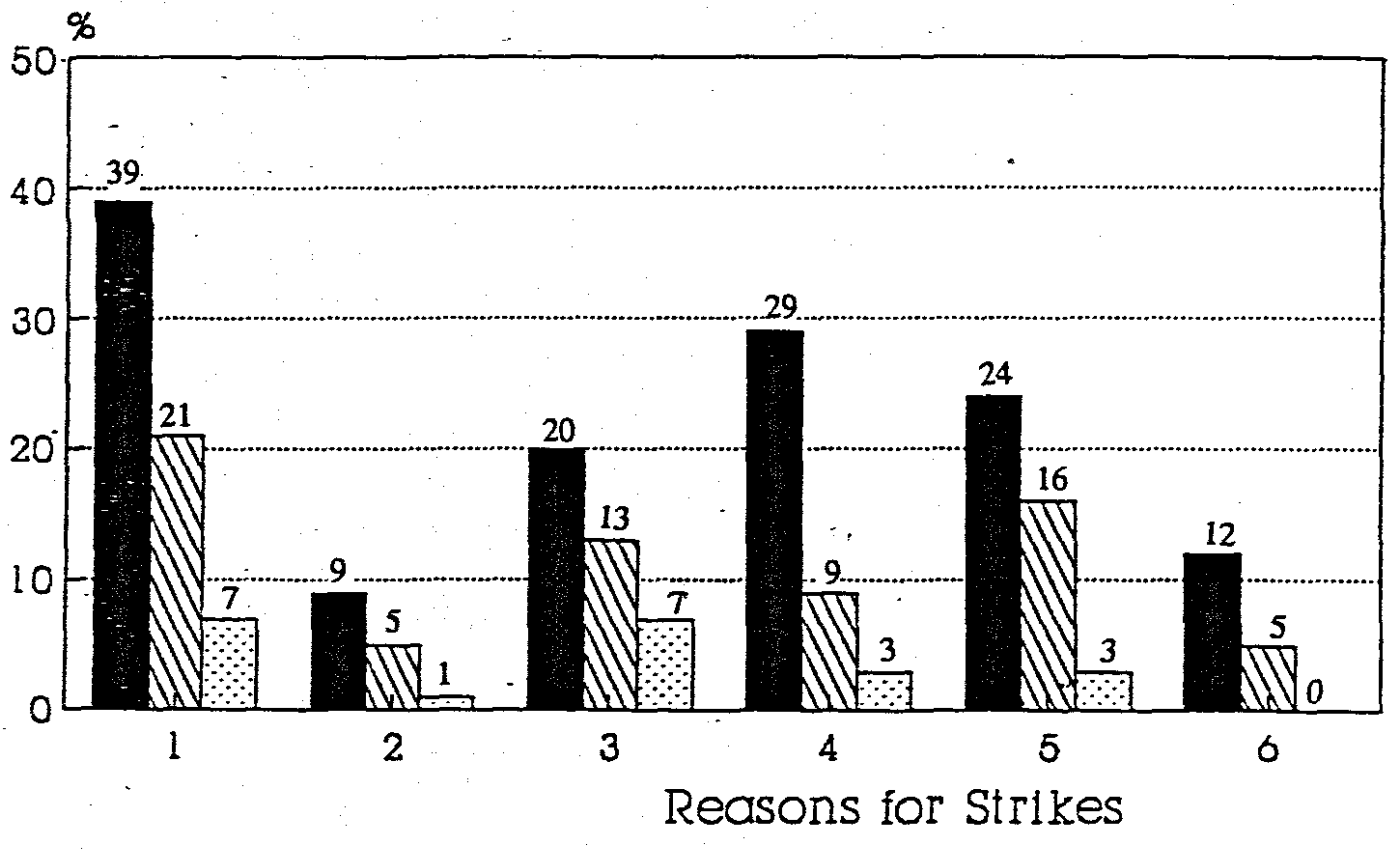
Respondents from Hospital C identified all categories listed in the questionnaire, except chief professional nurses, as having been involved in the strike action. All respondents except 2.6% (2) from Hospital D identified all categories including chief professional nurses. The rationale given for involvement of all categories of nurses was that the hospital was closed by the authorities. This meant that even those who wanted to work could not. Ideally personal functioning at managerial levels, ie. chief professional nurses, senior professional nurses and professional nurses in charge of units should form the skeleton staff which continues giving patient care in the event of strikes. Marriner-Tomey (1988:320) suggested the rescheduling of supervisory personnel to render patient care in the event of strikes as one of the contingency plans to minimise disruption of patient care.

ITEM 9 REASONS GIVEN FOR THE STRIKE(s)

This was an open-ended question giving nursing personnel the freedom to mention any reason that was stated for the strike. Numerous reasons were given but all pointed at long term unattended grievances, poor working conditions and dissatisfaction with authorities, including employers and management.

Reasons given by each respondent ranged from 1-5. SPN and PN will be grouped together for this and further analysis. Figure 6.1 presents categories of reasons given for the strikes.

FIGURE 6.1 REASONS FOR STRIKES



Key: NURSING CATEGORIES

- Senior Professional Nurses
- Enrolled Nurses
- Enrolled Nursing Assistants

KEY: REASONS FOR STRIKING - CATEGORY 1 - 6

Aspects highlighted under category of reasons are presented as they were identified by respondents.

Category 1- **SALARY DISSATISFACTION**

- Lack of consideration of cost of living
- no night duty allowance or delays in paying it out
- lack of incentives for additional qualification
- lack of parity between the different races
- unfulfilled promises: were promised 28% increase, instead money was deducted from their pay

Category 2- **UNFAIR PROMOTION PRACTISES 15% (12)**

promotions taking too long

unfair and biased

Category 3- **POOR WORKING CONDITIONS**

doing non nursing duties eg. escorting patients

over worked and staff shortages

overcrowded wards with floor beds

poor patient care facilities, including:

-inadequate equipment

-poor supplies of medication

-uneven distribution of resources on racial basis

Category 4- **POLITICAL INTERFERENCE 31% (24)**

feeling threatened by the presence of opposing parties in the working situation

some workers armed in the hospital premises

insecurity re-pension funds after government elections and merging of employing authorities

demanding to be paid their pensions

Category 5- **POOR INTER-PERSONAL RELATIONS BETWEEN STAFF AND MANAGEMENT/POOR MANAGEMENT PROCESS 32% (25)**

no transparency nor participative decision making

corruption and fraudulent staff offices

No communication with Medical Superintendent and no response to grievances forwarded

Category 6- **NEPOTISM AND FAVOURITISM**

in employment, promotion and study leave allocation

When the various categories of nurses were grouped together, the majority, 67% (15) mentioned issues related to salary dissatisfaction, followed by 32% (25) who referred to poor inter-personal relation between staff and management, 31% (24) mentioned political interference, 30% (23) referred to poor working conditions, 17% (13) mentioned nepotism and favouritism followed by 15% (12) who mentioned poor promotion practices. It was noted that no specific reference was made to first level nurse managers as being responsible for the strikes. This is in keeping with literature review on the subject of strikes, that strikes will occur because there is conflict between management and workers (Finnemore and van der Merwe, 1992:1) In terms of these findings the challenge facing employing authorities concerning nurese' salaries has been highlighted.

ITEM 10 BENEFITS OF THE STRIKE(s)

Responses to this item showed marked variations in perceptions of benefits or gains that resulted from the strikes. Table 6.4 presents responses by the various nursing categories.

TABLE 6.7 **BENEFITS OF THE STRIKES**

Benefits N=76	SPN PN		EN		ENA		Total % of all categories	
	F	%	F	%	F	%	F	%
Nothing Gained	12	16	2	3	1	1.9	15	20.9
Some salary adjustments and increases	9	12	3	4	2	3	17	22.3
Timeous payment of night duty allowance	9	12	1	1.9	1	1.9	11	14.8
Workers crisis committees appointed	10	13	1	1.9	2	3	14	17.9
Increase in number of promotions	3	4	3	4	0	0	6	8
Commission of enquiry	8	11	3	4	0	0	11	15
New Medical Superintendent employed	8	11	1	1.9	0	0	9	12.9
No more floor beds, patients transferred to other hospitals	7	9	4	5	1	1.9	12	15.9
No responses	2	3	5	5	12	16	22	24

(Respondents could give more than one answer)

KEY

SPN - Senior Professional Nurse PN- Professional Nurse

EN- Enrolled nurses ENA- Enrolled Nursing Auxilliary Nurse

The majority of respondents 24% (22) did not respond, followed by 20% (15) who indicated that nothing was gained. Benefits presented in table 6.4 showed that some nursing personnel were aware that some of the factors mentioned as causes of the strikes were attended to 22.3% (17) noted salary adjustments and increases while 14.8% (11) specifically referred to timeous payment of night duty allowance. Appointment of workers' committee was noted by 19% (14) of respondents while 14.8% (11) referred to appointment of commissions of enquiry into their grievances. 12.9% (9) stated that a new medical superintendent was appointed. 15.9% (12) Highlighted that there were no more floor beds as patients were transferred to other hospitals. A few respondents, 5% (4) noted an increase in number of promotions.

ITEM 11 ADVERSE EFFECTS OF THE STRIKE(s)

Literature emphasizes that strikes may be resorted to as a last resort only if other means are available to sort out problems. Strikes have many adverse consequences which may harm the employer, management, employee, trade union and/or consumers of the service. In nurses' strikes the patient suffers more than the employer (Hall and Goodale, 1986:170) (Rycroft and Jordaan, 1990:206) (van Tonder, 1992:33) (Finnemore and van der Merwe, 1992:200)

TABLE 6.8 **ADVERSE EFFECTS OF THE STRIKES**

ADVERSE EFFECTS	SPN/PN		EN		ENA		TOTAL	
N=76	F	%	F	%	F	%	F	%
Wards smuggled, theft of equipment, supplies	20	26	2	3	1	1.9	23	30.9
Closure of hospital, stigma and loss of public trust	8	11	3	4	0	0	11	14
Patients suffering, premature deaths, transferred to other hospitals far from relatives, neglected, confused	20	26	5	7	1	1.9	26	34.9
Threats and conflicts between strikers and non-strikers, intimidation & fear	13	17	2	3	1	1.9	16	21.9
Death of some staff members-special mention of one male nurse who was leader in the strike	12	16	8	11	3	4	24	31
Seniors and remaining nurses overworked	15	20	2	13	1	1.9	18	24.9
Uncertainty about the future-some workers terminated, jailed, South African Nursing Council discipline, poor chances of promotion	2	3	6	8	4	5	12	16
Poor staff control, lack of trust between staff and authorities	2	3	0	0	2	3	5	7

(Respondents could give more than one answer)

KEY

SPN - Senior Professional Nurse PN- Professional Nurse

EN- Enrolled nurses ENA- Enrolled Nursing Auxilliary

Table 6.8 indicates that the majority 34.9% (26) were concerned about patient suffering including premature deaths. This correlates positively with the nurses' ethical responsibility for patient care.

Numerous adverse effects on nursing personnel were identified. 31% (24) indicated deaths of some staff members, followed by 24.9% (18) who indicated overwork of nurses who had not joined the strikes. 21.9% (16) In the definition of legal strikes the protection of strikers and their leaders is emphasized (Rycroft & Jordaan, 1990"211). Uncertainty about the future was expressed by more Enroled nurses and Enroled nursing auxilliaries, 8% (6) and 5% (4) respectively, compared to 3% (2) Professional nurses.

30.9% (23) of respondents expressed concern about smuggling of wards and theft of equipment and supplies. This has implications for quality patient care since it is jeopardised by lack of resources.

ITEM 12 & 14 **PARTICIPATION IN THE STRIKES**

These items aimed at determining the extent to which the various nursing categories participated in the strikes and whether they participated willingly or unwillingly. Employees join strikes to express their dissatisfaction but also for other reasons, for example, obligation of union membership, solidarity and sympathy with other strikers, fear, intimidation and coercion to join the strikes by strikers who feel that their strike is weakened by those who take over their duties when they are on strike (Jordaan & Rycroft, 1990:220) (Uys 1992:33)

TABLE 6.9 PARTICIPATION IN THE STRIKES

Nursing Category	Number not Participating in the Strike(s)		Participation In Strikes					
			Total Number Participating		Kind of Participation			
					Willing		Unwilling	
	F	%	F	%	F	%	F	%
SPN/PN	14	18	30	39	13	17	17	22
EN	5	7	15	20	7	9	8	11
ENA	0	0	12	16	12	16	0	0
Total	19	25	57	75	32	42	25	33

KEY

SPN - Senior Professional nurse PN - Professional Nurse

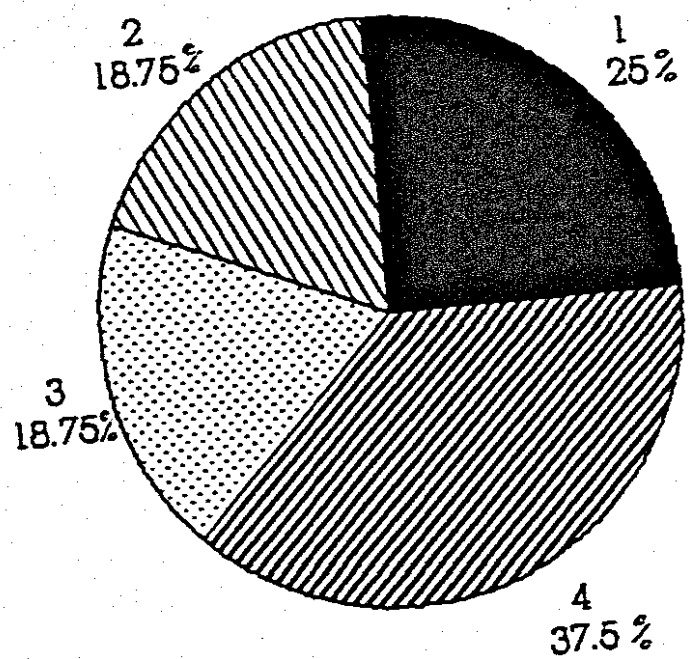
EN - Enrolled Nurse ENA - Enrolled Nursing Auxilliary

The majority of respondents, 75% (57) participated in the strike(s) and 25% (19) did not. Of those who participated 42% (32) indicated willing participation and 33% (25) indicated that they participated unwillingly. The unwilling participants comprise 22% (17) of the professional nurses and 11% (8) of the Enrolled Nurses. This is an indication of concern for continued patient care. It was noted that all enrolled nursing auxilliaries participated in the strikes and indicated that they did so willingly. Nurse managers and employers need to be aware that nurses have different reasons for participating in strikes.

ITEM 13 **REASONS FOR NOT PARTICIPATING**

The respondents who did not participate in the strikes were asked to indicate their reasons for not participating. Their reasons are presented as category 1 - 4 in figure 6.2

FIGURE 6.2 REASONS FOR NOT PARTICIPATING IN THE STRIKES



KEY: 1,2,3,4: Categories for reasons for not participating in the strikes

Responses appearing as categories 1 - 4 in Fig 6.2 are explained in the next paragraph:

Category 1 - **Ethically opposed to strikes 25% (4)**

- patients a priority
- considered unlawful by South African Nursing Council - fear of discipline and striking of register/roll
- against what she pledged as a nurse.

Category 2 - **NOT IN FAVOUR OF GRIEVANCES RAISED 18.75% (3)**

- Grievances not clearly defined
- still new and not aware of problems
- no interest in party political conflicts

Category 3 - **LACK OF UNDERSTANDING OF STRIKE ACTION 18.75% (3)**

- no communication nor guidelines given
- suspect wildcat strike with adverse consequences

Category 4 - **PREVIOUS EXPERIENCE OF STRIKES 37.5% (6)**

- nothing gained in previous strike
- subjected to South African Nursing Council discipline.

According to figure 6.2 the majority 37.5% (6) of those who did not participate were influenced by having failed to achieve any benefit in previous strikes and the experience of being subjected to South African Nursing Council discipline. 25% (4) indicated their ethical opposition to strikes.

ITEM 15 REASONS FOR UNWILLING PARTICIPATION

TABLE 6.10 **REASONS FOR UNWILLING PARTICIPATION IN THE STRIKES**

Reasons for Unwilling Participation N = 25	SPN/PN		EN		ENA		Total Participating Unwillingly	
	F	%	F	%	F	%	F	%
Fear and intimidation by the strikers	10	4	1	4	0	0	11	44
Influence of friends	0	0	2	8	0	0	2	8
Obligations of trade union membership	0	0	0	0	0	0	8	
Solidarity not associated with union	5	20	3	12	0	0	4	32
No response	2	8	2	8	0	0	12	16
Total	17	68	8	32		0	25	100

KEY: SPN - Senior Professional Nurse PN - Professional Nurse

EN - Enrolled Nurse ENA - Enrolled Nursing Auxilliary

Table 6.10 reveals that a higher percentage 40% (10) of Professional nurses were intimidated and joined the strike out of coercion while 20% (5) of them joined in solidarity with their colleagues even though they were not union members. Only 4% (1) Enrolled nurse indicated intimidation, 8% (2) were influenced by friends and 12% (3) joined out of solidarity with colleagues. Literature confirms the idea that some workers are coerced and intimidated to join strikes. Finnemore and van der Merwe(1992:206) highlighted violence which may occur between employers if organisers of the strike fail to maintain discipline and protection of individual rights. Hall and Goodale (1986:171) stated that non - strikers may be subject to verbal and physical abuse by the strikers.

ITEM 16 FEELINGS AFTER THE STRIKE

In consideration of the different reasons for which people join strikes it was seen as important to examine the respondents' feelings after the strike(s). This is even more important in nursing where the ethical responsibility for patient care has been tampered with. Table 6.11 presents feelings expressed by respondents from the hospitals which had strikes, that is, those who had participated and those who did not participate.

TABLE 6.11 FEELINGS AFTER THE STRIKE

Feelings after the strike	Senior Prof. Nurse		Enrolled Nurse		Enrolled Nursing Auxilliary		Total	
N = 76	F	%	F	%	F	%	F	%
Happy	15	20	6	9	2	3	23	30.3
Depressed	12	16	10	13	3	4	25	32.9
Guilty	9	12	4	5	1	1	14	18.4
Other	6	8	0	0	0	0	6	7.9
No Response	2	3	0	0	6	9	8	10.5
Total	44	59	20	27	12	17	76	100

Table 6.11 indicates that the majority of respondents, 32.9% (25) were depressed and 18% (14) felt guilty after the strike. 30.3% (23) expressed happy feelings. Of those who felt happy 20% (15) were professional nurses. This is contrary to the high degree of responsibility and accountability that professional nurses have for quality patient care at all times (Searle and Pera 1992:208)

According to Table 6.11, 8% (6) of the Professional Nurses indicated other types of feelings, including:-

- physical and emotional exhaustion
- hurt and loss of self-esteem
- a feeling of betrayal of colleagues for not taking part while expecting to benefit from the position outcomes of the strike.
- feeling defeated because nothing was gained.

Responses to this item are supported by Makunga (1991:9) who expressed her views on people's feelings after a strike. She highlighted negative feelings of loneliness, loss of self-esteem, insecurity, sadness, grief, disappointment, guilt, anger, suspicion and fear as indicated in (Chapter 2:32) of this report. In the enrolled nursing auxilliary category 9% (6) did not respond thus giving no indication of how they felt after the strike.

ITEM 17 SUMMARY OF REASONS FOR FEELINGS EXPRESSED IN ITEM 16

It was deemed important to find out reasons for the respondents' feelings after as this is believed to have implications for their future decisions for involvement or non-involvement in strikes.

The reasons for their feelings are summarised as follows:-

HAPPY FEELINGS 30.3% (20)

- some grievances attended to
- superiors inconvenienced and made aware of personal power and feelings. It was exciting.
- South African Nursing Council is being reviewed
- strike was well controlled - there were even prayers said.

DEPRESSED/GUILTY 32.9% (25)/18.4% (14)

- patients suffering/premature deaths
- unprofessional/violation of ethics
- no problems solved
- unknown outcome re - salary: may be underpaid in view of days not worked
- closure of hospitals/clinics: poor image in the community
- costly to the hospital
- strike longer than expected
- ill - informed about negotiations during the strikes
- fear of South African Nursing Council discipline
- conflict and mistrust among personnel

Responses to this item indicate that respondents had more reasons to be depressed and guilty than to be happy. This further highlights the undesirability of strikes and confirms management's challenge to prevent or minimise strikes.

ITEM 18 OPTING FOR A STRIKE IN FUTURE

In this item respondents were asked if they would still opt for a strike when faced with the circumstances that had led to the strike.

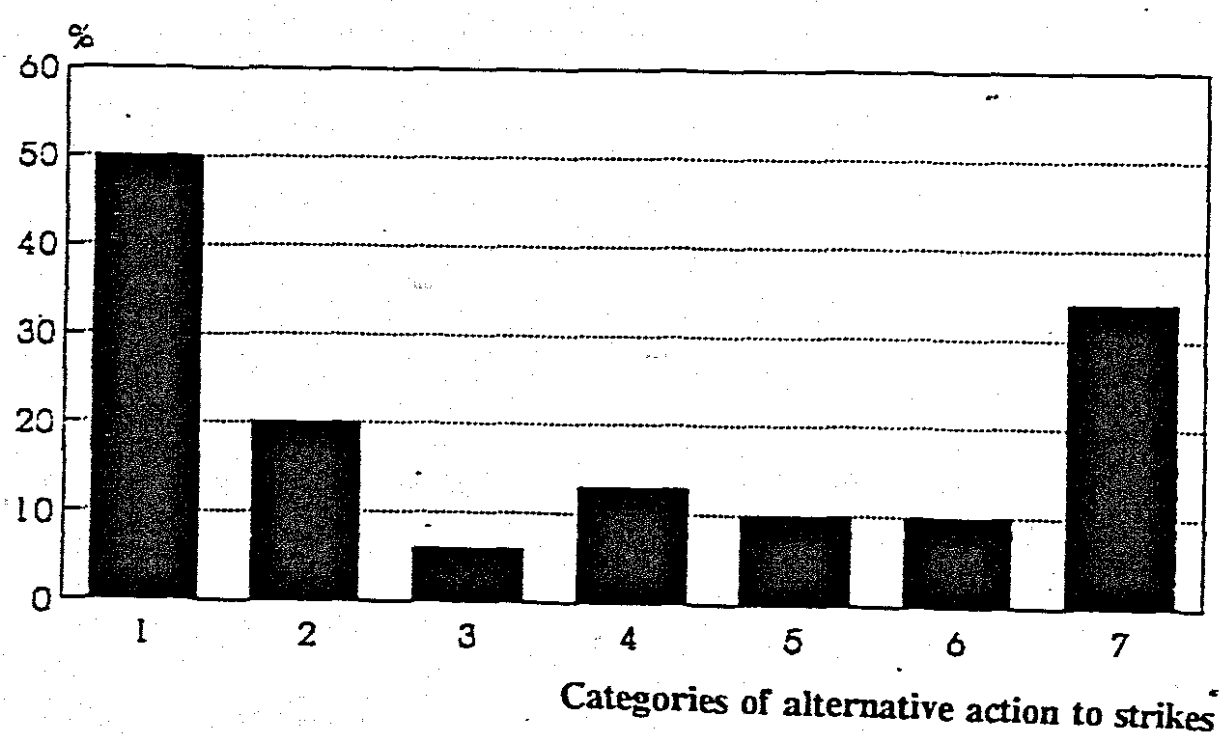
TABLE 6.12 OPTING FOR A STRIKE IN FUTURE

Responses	Senior Prof. Nurse/Prof. Nurse		Enrolled Nurse		Enrolled Nursing Auxilliary		Total	
N=76	F	%	F	%	F	%	F	%
Yes	25	32	11	15	10	13	46	60.5
No	19	25	9	12	2	3	30	39.5
Total	44	57	20	27	12	16	76	100

According to table 6.12 the majority, 60.5% (46) would opt for a strike if faced with similar circumstances in future. 39.5% (30) would choose not to strike. In the various nursing categories the majority of professional nurses, 32% (25), would opt for a strike and 25% (19) would not. 15% (11) enrolled nurses indicated that they would opt for a strike and 12% (9) would not. 13% (10) enrolled nursing auxilliary would opt for a strike and only 3% (2)

indicated they would not. These findings give an indication of possible future personnel behaviour and should be taken into consideration in planning for management of nursing services in the future.

ITEM 19 ALTERNATIVE ACTION TO BE TAKEN IF NOT OPTING FOR A STRIKE



Key : 1 - 7 : Categories of alternative action to strikes

Responses appearing as categories 1 - 7 in Fig 6.3 are explained in the next paragraph.

Category 1 - NEGOTIATIONS 50% (38)

- follow grievance procedure
- use existing or newly-formed communication structures eg. crisis committees.

Category 2 - ABSENCE FROM THE WORK-PLACE 20% (15)

- leave nursing and change to other occupation
- apply to other hospitals not prone to strikes
- take special leave or annual leave

Category 3 - SEEK ADVICE FROM IMMEDIATE SUPERVISOR 6% (5)

Category 4 - CONTINUE WITH WORK 13% (9)

- remain in the ward as skeleton staff
- help were patients have been transferred to

Category 5 - SEEK EXTERNAL CONSULTATION 10% (8)

- Involve the public
- discuss with hospitals faced with similar problems re-coping strategies

Category 6 - RESORT TO OTHER FORMS OF INDUSTRIAL ACTION 10% (8)

- prefer protest marches
- try go-slow strike to be able to give minimal service

Category 7 - NO RESPONSE 34% (26)

The majority of the responses 50% (38) showed that negotiation was considered as an important option to strikes whereby personnel remain committed to rendering the service while seeking a settlement.

The option of continuing to work was preferred by 13% (9) respondents, however experience has shown that employees who continue to work live under threats of potential harm to their bodies and property. This places a further challenge on management to devise strategies to protect non-strikers.

Protest marches used when people are off duty are an effective strategy which attracts public attention while not disrupting patient care. The option of leaving the strike-hit

hospital does not contribute to continued survival of the hospital. it is ideal to seek outside advice from people who have the same commitment and goals, that is, effective patient care. The option of seeking advice from supervisors was mentioned by only 6%(2) of the respondents who are enrolled nurses which indicates lack of trust nor confidence in senior categories in times of stress and crisis.

ITEM 20 VIEWS ON STRIKES BY NURSING PERSONNEL

This was a likert - scale item which was aimed at detecting shared or conflicting views of nursing personnel on strikes. It is important to gain insight into these views since they will continue to have an impact on the vulnerability of nurses to strike action. The views of the respondents are presented in table 6.11. The "strongly agree" and "agree" responses will be grouped together as "agree" while the strongly disagree and disagree responses will be grouped together as "disagree". Responses represent views of the total sample, that is, 155 subjects who had or had not experienced strikes.

TABLE 6.13. VIEWS ON STRIKES BY NURSING PERSONNEL

VIEWS ON NURSES STRIKES	SENIOR PROF. NURSE/ PROF. NURSE				ENROLLED NURSE				ENROLLED NURSING ASSISTANT				TOTAL				TOTAL NUMBER	
N=155	AGREE		DISAGREE		AGREE		DISAGREE		AGREE		DISAGREE		AGREE		DISAGREE			
	F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
20.1.(a) Nurses have the right to strike	30	19%	37	24%	28	18%	27	17%	19	12%	14	9%	77	49,6	78	50,4 %	155	100
20.2.(b) Nurses strikes are an effective strategy to influnce authorities to grant nurses request	51	33%	16	10%	30	19%	25	16%	20	13%	13	8%	101	65%	54	35%	155	100
20.3.(c) If nurses strike the patient suffers more than the employer	57	37%	10	7%	52	34%	3	2%	30	19%	3	2%	139	90%	16	10%	155	100
20.4. (d) Strong disciplinary action should be taken for neglect of patients during nurses strikes	40	26%	27	18%	19	12%	36	23%	13	8%	20	13%	72	46%	83	54%	155	100
20.5. (e) Opinions of the public should be sought before nurses go on strike	37	24%	30	19%	10	7%	45	29%	11	7%	22	14%	58	37%	97	63%	155	100
20.6. (f) Nurses strikes can be prevented by fair and just management policies	64	41%	3	2%	51	33%	4	3%	32	21%	1	0,6%	147	95%	8	5%	155	100

(Respondents could give more than one response)

20.1 NURSES HAVE THE RIGHT TO STRIKE

Respondents were equally divided on the issue of nurses' right to strike. 49% (77) supported this right while 50.4% (78) were opposed to it. In the category of professional nurses the majority, 24% (37) opposed, while 19% (30) supported the nurses right to strike. This has implications for decisions made by supervisory personnel who are either in favour or opposed to strikes by nursing personnel.

20.2 NURSES STRIKES ARE AN EFFECTIVE STRATEGY TO INFLUENCE TO GRANT NURSES' REQUESTS

65% (101) of the respondents agreed that strikes are effective in influencing authorities to grant requests of personnel while 35% (54) disagreed. 33% (51) Professional nurses agreed while 10% disagreed. This raises questions on the view held by the majority of professional nurses that nurses do not have the right to strike if they also believe it is an effective strategy.

20.3 IF NURSES STRIKE THE PATIENT SUFFERS MORE THAN THE EMPLOYER

The majority of respondents 90% (139) agreed that patients suffer more than the employer if nurses strike while 10% (16) disagreed. This supports the feelings of depression and guilt expressed by the respondents in item 16.

20.4 STRONG DISCIPLINARY ACTION SHOULD BE TAKEN FOR NEGLECT OF PATIENTS DURING NURSES' STRIKES

Respondents were almost equally divided on the need for disciplinary action if nurses have neglected patients whilst on strike as 46% (72) agreed and 54% (83) disagreed with the idea. The majority of professional nurses 26% (40) supported disciplinary action whilst 18% (27) were opposed to it. This is in keeping with their accountability for patient care.

The reverse was noted in the other nursing categories where 23% (36) and 13% (20) of Enrolled nurses and Enrolled as respectively were against discipline while 12% (19) and 8% (13) of Enrolled nurses and Enrolled respectively supported the need for discipline.

20.5 OPINIONS OF THE PUBLIC MUST BE SOUGHT BEFORE NURSES GO ON STRIKE

The majority of respondents 63% (97) supported the idea of seeking public opinion before nurses go on strike while 37% (58) were opposed to it. It was noted that more Professional nurses 24% (37) supported the idea while 19% (30) did not. In the Enrolled nurses and the Enrolled categories the majority 29% (45) and 14% (22) respectively, were opposed to the idea while 7% (11) in each category supported it. This suggests awareness of the professional nurses of their contract and obligations to society for the provision of nursing care as supported by Searle and Pera (1992:109)

20.6 NURSES' STRIKES CAN BE PREVENTED BY FAIR AND JUST MANAGEMENT POLICIES

Respondents shared the view that fair and just management policies can prevent nurses' strikes as 95% (147) agreed with it and 5% (8) only disagreed. This highlights the challenge for management to review its policies and practices in an effort to minimise or prevent nurses' strikes.

ITEM 21 ADDITIONAL COMMENTS ON STRIKES BY NURSING PERSONNEL

This item was included to tap further information on strikes which had not been catered for in the questionnaire. An attempt was made to allow freedom of expression by providing open ended questions but even with this approach it may not be possible to exhaust available information.

TABLE 6.14 **SUMMARY OF ADDITIONAL COMMENTS ON STRIKES**

COMMENTS ON STRIKES N = 155	F	%
1. Nurses must never strike		
- patients suffer and die	12	7.7
-it is a disgrace	5	3.2
- nursing is a calling	4	2.6
- hold regular meetings to discuss problems	15	9.7
2. Strikes must be prevented		
- transparency and consistency in implementation of policies	22	14.2
- teach Industrial Relations to first line managers and workers committees	6	3.9
- employers and management not to put patients and nurses' pledge before nurses' needs	20	12.9
- management to forward all grievances to employing authority, follow up and give feedback to personnel	5	3.2
- allow direct communication with Head Office where necessary	2	1.3
- staff interests sought in allocation	6	3.9
- public not to comment on nurses' affairs	7	4.5
- give money instead of hours for time owing	5	3.2
- nurses not to lag behind other civil servants on salary allocation	14	9.0

TABLE 6.14 (CONTINUED)

COMMENTS ON STRIKES	F	%
3. Strikes will continue		
- if nurses' hard work is not appreciated	6	3.9
-if nurses are expected to accept injustices without complaining	9	5.8
- because nurses are the most undermined employees	3	1.9
-because negotiations don't help	15	9.7
-because management exploit nurses, sometimes not using employer policies	3	1.9
-when general assistants strike their demands are met promptly	2	1.3
-nurses do not like strikes but are left with no option	7	4.5
4. If strikes occur		
-ensure skeleton staff	8	5.2
-no aggression	6	3.9
-no involvement of political organisations	4	2.6
-South Arican Nursing Council must investigate cause of strikes not only consequences because many nurses join strikes through coercion	12	7.7
-must not go back to work until an acceptable settlement has been reached	3	1.9

Responses were grouped together for this analysis because there were no marked differences according to nursing category. The responses confirmed that nurses remain divided on the issue of nurses' strikes. 7.7% (12) suggested that nurses must never strike because of resultant patient suffering. It was only a few respondents 3.2 %(5) and 2.6% (4) respectively who highlighted that it is a disgrace for nurses to strike because nursing is a calling. The majority of respondents 14.2% (22) expressed a feeling that strikes must be prevented and this is a responsibility of management and the employers. Other

respondents indicated that strikes would continue if nurses needs continued to be neglected. Other respondents 27% (42) considered that strikes would occur from time to time and some 9% (14) made suggestions that management and strikers should ensure skeleton staff and no aggression to enable those willing to work to continue rendering the service. The South African Nursing Council was criticised by 7.7% (12) of the respondents for not considering why and how the nurses joined the strike before disciplining them.

6.4 CONCLUSION

In this chapter data collected from the various categories of nursing personnel has been analyzed. It has revealed that there are marked differences of opinions or views on strikes even amongst nurses of the same category.

Data collected from the nurse managers will be analyzed in chapter seven(7)

CHAPTER SEVEN

DATA ANALYSIS AND INTERPRETATION OF FINDINGS: NURSE MANAGERS

7.1 INTRODUCTION

Analysis of data obtained from questionnaires completed by nurse managers in the various hospitals is presented in this chapter. Questionnaires from the four hospitals were not separated for purposes of analysis except where specific points need to be highlighted. Comparisons were made with data obtained from nursing personnel where necessary to test for shared or conflicting views on nurses' strikes between nurse managers and other categories of nursing personnel.

7.2 SECTION 1: PERSONAL PARTICULARS

ITEM 1: GENDER

TABLE 7.1 GENDER DISTRIBUTION

GENDER	FREQUENCY	PERCENTAGE
Female	99	90.8
Male	10	09.2
TOTAL	109	100

Table 7.1 indicates that 90.8% (99) of respondents were female and 9.2% (10) were male. In chapter 6 (item 1:68) reference was made to the female predominance over males in nursing. This trend is observed worldwide and is the opposite of the medical profession which is male dominated.

ITEM 2 AGE DISTRIBUTION

Inclusion of this variable was based on the assumption that people gain more emotional maturity, stability and enduring commitment as they advance in age. These characteristics are important in nurse managers because they are the people who give direction and shape to nursing services through their supervisory, leadership and policy-making roles.

TABLE 7.2 AGE DISTRIBUTION

N=109

Age Group in Years	Frequency	Percentage
21 - 30	4	3.6
31 - 40	29	26.6
41 - 50	44	40.4
51 - 60	32	29.4
61 - 70	0	0
Total	109	100

According to table 7.2 the majority of respondents, 40.4% (44) were in the 41 - 50 age group, followed by 29.4% (32) in the 51 - 60 age group. 26.6% (29) were in the 31 - 40 age group. It was only a few respondents 3.6% (4) who were in the younger age group of 21 -30. No respondents were above 60 years.

A predominance of respondents 69.8% (76) in the older age group of 41 - 60 was observed. Attitudes of elderly nursing personnel who do not adapt to change easily have been noted and may pose problems for the younger generation This could be related to their commitment to existing goals and image of the profession and their efforts of maintaining stability within the nursing profession.

TABLE 7.4 DESIGNATION OF NURSE MANAGERS AND AGE DISTRIBUTION

AGE GROUP IN YEARS	DESIGNATION													
	PN		SPN		CPN		NSM		SNSM		CNSM		TOTAL	
N=109	F	%	F	%	F	%	F	%	F	%	F	%	F	%
31-30	3	2.7	1	0.9	0	0	0	0	0	0	0	0	4	3.6
31-40	6	5.5	18	16.5	4	3.6	1	0.9	0	0	0	0	29	26.6
41-50	6	5.5	25	22.9	5	4.6	4	3.6	3	2.8	1	0.9	44	40.4
51-60	2	1.9	16	14.7	11	10.1	1	0.9	2	1.9	0	0	32	29.4
61-70	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	17	15.6	60	55.1	20	18.3	6	5.5	5	4.6	1	0.9	109	100

KEY

PN =Professional Nurse

SPN =Senior Professional Nurse

CPN =Chief Professional Nurse

NSM =Nursing Service Manager

SNSM =Senior Nursing Service Manager

CNSM =Chief Nursing Service Manager

According to Table 7.4 the majority of Professional Nurses in charge of units, 11% (12) were equally distributed in the 31-40 and 41-50 age groups respectively. A small percentage 2.7% (3) were in the younger age group of 21-30.

The majority of Senior Professional Nurses in charge of units 22.9% (25) were in the 41-50 age group followed by 16.5% (18) in the 31-40 and 14.7% (16) in the 51-60 age groups. Only 0.9% (1) was in the youngest age group of 21-30. The majority of Chief Professional nurses, 10.1 (11) were in the 51-60 age group, followed by 4.6% (5) in the 41-50 and 3.6% (4) in the 31-40 age group. 3.6% (4) Nursing Service Managers were in the 41-50 age group, followed by 0.9% (1) in each of the 31-40 and 51-60 age groups. 32.8% Senior Nursing Service Managers were in the 41-50 age groups while 1.9% (2) were in the 51-60 age groups. Only 0.9% (1) of the respondents was a Chief Nursing Service Manager in the 41-50 age group. It was only one of the four hospitals which had this category of manager at the time of doing this research. It was noted that there were no middle and top level managers in the younger age group of 21-30 years.

ITEM 4 LENGTH OF SERVICE

TABLE 7.5 LENGTH OF SERVICE IN THE INSTITUTION AND NURSE MANAGER'S DESIGNATION

LENGTH OF SERVICE IN YEARS	DESIGNATION OF NURSE MANAGER													
	PN		SPN		CPN		NSM		SNSM		CNSM		TOTAL	
N=109	F	%	F	%	F	%	F	%	F	%	F	%	F	%
1-10	5	4.6	9	8.3	3	2.7	1	0.9	0	0	0	0	18	16.5
11-20	9	8.3	22	20.2	7	6.4	2	1.9	1	0.9	1	0.9	42	38.5
21-30	3	2.7	28	25.7	6	5.5	1	0.9	2	1.9	0	0	40	36.7
31-40	0	0	1	0.9	4	3.6	2	1.9	2	1.9	0	0	9	8.3
TOTAL	17	15.6	60	55	20	18.3	6	5.5	5	4.6	1	0.9	109	100

KEY

PN =Professional Nurse

SPN =Senior Professional Nurse

CPN =Chief Professioanl Nurse

NSM =Nursing Service Manager

SNSM =Senior Nursing Service Manager

CNSM =Chief Nursing Service Manager

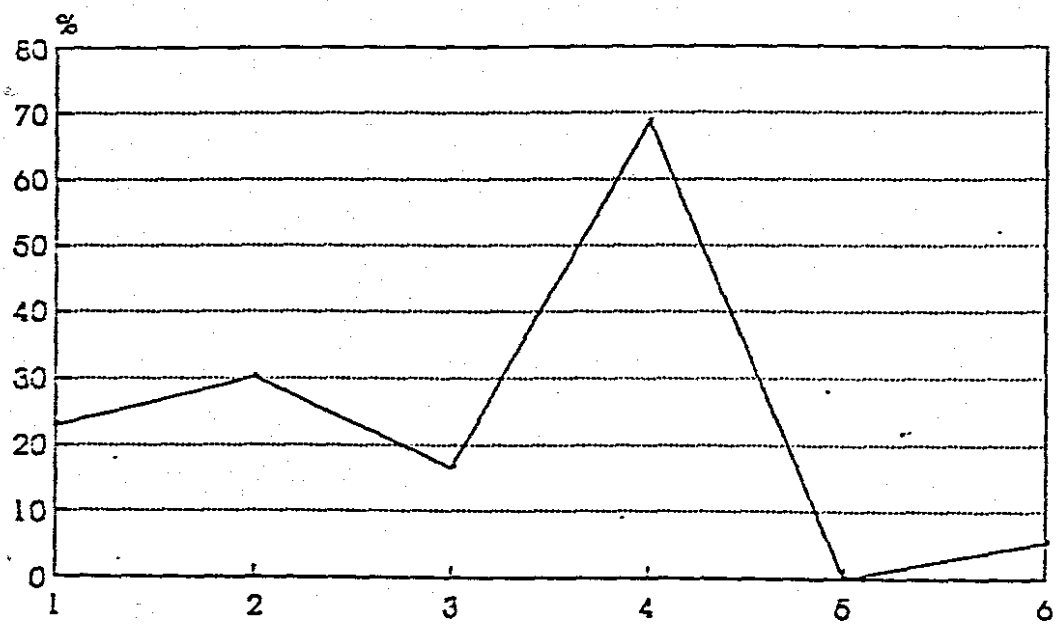
The majority of respondents, 38.5% (42) and 36.7% (40) were in the 11-20 and 21-30 years' service respectively. 16.5% (8) of the respondents were in the 1-10 years'service range and these were from the levels of Professional nurse in charge to the levels of Nursing Service Manager where there was only 0.9% (1) respondent. The least percentage 8.3% (9) were in the 31-40 years'service range. These findings suggest that nursing services are supervised by personnel who have been in those hospitals for a long time.

ITEM 5 PREPARATION FOR SUPERVISORY ROLE

Preparation of nurse managers has been given considerable attention in South Africa as nursing services continue to grow and become larger and more complex, operating according to the comprehensive health care approach. Different educational programmes have been prepared to equip nurses with principles and skills of management.

Diploma in Nursing Administration was introduced in South Africa in 1951, then called Diploma in Hospital Administration. Various universities offer degrees and post-graduate degrees in Nursing Administration. In 1982 the commission for administration laid down the minimum requirement that all Professional nurses must have done the First-level Supervisors' Course before promotion to Senior Professional Nurse (Searle, 1985:49 and 69-77). In the integrated basic nursing course which was introduced in 1986 a Nursing Administration module was included in the fourth and final year of study to prepare the newly qualified professional nurse for her supervisory role. Preparation received by the various categories of nurse managers in the sample is presented in Fig 7.1.

FIGURE 7.1 PREPARATION OF NURSE MANAGERS FOR SUPERVISORY ROLE



PREPARATION OF NURSE MANAGERS

KEY

1 =Degree with Nursing Administration major

2 =Diploma in Nursing Administration (DNA)

3 =Diploma in Clinical Care, Administration and Instruction (DCCAI)

4 =First level supervisors course

5 =Nursing Administration module in 4th year Basic Nursing Course

6 =In-Service education only

Figure 7.1 indicates that the majority of respondents, 68.8% (75) did the first-level supervisors course. 38.5% (42) indicated this course as the only preparation while 30.2% (33) indicated that they had done the other courses. 22.9% (25) had done the degree and

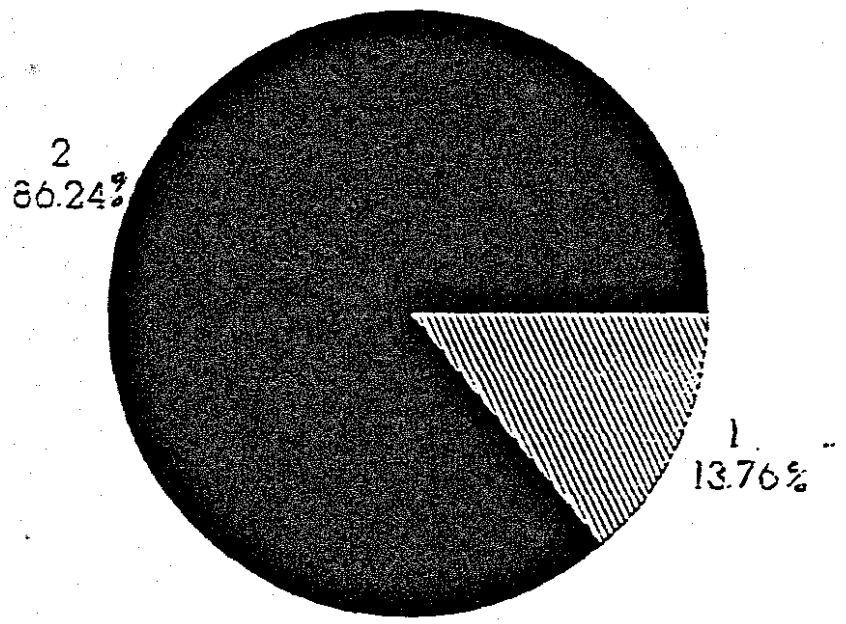
majored in Nursing Administration while 14.8% (16) had done the Diploma in Clinical Care, Administration and Instruction course which prepared them for ward level management responsibilities. Only 5.5% (6) indicated that they had only been prepared through in-service education. None of the respondents had the nursing administration module of the 4th year integrated basic nursing course. This could be related to the fact that this course was only introduced in 1986 and the majority of Professional nurses qualified through it might not have reached managerial levels. It is therefore concluded that the first-level supervisors' course is the one which has been most available to most nurse managers.

ITEM 6 ATTENDANCE OF INDUSTRIAL RELATIONS COURSE

In this item respondents were to indicate whether or not they had done the industrial relations course which is regarded as important in contemporary personnel management and in particular for dealing with strikes.

In 1991 the KwaZulu Nurses Organisation, a professional body, took an initiative of organising Industrial relations courses for its members to enable them to know more about industrial relations, to communicate assertively and to deal with conflict and negotiate effectively. It was not possible to continue with these courses on a wide scale as desired because of financial constraints (KNO Records, 1991:3). The researcher has noted that some nurses are taking the initiative to attend Industrial Relations Courses available in the community . Figure 7.2 represents the respondents who had or had not done the Industrial Relations courses. Searle and Pera (1992:326) warned that all employer-employee relationships present potential conflicts therefore nurse managers and all nurses must undergo Industrial Relations courses and these should be compulsory in both basic and post-basic courses. These authors recommend utilisation of labour relations experts to teach these courses.

FIGURE 7.2 ATTENDANCE OF INDUSTRIAL RELATIONS COURSES



KEY: 1 - YES

2 - NO

Figure 7.2 indicates that the majority of nurse managers 86.24% (94) had not done the Industrial Relations course, against only 13.76% (15) who had done it. The challenge therefore still exists for opportunities to be created to enable more nurse managers and other nursing personnel to do the Industrial Relations courses.

TABLE 7.6 ATTENDANCE OF INDUSTRIAL RELATIONS COURSES BY VARIOUS CATEGORIES OF NURSES MANAGERS

N=15

Category of Nurse Manager	Frequency	Percentage
Prof. Nurse	1	6.7
Senior Prof. nurse	6	40.0
Chief Prof. Nurse	3	20.0
Nurse Service Manager	2	13.3
Senior Nurse Service Manager	3	20.0
Chief Nursing Service Manager	0	0
Total	15	100

Table 7.6 indicates that all categories had been considered when organising and allocating personnel for Industrial Relations courses but the Chief Nursing Service Manager who is the key person in nursing services had not attended the course. There might be a possibility of conflict on ideas and focus between the Chief Nursing Service Manager and the rest of managers under her supervision.

ITEM 7 DURATION OF THE INDUSTRIAL RELATIONS COURSES ATTENDED

TABLE 7.7. DURATION OF INDUSTRIAL RELATIONS COURSE

N=15

Duration of Industrial Relations Course	Frequency	Percentage
1 day	2	13.3
2 days	3	20.0
4 days	1	6.7
5 days	6	40.0
2 days	3	20.0
Total	15	100

Responses to this item were varied, ranging from a duration of 1 day to a 2 weeks' duration. It is not possible for the diverse basic issues to be adequately covered in either 1 or 2 days. The majority of respondents 40% (6) had attended courses of 5 days' duration, while 20% (3) had attended 2 weeks' courses.

ITEM 8 ASPECTS COVERED IN THE INDUSTRIAL RELATIONS COURSES

This variable was included to detect which aspects were given priority consideration since it would not be possible to include all aspects of industrial relations in the short courses offered. Respondents could give more than one answer.

10 Aspects were identified in the questionnaire and listed as follows:-

1 -industrial relations in South africa

2 -Industrial relations Act

3 -Trade unionism

4 -disciplinary procedures

5 -handling of grievances

6 -collective bargaining

7 -dispute resolution procedure

8 -strikes in general

9 -strikes in health services

10 -health worker concept

Responses are summarised to indicate aspects which were covered in the courses attended by the respondents.

33.3% (5) of the respondents indicated that they covered all aspects 1-10 listed and they were in the 5-day and 2 week course groups. The possibility of adequately covering these diverse aspects in a 5 - day period is questionable. 20% (3) of respondents covered aspects 1-8 and were in the 4-day and 2 week course groups. This indicates that the course was not specifically health-care orientated since aspects 9 and 10, that is strikes in health services and health worker concept, were omitted. 13.3% (2) of respondents in the 5-day course group indicated that the health worker concept was not covered. 33.3% (5) of respondents in the 1-day and 2-days course groups indicated that they covered aspects 4,5,6 and 7 only.

In this era of frequent upheavals at the workplace the teaching of industrial relations cannot be over-emphasized. This view is supported by Gerber, Nel and van Dyk (1987:403) who stated that industrial relations training is necessary to communicate to employees the code of behaviour outlined in the industrial relations policy. Managers and supervisors need this training to enable them to interpret and implement the policies and procedures correctly. Worker representatives should be trained on the functioning and conducting of worker forums or council meetings. These authors further state that training of trade union members should be a joint function of management and the trade union to facilitate co-operation.

SECTION 2 AWARENESS OF STRIKES

Responses to this and the next section will be grouped according to the three levels of management as follows:-

Professional nurse (PN/SPN) = 1st Level Managers
Senior Professional nurse
Chief Professional nurses (CPN) = Middle Managers
Nursing Service Managers
Senior Nursing Service Managers (NSM/SNSM/CNSM)= Top Managers
Chief Nursing Service Managers

This grouping was done in accordance with the varying supervisory roles that they play.

ITEM 9 INCIDENCE OF NURSES' STRIKES IN THE KWAZULU NATAL PROVINCE IN THE 1990's

It is important that nurse managers remain alert to strike activity around them, in the health or other employment sectors, even if it does not involve their own place of employment.

TABLE 7.8 INCIDENCE OF NURSES' STRIKES

N-109

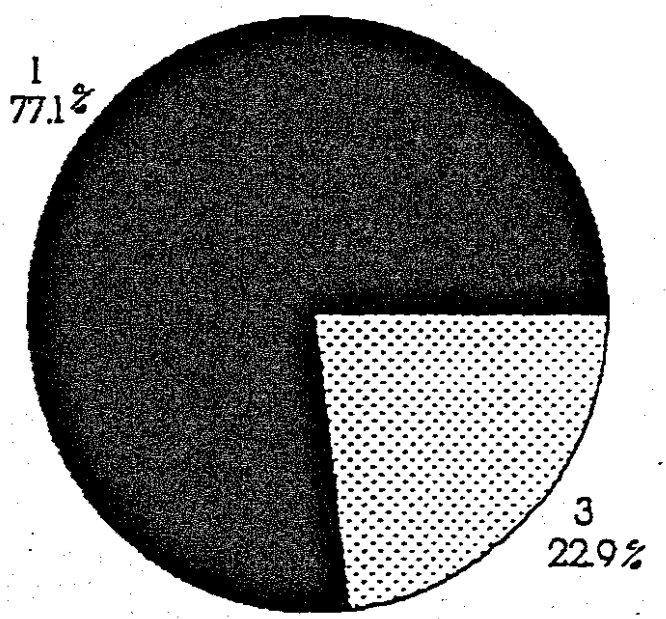
Incidence	First Level Managers		Middle Managers		Top Managers		Total	
	F	%	F	%	F	%	F	%
Very Frequent	19	17.4	5	4.6	10	9.2	34	31.2
Frequent	47	43.1	12	11.0	2	1.9	61	55.9
Seldom	9	8.2	3	2.7	0	0	12	11.0
Never	2	1.9	0	0	0	0	2	1.9
Total	77	70.6	20	18	12	11.0	109	100

Table 7.8 shows that all except 1.9% (2) respondents were aware of the occurrence of nurses' strikes. The majority, 87.1% (95) indicated that nurses' strikes occur frequently while 12% (11) stated that they seldom occur.

ITEM 10 INCREASE OR DECREASE IN THE INCIDENCE OF NURSES' STRIKES IN THE 1990's

This was included to detect the respondents' perceptions on whether nurses' strikes had increased or decreased in the 1990's. A general strike wave has been noted and continuously reported on in the media in South Africa as reported in chapters 2 and 3 of this report.

FIGURE 7.3 INCREASED OR DECREASED INCIDENCE OF NURSES' STRIKES



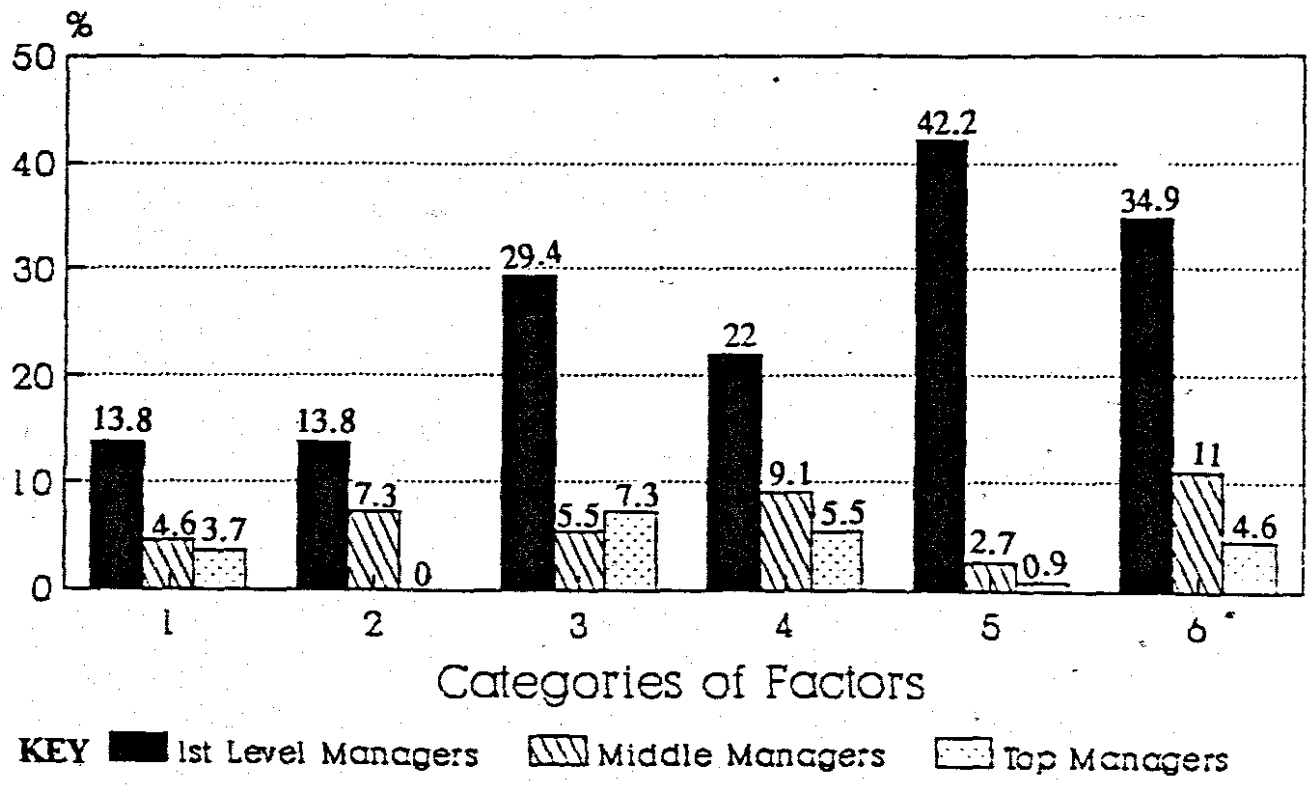
KEY : 1 = Increase
2 = Decrease
3 = No Change

Figure 7.3 indicates that the majority of respondents 77.1% (84) agreed that the incidence of strikes by nursing personnel has increased in the 1990's which shows an awareness of strike activity. None of the respondents indicated a decreased incidence, while 22.9% (25) indicated no change. The majority, 18.3% (20) of those who did not respond were first level managers followed by 3.7% (4) middle managers. Only 0.9% (1) Senior Nursing Service Manager indicated no change.

ITEM 11 FACTORS WHICH HAVE RESULTED IN THE INCREASED INCIDENCE OF STRIKES

It is important to note that the reasons highlighted were given by all respondents in the sample regardless of whether they had experienced strikes or not. Responses reflected the respondents' perceptions of factors that could lead to strikes. In analyzing the responses it was found that they were the same as the reasons given by nursing personnel for the strikes they had experienced in their institutions. Respondents could give more than one answer. Responses given by each respondent ranged from one to eight which indicated sensitivity to the potentiality of strikes. Figure 7.4 presents categories of factors leading to increased incidence of strikes.

FIGURE 7.4 FACTORS LEADING TO INCREASE IN NURSES' STRIKES



Key - 1-6: Categories of factors leading to increase in nurses' strikes presented in Fig 7.4 are explained in the following paragraphs

CATEGORY 1 - SALARY DISSATISFACTION 22.1%(24)

- lack of parity with other races
- no consideration for rising cost of living
- nursing lagging behind other professions in remuneration in spite of grave responsibilities

Pratt and Bennet (1985:307) state that 'pay is the most commonly stated cause of strikes, although it often masks other deep-rooted grievances'

CATEGORY 2 - UNFAIR PROMOTION PRACTICES AND NEPOTISM 13.8%(15)

- Appointment of relatives to senior positions was mentioned by respondents from the first-level manager category only and none of the middle and top level managers. It is important that senior managers take cognisance of this issue as perceived by the first-level managers

CATEGORY 3 -POOR WORKING CONDITIONS 42.2 % (46)

Many aspects were highlighted under this category, including:-

- multiple rigid rules which give little consideration to human rights and freedom of expression. Nurses have no say in decisions affecting them. They expressed the belief that other departments get their needs satisfied through strikes.
- staff shortages leading to long hours of duty and overwork, resulting in job dissatisfaction

CATEGORY 4 - POLITICAL ISSUES AND TRANSITION PROBLEMS 36.6% (40)

- imminent change in government, increased and unrealistic expectations
- ignorance in handling freedom of expression and freedom of association
- lack of understanding of democracy
- integration of different management policies of previously fragmented health services.

CATEGORY 5 - POOR RELATIONS AND POOR MANAGEMENT POLICIES 45.8% (52)

- poor response of authorities to personnel grievances
- bureaucratic management - too long communication lines
- lack of or unknown negotiation structures
- poor problem solving skills
- non-assertive managers versus assertive and sometimes aggressive younger professionals
- fraud and corruption in management

CATEGORY 6 - OTHER RESPONSES 50.5% (55)

In this categories miscellaneous responses were grouped together, including:-

- lack of commitment: nursing no longer a calling
- untrained workers' committees misleading members
- increased awareness of rights
- media influence or other outside forces eg.
  - television programmes creating awareness of strikes
  - influence of overseas strikes
  - influence of strikes in other employment sectors
- poor knowledge of labour relations
- nurses allowed to join unions and allowed to strike
- students previously involved in strikes brought strike attitude from schools into nursing
- perceived failure of professional associations to represent nurses.

Responses to this item indicate that there is a wide diversity of factors that nurse managers perceive as being responsible for the increase in nurses' strikes. There is a correlation between responses given by nurse managers and those given by nursing personnel as reasons for the strikes they experienced. (Chapter 6:75-77)

ITEM 12 HEALTH SERVICES MORE PRONE TO STRIKES BY NURSING PERSONNEL IN THE KWAZULU - NATAL PROVINCE

This variable was included to test if some health services were perceived to be more prone to nurses' strikes than others. This further tests the level of awareness of the occurrence of nurses' strikes. Responses to this item are reflected in table 7.7

TABLE 7.7 HEALTH SERVICES MORE PRONE TO NURSES' STRIKES

Type of Health service	First Level Manager		Middle Manager		Top Manager		Total	
N=109	F	%	F	%	F	%	F	%
Private Hospitals	0		0		0		0	
KwaZulu-Natal Prov. hospitals	35	32.1	8	7.3	6	5.5	49	44.9
Big hospitals (500+beds)	39	35.8	5	4.6	5	4.6	49	44.9
Small hospitals (Less than 500 beds)	1	0.9	1	0.9	0	0	2	1.9
Rural Hospitals	6	5.5	0	0	0	0	6	5.5
Urban Hospitals	28	25.7	9	8.3	8	7.3	45	41.3

(Respondents could give more than one answer)

The types of health services perceived by the majority of respondents to be more prone to nurses' strikes were the KwaZulu-Natal Province hospitals 44.9% (49) big hospitals of 500 beds and over 44.9% (49) and urban hospitals 41.3% (45). Pratt and Bennet (1989:307-310) maintain that most theories do not explain strike proneness adequately but it has been suggested through some studies in the United Kingdom that the larger work group with a wider span of control of the supervisor has more potential for industrial action. Therefore

small enterprises are seen to be less prone to strikes than bigger ones which supports the findings above. No respondent identified private hospitals as being prone to nurses' strikes.

ITEM 13 RESPONSIBILITY FOR ISSUES THAT LEAD TO NURSES' STRIKES

The variable was included to test nurse manager's perceptions of whom they saw as being responsible for issues that lead to nurses' strikes.

TABLE 7.10 RESPONSIBILITY FOR ISSUES THAT LEAD TO NURSES' STRIKES

Responsibility	First level Managers		Middle Managers		Top Managers		Total	
	F	%	F	%	F	%	F	%
Employing authorities	63	57.8	13	11.9	6	5.5	82	75.2
Top management	35	32.1	4	3.7	7	6.4	46	42.2
1st level Supervision	1	0.9	0	0	0	0	1	0.9
Other Nurses	1	0.9	2	1.9	0	0	1	0.9
Other	1	0.9	4	3.7	0	0	5	4.9

(Respondents could give more than one answer)

Table 7.10 reflects that employing authorities were believed to be responsible for issues leading to nurses' strikes by the majority, 75.2% (82) of respondents. This is in line with the fact that it is the employer who determines employment policies, especially salary structures and working conditions. 42.8% (46) respondents referred to top management. Of these respondents, 34.9% (38) referred to both employing authorities and top management. First-level supervisors and other nurses were mentioned by 0.9% (1) only and other nurses were mentioned by 1.9%(2) respondents. In the 'other' category it was only trade unions which were mentioned by 4.9% (5) respondents. These responses showed a correlation with reasons for strikes given by nursing personnel which highlighted employer and management related issues (chapter 6: 75-76)

ITEM 14 THE NURSES' RIGHT TO STRIKE

In this item respondents were requested to give their own opinion on the nurses right to strike. There are conflicting views on this issue because of its implications for patient care. While some members of the public and other health personnel are opposed to this right, others hold the view that nurses are also people with rights, feelings and needs to be satisfied and can react by withholding their labour when they feel that their rights are severely violated. Knowledge of nurse manager's opinions on this is important because of the role they play in formulation and interpretation of policy.

TABLE 7.11 OPINIONS ON THE NURSES RIGHT TO STRIKE

N=109

Opinion on right to strike	First level Managers		Middle Managers		Top Managers		Total	
	F	%	F	%	F	%	F	%
Yes	36	33	4	3.6	6	5.5	46	42.2
No	39	35.8	16	14.7	6	5.5	61	55.9
No response	2	1.9	0		0		2	1.9
	77	70.7	20	18.3	12	11	109	100

According to table 7.11 nurse managers were divided in their opinions on the nurses' right to strike. The majority, 55.9% (61) of respondents supported this right while 42.2% (46) were opposed to it. 33% (36) first-level managers supported the nurses' right to strike while 35.8% (39) did not support it. The majority of middle managers 14.7% (16) did not support the nurses' right to strike while only a few of them, 3.6% (4) supported it. Top managers were equally divided on this issue as demonstrated by 5.5% (6) who supported and 5.5%(6) who opposed the nurses right to strike.

The findings that 42.2% (46) supported the nurses' right to strike could pose a problem for patient care especially in a situation where strategic plans for patient care have not been

made. The lack of shared opinions on the nurses' right to strike could create conflicts in decision-making regarding nurses striking.

ITEM 15 HOW NURSES SHOULD EXPRESS THEIR DISSATISFACTION IF THEY DO NOT HAVE THE RIGHT TO STRIKE

The 55.9% (61) respondents who did not support the nurses' right to strike were expected to give their views on how nurses should express their dissatisfaction.

The strategies suggested by the majority of respondents 51.4% (53) centered around negotiations which included

- collective bargaining through recognised crisis committees
- following correct channels of communication and proper grievance procedures
- forwarding minor complaints to management before they became major grievances
- nurses to be allowed direct access to management and employing authority
- holding regular meetings and discussion groups
- creating forums of nurses only to represent nurses at local, regional and national levels
- writing memoranda and petitions to management if grievances are not attended to

A report in the Business Times section of the Sunday Times newspaper indicated that worker forums were considered as important in the 1995 Labour Bill to facilitate negotiation at the functional units (plant level) so that worker problems and grievances could receive prompt attention (Davie, 1994 February 5:1).

Responses from 7.3% (8) of first level managers suggested that nurses should use their professional associations as a mouth piece while a minority of 2.8% (3) suggested that nurses should act according to South African Nursing Council regulations. One respondent 0.9% (1), a Nursing Service Manager, suggested that the professional association should have a union wing. One other respondent 0.9% (1), a middle manager, suggested that nurses could make demonstrations in turns during their free time so that patient care is not interrupted. The strategy of negotiations was also considered an important alternative option to nurses'

strikes by 50% (78) of the nursing personnel. Protest marches by nurses who are off duty were also suggested by 34% (53) of the nursing personnel (chapter 6, item6:92) It is therefore noted that both nursing personnel and nurse managers see negotiations as a way of minimising or dealing with strikes.

ITEM 16 CONSEQUENCES OF STRIKES BY NURSING PERSONNEL

In this item respondents were to indicate the consequences or effects of nurses' strikes on patients, the community, employing authority, management, nursing personnel and the nursing profession. A minority 1.9% (2) identified positive effects of job satisfaction because grievances are attended to, change of undesirable policies and practices as well as improved working conditions. One other respondent 0.9% (1) indicated that there is nothing wrong with strikes because patients do not suffer if the strikes are well organised. The rest of the respondents 97.2% (106) indicated negative consequences as shown in tables 7.12 - 7.17.

TABLE 7.12 CONSEQUENCES ON PATIENTS

Consequences of Strikes	First Level Managers		Middle Managers		Top Managers		Total	
N=109	F	%	F	%	F	%	F	%
- Patient neglect,suffering and threat to their lives	74	67.9	20	18.3	12	11	106	97.2
- Increased No. of deaths	24	22	16	14.7	7	6.4	47	43.1
- Psychological trauma	4	3.7	6	5.5	2	1.8	12	11.0
- Relapses and prolonged hospitalisation	3	2.8	0	0	0	4.6	3	2.8
- Deterioration due to delayed treatment	3	2.8	1	0.9	5	0.9	8	7.3
- Risks and inconvenience when transferred to other hospitals-lost to family	3	2.8	0	0	1	3.7	4	3.6
- Poor nurse-patient relationship	2	1.8	1	0.9	4	3.7	6	5.5

(Respondents could give more than one response)

According to table 7.12 97.2% (106) respondents indicated that patients suffer and have

their lives threatened because of neglect while 43.1% (47) also referred to increased deaths. The nurse managers showed more concern for patient suffering which was mentioned by only 34.9% (26) out of nursing personnel (Chapter 6, table 6.8:80). The other responses represented in this table were a further indication of negative consequences of nurses' strikes on patient care which further confirms the challenge for nurse managers to minimise the need to strike.

TABLE 7.13 CONSEQUENCES ON THE COMMUNITY

Consequences	First Level Managers		Middle Managers		Top Managers		Total	
N=109	F	%	F	%	F	%	F	%
Suffering-denied a service and the right to nursing care	78	71.6	6	5.5	10	9.2	94	86.2
Mistrust,lack of confidence and respect for nurses-poor image	65	59.6	12	11	9	8.3	86	78.9
High morbidity and mortality rates	3	2.8	3	2.8	6	5.5	12	11.0
Frustration, anger and confusion	9	8.3	4	3.6	3	2.8	16	14.6
Insecurity and concern in having to nurse their sick at home	1	0.9	4	3.6	0	0	5	4.6
Inconvenience - trying to locate relatives	2	1.9	0	0	1	0.9	3	2.8

(Respondents could give more than one response)

Table 7.12 indicates that violation of the community's right to nursing care and poor image and mistrust in nurses were considered the most important negative consequences by 86.2% (94) and 78.9% (86) respondents resrectively. The responses of the nurse managers are in line with Searle and Pera's views (1992:109) that nurses have a social contract with society and professionals who serve in the health field must do so ethically.

TABLE 7.14 CONSEQUENCES ON THE EMPLOYING AUTHORITY

Consequences	First level Manager		Middle Manager		Top Manager		Total	
N=109	F	%	F	%	F	%	F	%
Economic implications	68	62.4	17	15.6	11	10.1	96	88.1
Problems in recruitment due to stigma attached to the hospital	4	3.6	4	3.6	6	5.5	14	12.8
Breakdown of authority, confusion if no pre-warning, intimidation	41	37.6	15	13.8	12	11	68	62.4
Objectives not achieved	3	2.8	6	5.5	5	4.6	14	12.8
Poor image and humiliation	0	0	2	1.8	6	5.5	8	7.3
Breach of contract : can be sued	0	0	5	4.6	9	8.3	14	12.8
Neglect of work to address strike issue	0	0	1	0.9	3	2.8	4	3.6
Forced to change their strategies	1	0.9	0	0	2	1.8	3	2.8

(Respondents could give more than one answer)

Economic implications of nurses' strike were identified by 88.1 % (96) of respondents. These were said to include:-

- getting alternative help or paying other hospitals which take over patients.
- loss of equipment, supplies and destruction of physical facilities
- authorities forced to pay strikers for time not worked
- high staff turnover

62.4 % (68) respondents identified breakdown of authority because authorities are intimidated and cannot maintain control due to fear for their lives. More of the top managers, 5.5 % (6), than middle managers 1.8% (2) were concerned with poor image of the hospital, breach of contract for which they could be sued as well as neglect of work while addressing the strike issues.

TABLE 7.15 CONSEQUENCES ON MANAGEMENT

Consequences	First level Managers		Middle Managers		Top Managers		Total	
N=109	F	%	F	%	F	%	F	%
Psychological trauma	64	58.7	9	8.3	11	10.1	84	77.1
Stress,frustration,embarrassment and guilt	32	29.4	6	5.5	10	9.2	48	44
Insecurity - feel abandoned and criticised by employer,personnel and the public	5	4.6	4	3.6	9	8.3	18	16.5
Unable to achieve objectives	16	14.7	4	3.6	8	7.3	28	25.7
Mistrust in personnel	4	3.6	2	1.8	4	3.6	10	9.2
Harassed by workers,loss of respect and control	12	11	4	3.6	5	4.6	21	19.3
Deterioration of interpersonal relations	2	1.8	2	1.8	6	5.5	10	9.2
Overwork-dealing with strike and providing patient care	26	23.9	12	0	4	3.6	42	38.5
Crisis management challenge	0	0	**0**	11	4	3.6	4	3.6

(Respondents could give more than one response)

The majority 77.1% (84) of respondents referred to psychological trauma. This can be related to the other consequences mentioned, for example, failure to attain objectives of the institution which is their ultimate responsibility and accountability. 16.5% (18) of respondents stated that managers felt abandoned during strikes as they were criticised by the employers they represent, the personnel that they manage and the patients or the public that they serve. Poor interpersonal relations are an important concern because it leads to breakdown in communication. It was a minority of the top managers, 3.5% (4) who highlighted the challenge of crisis management which makes it impossible to manage the hospital and personnel according to plans.

TABLE 7.16 CONSEQUENCES ON NURSING PERSONNEL

Consequences N=109	First Level Manager		Middle Manager		Top Managers		Total	
	F	%	F	%	F	%	F	%
Friction and hostility amongst themselves and towards management	58	53.2	6	5.5	7	6.4	71	65.1
Frustration over objectives of strikes not achieved and unfulfilled promises	21	19.3	0	0	1	0.9	22	20.2
More problems created	3	2.8	1	0.9	4	3.7	8	7.3
Loss of professionalism-subject to SANC discipline	2	1.8	2	1.8	65	5.5	10	9.2
Burnout, low self-esteem,high staff turnover	4	3.7	3	2.8	2	4.6	12	11
Intimidation,loss of lives or property	18	16.5	1	0.9	2	1.8	21	19.3
Aggression due to anxiety, fear and insecurity	2	1.8	0	0	2	1.8	4	3.7
Concern about loss of job and salary	15	13.8	2	1.8	0	0	17	15.6
Nurses from strike-hit hospitals unemployable	5	4.6	2	1.8	0	0	7	6.4
Pressure and overwork on remaining nurses	12	11	7	6.4	2	1.8	21	19.3

(Respondents could give more than one response)

Friction and hostility was mentioned by the majority of respondents, 65.1% (71). All the responses indicated dissatisfaction with consequences of strikes which could have short and long term adverse effects.

TABLE 7.17 CONSEQUENCES ON THE NURSING PROFESSION

Consequences	First Level Managers		Middle Managers		Top Managers		Total	
N=109	F	%	F	%	F	%	F	%
Disgrace and spoiled reputation of the profession	45	4.1	6	5.5	9	8.3	60	55
Lowered standards of nursing	27	24.7	8	7.3	10	9.2	45	41.3
Loss of faith and interest in the profession resulting in recruitment problems	1	0.9	5	4.6	5	4.6	11	10.1
Contradiction of code of conduct	1	0.9	0	0	1	0.9	2	1.9
Despised by other professions	2	1.9	0	0	0	0	2	1.9
Politicisation of the profession	0	0	0	0	2	1.9	2	1.9
Need for restructuring the profession	3	2.8	0	0	0	0	3	2.8

(Respondents could give more than one response)

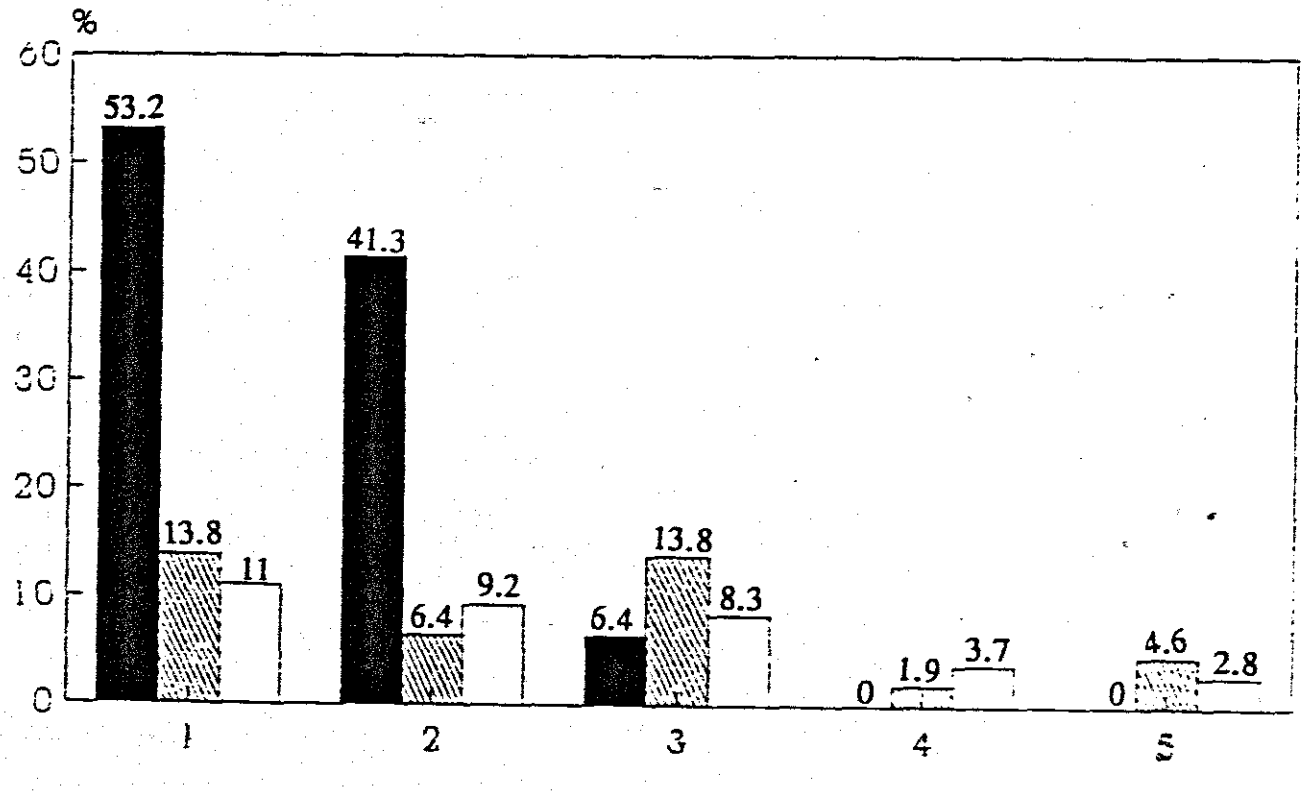
The majority of resepondents, 55% (60) identified disgrace and spoiled reputation of the profession if nurses strike. Lowered standards of nursing were identified by 41.3% (45) of respondents from all management levels. Recruitment problems due to loss of faith in the profession was indicated by 10.1% (11) of the respondents. This has implications for nursing standards in the future as these can be maintained only if the right quality of people are recruited into the profession.

Responses to item 16 showed that nurse managers at various levels were aware of the negative effects of nurses' strikes. These responses highlighted that all categories of providers and consumers of health care are adversly affected. This further confirms the challenge of minimising or preventing the need to strike by controlling the factors mentioned in item 11 of this chapter as leading to strike action. The consequences highlighted correspond with those mentioned by nursing personnel who had experienced strikes in their hospitals (chapter 6, item 11:79-80)

ITEM 17 OPINIONS ON WHAT CAN BE DONE TO MINIMISE NURSES' STRIKES

It is important to note the strategies that nurse managers see as important in minimising strikes so that these are considered in policy formulation and designing of work procedures for nursing services.

FIGURE 7.5 STRATEGIES TO MINIMISE OR PREVENT NURSES' STRIKES



Key to categories of strategies to minimise nurses' strikes as presented in figure 7.5.

CATEGORY 1 : GOOD WORKING CONDITIONS 78% (85)

Aspects highlighted in this category included:-

- good salaries, parity, matching with cost of living
- attending to personnel needs and problems promptly
- good working hours, include flexitime
- no favouritism, fair promotions, consistency
- adherence to code of conduct and policies, no corruption by managers and staff officers
- incentives and recognition of additional qualifications and the nurses' hard work
- adequate staff, equipment and supplies

These findings highlighted the need for urgent review and improvement of working conditions

CATEGORY 2 - EFFECTIVE COMMUNICATION 56.9% (62)

This included:-

- open lines of communication/open door policy
- transparency regarding rules and regulations, policies and expectations
- regular consultation between management and personnel
- thorough investigation of all minor complaints
- management to have a listening ear and a sensitivity
- employer/employee committees or forums
- follow correct grievance procedure

These responses highlighted dissatisfaction with communication practices in nursing services

CATEGORY 3 - FREEDOM OF ASSOCIATION 28.5% (31)

Respondents were divided on who should represent nurses. 14.8% (16) suggested that nurses should not join trade unions but must be represented only by their Professional Associations, attend Professional Association meetings and forward their grievances. 3.7% (4) suggested representation by nurses at parliamentary level. Others, 13.8% (16) suggested that there be no representation by Professional Associations because they are biased and nurses must be free to join any organisation of their choice.

CATEGORY 4 - RESEARCH ON NURSES' PROBLEMS 5.6% (6)

It was noted that only senior nurse managers expressed a need for research so as to gain more insight into nurses problems as indicated by 1.9% (2) of middle and 3.7% (4) of top managers. None of the first level managers indicated a need for such research.

CATEGORY 5 - TEACHING INDUSTRIAL RELATIONS TO ALL CATEGORIES OF NURSES 7.4% (8)

Responses indicate that none of the first level managers saw the need to teach nurses industrial relations. 4.6% (5) of middle managers and 2.8% (3) of top managers indicated this need and stated that all categories of nurses should be taught. The first level manager is an important linkage between management and personnel in the functional area. She should therefore be concerned with obtaining knowledge on industrial relations in order to facilitate personnel management at unit or departmental level.

The strategies suggested by nurse managers in this section show a correlation with strategies for prevention of strikes suggested by nursing personnel in their additional comments on strikes (table 6.12, 6:97-98)

ITEM 18 VIEWS ON DISCIPLINARY ACTION BY SOUTH AFRICAN NURSING COUNCIL (SANC) FOR NEGLECT OF PATIENTS DURING NURSES' STRIKES

Kotze (1991) emphasized that striking nurses would continue to be disciplined, not for striking but for neglecting patients whilst involved in strikes. This item aimed at testing nurse managers' views on this.

TABLE 7.18 NEED FOR SOUTH AFRICAN NURSING COUNCIL (SANC) DISCIPLINE OF STRIKING NURSES

Need for discipline	First Level Manager		Middle Manager		Top Manager		Total	
N=109	F	%	F	%	F	%	F	%
Yes	33	30.3	18	16.5	11	10.1	62	56.9
No	40	36.7	1	0.9	0	0	41	37.6
No response	4	3.7	1	0.9	1	0.9	6	5.5
Total	77	70.7	20	18.3	12	11.0	109	100

Table 7.18 indicates that the majority of nurse managers 56.9% (62) supported while 37.6% (41) did no support the practice of SANC discipline of nursing staff for neglect of patients during strikes. 5.5% (6) of the nurse managers did not respond. The majority of top managers, 10.1% (11) supported SANC discipline while .09% (1) did not support it, 16.5% (18) middle managers supported while 0.9% (1) did not support SANC discipline. It was the first level managers who were divided on this issue as 30.1% (33) supported and 36.7% (40) did not support it.

The need for SANC discipline was supported for the following reasons:-

- failure to comply with rules and regulations of SANC
- breach of contract
- patient neglect is a crime and SANC is a watchdog for the public
- protection of public image
- violation of the nurses' pledge

Some responses indicated support of discipline only under certain conditions, including:-

- must follow a thorough investigation, to discipline only if found guilty
- only if strike more than 2 days
- only if proper channels not followed and only if illegal strikes

- only if strike not organised well to enable proper patient care
- to discipline only those who started the strike, not those who were forced to join
- managers must weigh facts before reporting to SANC

According to the findings opposition to SANC discipline was based on the following reasons:-

- the 'no-strike' clause has been removed from the Nursing Act.
- discipline solves no problem, strikes continue in spite of it
- SANC should not use patients as a shield to destroy nurses, it should care about nurses' welfare and have input into nurses' salary decisions.
- SANC should provide a strong union wing to prevent nurses being misled by non professional unions
- SANC should go to the institution during the strike, find the cause and deal with it, not to wait for the consequences
- nobody likes to strike, discipline adds more stress to already frustrated nurses
- SANC had shown no interest in nurses' problems except to discipline them. It was perceived as an oppressor formed during apartheid policy
- rather do extensive research to find out why nurses strike.

These findings indicate that the first level managers had many reasons for their opposition to SANC discipline and felt it would not stop nurses' strikes. Nursing personnel were also divided on this issue because 46% (71) supported and 54% (84) were opposed to SANC discipline (Table 6.11, chapter 6:94)

SECTION 3 PERSONAL EXPERIENCE OF STRIKES BY NURSING PERSONNEL

This section was intended to detect whether or not respondents had experienced strikes either through threatening strikes, personal involvement or by working in a hospital with strikes. It was different from section 2 where awareness was investigated irrespective of whether or not respondents had experienced strikes.

ITEM 19 THREATENING STRIKE(S) IN THE HOSPITAL

In this item respondents were asked to indicate their awareness of any threatening nurses' strike which was prevented from becoming an actual strike. It is assumed that, because of the undesirability and the negative consequences of strikes, steps should be taken to prevent threatening strikes from becoming actual strikes. According to Rycroft and Jordaan (1990:206) a threat of a strike"ensures that the employer will bargain more fairly " and therefore nurse managers who are alert to threatening strikes are challenged to promptly take steps to prevent the actual occurrence of strikes by finding and removing the cause of the strikes and negotiating fairly. Table 7.19 presents responses to awareness of threatening strikes in the hospitals.

TABLE 7.19 AWARENESS OF THREATENING STRIKES(S)

N-109

Threatening strike(s)	First Level Managers		Middle Managers		Top Managers		Total	
	F	%	F	%	F	%	F	%
Yes	16	14,6	7	6,4	6	5,5	29	26,6
No	53	48,6	11	10,1	3	2,8	67	61,5
No response	8	7,3	2	1,9	3	2,8	13	11,9
Total	77	70,7	20	18,3	12	11,0	109	100,0

Table 7.19 indicates that the majority of respondents 61,5% (67) were not aware of any threatening strikes by nursing personnel in their hospitals. It was a minority 26,6%(29) who were aware of threatening strikes which did not become actual strikes. Positive and negative responses came from respondents in hospitals which had or had not been involved in strikes by nursing personnel. Those who did not respond were noted to be in hospitals which did not have strikes.

ITEM 20 HOW THE THREATENING STRIKE(S) WAS PREVENTED FROM BECOMING AN ACTUAL STRIKE (S)

The 26,6% (29) of respondents who had indicated awareness of threatening strikes were expected to respond to this item. Responses from the three levels of nurse managers is presented in table 7.20.

TABLE 7.20. MEASURES TAKEN TO PREVENT THREATENING STRIKE(S) BECOMING ACTUAL STRIKE(S)

Responses N=29	Frequency	%
General staff meeting called, staff addressed by officer from employing authority	5	17,2
Negotiations started and need for strike obviated	9	31,03
Unfulfilled promises fulfilled	6	20,7
Quick intervention by Hospital Management Committee	5	17,2
Worker committees formed	3	10,3
Security deployed	4	13,8
No responses	8	27,6

(Respondents could give more than one response)

These findings indicate a wide diversity of measures that were believed to have prevented the strike(s) from occurring. The majority of respondents 31,03% (9) identified negotiations which were initiated thus obviating the need to strike. This was followed by 20,7% (6) of respondents who identified the fulfilment of promises. Intervention of employing authority and of Hospital Management committee was each identified by 17,2% (5) respondents. 27,6% (8) did not respond. This indicated that though they were aware of threatening strikes they were not aware of what prevented occurrence of the strike(s).

ITEM 21 PROACTIVE MEASURES WHICH COULD HAVE BEEN TAKEN TO PREVENT NURSING PERSONNEL FROM THREATENING TO STRIKE

This item was intended to test nurse managers knowledge of proactive steps that could be takes to prevent threatening nurses strikes.

TABLE 7.21 PROACTIVE MEASURES FOR PREVENTION OF NEED FOR THREATENING TO STRIKE

Responses N=109	Frequency	%
Short and long terms planning to prevent crisis management	18	16,5
Timeous salary increments and incentives for achievements	52	47,7
Prompt attention to staff problems and urgent referral to appropriate authority	43	39,4
Feedback to staff on grievances forwarded	10	9,1
Improved communication, flattened hierarchy, more transparency, management readily available to rank and file.	26	23,8
Insight into and prevention of problem-and conflict- creating situations	6	5,5
Urgent staff meetings to clear the grapevine.	12	11
Creating nurses forums	5	4,5
Re-emphasis of nurses commitment to patient care in spite of unfavourable conditions	3	2,7
Adequate health care facilities	10	9,1
Provision of creches and recreation facilities for staff	8	7,3
More attention to staff development on personnel matters	4	3,6
Change in nursing education system with more emphasis on practice than theory to facilitate effectiveness and security	3	2,7

(Respondents could give more than one response)

The majority of respondents 47,7% (52) made reference to timeous salary increments and incentives for achievements. Of these the majority 41,3% (45) were first level managers 4,6 % (5) were middle managers and 1,8% (2) were top managers. This indicates that salary dissatisfaction is an important issue to personnel at the lower levels of nursing hierarchies because it was also identified by the majority of nursing personnel 67% (43) as one of the reasons for strikes which occurred in the hospitals (Chapter 6:75).

39,4% (43) identified prompt attention to personnel problems and 23,8% (26) referred to

improvement in communication which could result in more transparency of management to the rank and file. 11% (12) highlighted a need to clear the grapevine through urgent staff meetings.

The diversity of responses indicates that nurse managers are aware of weaknesses in management which need to be attended to or improved in order to prevent a need for nurses threatening to strike. These findings are supported by Quick and Quick (1984:147) who state that good managers are proactive rather than reactive. They take steps to prevent undesirable behaviour rather than react to such behaviour when it has occurred. These authors maintain that this primary prevention is achieved through timeous modification of organisational stressors before they lead to "distress". Quick and Quick (1984) also state that successful prevention depends on the nature of the stressor, characteristics of the individual and resources available. This is supported by Roy's Adaptation theory which indicates that if stressors are within the individuals' or groups' adaptation level it is possible to use coping mechanisms to adapt to stress producing situations (Roy & Roberts 1981 : 56-59)

ITEM 22 OCCURRENCE OF STRIKE(S) IN THE HOSPITAL(S)

Respondents were asked to indicate if strikes had occurred in their hospitals. Responses showed that strikes had occurred in two of the four hospitals from which data was obtained, that is Hospitals C and D as indicated by nursing personnel in item 5 (chapter 6:72)

TABLE 7.22 OCCURRENCE OF STRIKES IN HOSPITALS OF RESPONDENTS

Strikes Occurrence	Frequencies	Percentages
Yes	55	50,5
No	54	49,5
Total	109	100,0

The next items (items 23 to 34) were responded to by the 50,5% (55) respondents who had experienced strikes in their hospitals, comprising 34,3% (36) first level managers 11% (12) middle managers and 6,4% (7) top managers. For these items therefore sample is N=55.

ITEM 23. REASONS GIVEN FOR THE STRIKES

In this item nurse managers were to give reasons that were stated for the strikes. It was considered important to test if there was any correlation between the reasons stated by nursing personnel and those stated by nurse managers. In item 13 of this chapter it was noted that 75,2% (82) respondents indicated that employing authorities were responsible for issues leading to strikes while 42,2% (46) referred to top management as responsible. Of these respondents 34,9% (38) referred to both employer and top management.

TABLE 7.23 REASONS GIVEN FOR THE STRIKES WHICH OCCURRED IN THE HOSPITALS

Reasons	First Level Manager		Middle Manager		Top Manager		Total	
N=55	F	%	F	%	F	%	F	%
Uncertainty about pensions after integration of health services post elections	22	40	7	12,7	3	5,4	42	76,3
Salary disparity and low salaries	26	47,3	3	5,4	1	1,8	30	54,5
Tax too high after increments	3	5,4	1	1,8	0	0	4	7,3
Unfulfilled promises:promised increase in salary instead money deducted	32	58,2	6	10,9	1	1,8	39	70,9
Demand for incentive given to personnel who worked during strikes in other employing authorities	12	21,8	0	0	1	1,8	13	23.6
Unfair meriting and delays in giving money for meriting, no feed back after self-evaluation reports	14	25,5	2	3,6	1	1.8	17	30.9
Shortage of human and material resources	28	50,9	5	9,1	5	9,1	38	69
Head Office showing no concern for nurses' problems	6	10,9	3	5,4	4	7,3	13	23.6
Nurses used for non-nursing duties	4	7,3	0	0	0	0	4	7,3
Too much paper work	2	3,6	0	0	0	0	2	3,6
Dissatisfaction and demand for removal of some top managers and staff officers accused of bribery and corruption	11	20	7	12,7	4	7,3	22	40
Unsatisfactory working conditions	30	54,5	10	18,2	3	5,4	43	78,1
Lack of communication	6	10,9	4	7,3	0	0	10	8,2
Unfair release of posts and nepotism	7	12,7	2	3,6	2	3,6	11	20
Conflicts between opposing political parties and insecurity	14	25,5	0	0	0	0	14	25,5
Failure of management to handle grievances	18	32,7	1	1,8	4	7,3	23	41,8

(Respondents could give more than one response)

Table 7.23 presents a list of the reasons indicated by the various levels of managers. Respondents gave a diversity of reasons ranging from one(1) to seven (7) per respondent. First level managers gave more reasons for the strikes compared to the middle and top managers. This can be related to the close interaction of first level managers with personnel at functional or unit levels . They therefore gain more insight into reasons for strikes by nursing personnel. The findings indicate numerous reasons for the strikes. The majority of respondents 78,1% (43) identified unsatisfactory working conditions as reasons for the strikes 76, 3% (42) indicated uncertainty about safety of their pensions during and after change of government 70,9% (39) highlighted unfulfilled promises while 69% (38) identified shortage of human and material resources. Salary dissatisfaction was identified by 54,5% (30) of the respondents. The reasons given show a correlation with those given by nursing personnel in item 9 (chapter 6:78-79) except that salary dissatisfaction was not the reason identified by the highest majority of nurse managers.

ITEM 24 CATEGORIES OF NURSES WHO WERE INVOLVED IN THE STRIKES

All respondents cited Senior Professional Nurse, Professional Nurses, Enrolled Nurses and Enrolled Nursing Auxilliaries as having been involved in the strike while 20 (36,4%) respondents included students and pupil nurses. 22 (40%) respondents from Hospital D indicated that middle managers were also involved. This could be related to closure of the hospital mentioned by nursing personnel (Chapter 6: 84). Other categories included by respondents from both hospitals were general assistants, clerks, porters, laboratory technicians and other workers of ancillary departments.

ITEM 25 NOTIFICATION OF THE STRIKE(S)

In this item respondents were to indicate if there was any notification of the strikes.

TABLE 7.24 NOTIFICATION OF THE STRIKE(S)

Notification	First Level Managers		Middle Managers		Top Managers		Total	
N=55	F	%	F	%	F	%	F	%
Yes	20	36,4	4	7,2	1	1,8	25	45,5
No	10	18,2	6	10,9	6	10,9	22	40,0
Don't Know	2	3,6	1	1,8	0	0	3	5,5
No Response	4	7,2	1	1,8	0	0	5	9,0
Total	36	33	12	21,8	7	12,7	55	100,0

According to table 7.24, 45,5% (25) respondents stated that there was notification of the strikes and 40% (22) stated that there was no notification. 5,5% (3) respondents from the same institution gave different responses to this item. This indicated lack of information disclosure especially because it was more of the first level managers 36,4%(20) who were aware of notification while the majority of the middle and top managers 21,8% (12) stated that there was no notification. 9%(5) of the middle and top managers were aware of the notification. This raised questions of who was notified because it is the higher management levels who should be notified.

ITEM 26 PERIOD OF NOTICE OF STRIKE(S)

There was no agreement on this issue as respondents from the same institutions gave a wide diversity of responses as reflected in table 7.24

TABLE 7.25 PERIOD OF NOTICE OF STRIKE(S)

Period of Notice	First Level Managers		Middle Managers		Top Managers		Total	
N=25	F	%	F	%	F	%	F	%
2 days	1	4	2	8	1	4	4	16
3 days	8	32	1	4	0	0	9	36
4 days	2	8	0	0	0	0	2	8
7 days	2	8	0	0	0	0	2	8
10 days	1	4	0	0	0	0	1	4
3 weeks	2	8	0	0	0	0	2	8
3 months	1	4	0	0	0	0	1	4
No Response	3	12	1	4	0	0	4	16
Total	20	80	4	16	1	4	25	100

There was no correlation on the period of notice of strikes given which suggests lack of consensus on what constitutes a notice of strikes. It was observed that the first level managers stated longer periods while the senior managers indicated only 2 and 3 days. The Public Service Labour Relations Act (105 of 1994) stipulates a minimum 10 days' notice of strikes in the public service.

ITEM 27 VIEWS ON NEED AND IMPORTANCE OF NOTIFICATION OF STRIKES

In this item respondents were to indicate whether or not in their opinion, notification of strikes was essential. It is assumed that potential strikers would notify management if they saw the importance of strike notification.

TABLE 7.26 NEED FOR STRIKE NOTIFICATION

Notification Essential	First Level Managers		Middle Managers		Top Managers		Total	
N=55	F	%	F	%	F	%	F	%
Yes	32	58,1	11	20	7	12,7	50	91,0
No	2	3,6	1	1,8	0	0	3	5,4
No Response	2	3,6	0	0	0	0	2	3,6
Total	36	65,5	12	21,8	7	12,7	55	100,0

Table 7.26 indicates that the majority of respondents 91,0 %(50) stated that notification of strikes is essential and 5,4% (3) stated that it is not essential. 3,6 %(2) did not respond. It was 3,6% (2) of the first level managers 1,8% (1) of the middle managers and none of the top managers who stated that notification of strikes is not essential.

ITEM 28 REASONS WHY NOTIFICATION OF STRIKES IS ESSENTIAL OR NOT ESSENTIAL

The 5,4%(3) repondents who saw no need for strike notification gave the following reasons:-

- other nurses who were not interested could get emotionally involved and decide to join the strike.
- management could get time to try more tricks of victimisation.
- management failed to meet peoples demands therefore if people had decided to go on strike nothing could stop them.

Reasons given by the 91%(50) respondents who supported notification of strikes are given in table 7.27.

TABLE 7.27 REASONS WHY NOTIFICATION OF STRIKES IS ESSENTIAL

N=50	1st Level Managers		Middle Managers		Top Managers		Total	
	F	%	F	%	F	%	F	%
Negotiation to give time for management to respond to grievances give feedback to staff;call for Head Office intervention prevent the strike	26	52	9	18	7	14	42	84
Time for personnel to meet,discuss,agree on causes of the strike and find possible ways of preventing it	2	4	0	0	0	0	2	4
To make alternative plans for patient care eg arrange for skeleton staff and discharge or transfer patients	19	38	2	4	4	8	35	70
"To inform patients relatives	6	12	2	4	3	6	11	22
To check and lock up equipment	5		0	0	0	0	5	10
To get advice and support on how to handle strikes	0	0	1	2	3	6	4	8
To make arrangements to remain in hospital if travelling becomes unsafe	1	2	0	0	0	0	1	2

(Respondents could give more than one response)

Table 7.27 indicates that the need for negotiation was seen as important by the majority 84%9(42) of respondents followed by the need for time to make alternative patient care arrangements which was mentioned by 70%(35) of the respondents.

It was only the first level managers who mentioned the need for personnel to agree on the cause of the strike and possibly find ways of preventing it, the need to lock up equipment and the need to remain available in the hospital. These findings were not in keeping with the higher degree of responsibility for patient care and control or safety of resources expected of senior management.

ITEM 29. THE MOST DIFFICULT OR UNDESIRABLE EXPERIENCES IN THE NURSE MANAGERS WORK DURING THE STRIKE(S)

Managers act as middle men and advocates for both the higher authority the personnel and patients or clients in nursing services. When strikes occur they bear the responsibility of maintaining stability and continuity of the service, whilst ensuring that personnel needs are satisfied and their safety ensured. Their responses ranged from 1 to 3 whereas the responses ranged from 1 to 8 on reasons for the strikes which indicates more concern about causes of strikes than the undesirable consequences.

Undesirable Experience	1st Level Managers		Middle Managers		Top Managers		Total	
N=55	F	%	F	%	F	%	F	%
Lack of authority and direction from management	6	10,9	1	1,8	0	0	7	12,7
Leaving unconscious, bedridden helpless and critically ill patients unattended, increase in death rates	18	32,7	2	3,6	3	5,4	23	41,8
Premature discharges transfer of patients to other hospitals and seeing relatives looking in vain for their relatives	6	10,9	1	1,8	1	1,8	8	14,5
Dirty chaotic environment	11	20	4	7,3	2	3,6	17	30,9
Threats and intimidation of non-strikers	16	29	5	9,1	1	1,8	22	40
Insecurity and danger when travelling to work	12	21,8	2	3,6	0	0	14	25,5
Heavy workloads on remaining personnel, lowered standards of nursing care	19	34,5	3	5,4	1	1,8	23	41,8
Theft of equipment	19	34,5	1	1,8	0	0	20	31,4
Management dominated by politicians	6	10,9	0	0	1	1,8	7	12,7
Concern for no work, no pay	9	16,4	3	5,4	2	3,6	14	25,5
Uncertainty due to protracted period of negotiation	4	7,3	0	0	0	0	4	7,8
Termination of some employees	2	3,6	0	0	0	0	2	3,6
Violation of some employees	0	0	1	1,8	3	5,4	4	7,8
No responses	1	1,8	3	5,4	0	0	4	7,8

(Respondents could give more than one response)

The highest percentage of repondents 41,8 % (23) expressed concern for failure to provide patient care as patients were left unattended without acceptable standards of nursing care. This correlates with their ethical responsibility for the provision of continuous, safe nursing care.

Concern of nurse managers for their own welfare was also expressed by 40 % (22) who stated that they were intimidated by the strikers and 25,5 % (14) who expressed concern about possible salary losses. In support of the latter, clause 19(7) of the Public Service Labour Relations Act (105 of 1994) rules that "No employee shall be remunerated for the period of his or her participation in any strike..." It is further stated by Gerber Nel and van Dyk (1992:395) that managers should react in a manner which is most likely to resolve issues that caused the strike as speedily as possible with no injury nor damage to property. 34,5 % (19) first level managers and 1,8%(1) middle managers expressed concern over theft of equipment.

The undesirable experiences indicated further emphasize the challenge facing nurse managers and employers to develop strategies to minimise or prevent nurses strikes. This challenge is supported by Hein and Nicholson (1986:243) who state that nurse managers or hospital administrators should ensure that their services are not threatened by strikes so that they are not at risk of interruption of their mission which is quality patient care.

The undesirable experiences of nurse managers showed correlation with the adverse effects of strikes expressed by nursing personnel (item 11 chapter 6 :79-80) This showed that nurse managers and nursing personnel share similar perceptions on the adverse effects of strikes.

ITEM 30 PLANNING FOR EFFECTIVE PATIENT CARE DURING STRIKES

This is an issue which calls for urgent attention and expertise in the handling of strikes by nursing personnel. Patients are vulnerable and any omission or delay of required care and treatment can put their lives at risk. Nurse managers therefore need to plan for continuity of patient care in the event of strikes. In this item respondents were to express their views on the adequacy of the plans that were made for effective patient care during the strikes.

TABLE 7.29 ADEQUACY OF PLANS FOR PATIENT CARE DURING STRIKES

Adequate Plans	1st Level Managers		Middle Managers		Top Managers		Total	
N=55	F	%	F	%	F	%	F	%
Yes	16	29,1	8	14,5	1	1,8	25	45,5
No	20	36,4	3	5,4	6	10,9	29	52,7
No Response	0	0	1	1,8	0	0	1	1,8
Total	36	65,5	12	21,7	7	12,7	55	100,0

According to table 7.29 the majority of respondents 52,7% (29) indicated that there were no adequate plans for patient care during strikes while 45,5% (25) stated that there were adequate plans. Amongst the various categories 29,1% (16) first level managers indicated adequate plans while 36,4%(20) indicated no plans. 14,5% (8) of middle managers indicated adequate plan while 5,4 % (3) stated that there were no plans. 1,8% (1) of top Managers indicated adequate plans while 10,9% (6) stated that there were no plans. The latter findings raise concern because it is the top managers who must give direction to these plans since they bear the ultimate responsibility for patient care. These findings can be related to lack of strike notification that the same respondents 10,9% (6) had indicated in (table7.24:139).

ITEM 31 TYPE OF PLANS THAT WERE MADE FOR PATIENT CARE

In this item the 45,5%(25) respondents who had indicated that adequate plans were made for effective patient care were to mention these plans. Table 7.25 presents a summary of these plans.

TABLE 7.30 PLANS MADE FOR PATIENT CARE DURING STRIKES

Plans N=25	First Level Manager		Middle Managers		Top Managers		Total	
	F	%	F	%	F	%	F	%
Re-distributing off duties to provide skeleton staff	10	40	5	20	1	4	16	64
Discharging patients	3	12	2	8	0	0	5	20
Transferring patients to other hospitals	7	28	4	16	1	4	12	48
Patients combined in a few wards	0	0	2	8	0	0	2	8
Nurses to do essential non-nursing duties as well	6	24	1	4	0	0	7	28
24 hour protection of staff by police from the department of safety and security	5	20	1	4	0	0	6	24

According to table 7.29 the plans identified by the respondents correlate with the plans highlighted in various sources of literature to be necessary as indicated in (Chapter 3 :43-44). If these plans were implemented disruption of patient care would have been eliminated or minimised.

The majority of respondents 64% (16) who were aware that alternative plans were made referred to re-distribution of staff to provide skeleton staff which indicates attempts made to ensure continuity of patient care. 28%(7) also made reference to reshuffling duties so that available personnel could do essential non-nursing duties if non-nursing personnel, for

example general assistants, were involved in the strike. Examples given were serving of meals and minimal cleaning of wards. Combining of patients in a few wards was identified by 8%(2) respondents. It was done to enable the few remaining nurses to manage a few wards.

Gerber and Van Dyk (1987:396) advised managers to commend those workers who did not participate in the strike and express appreciation for their loyalty to the enterprise. In 1993 the then Transvaal Provincial Administration showed appreciation to workers who worked during strikes in some of its hospitals by giving them a R 500 bonus. This sparked further problems when personnel in other hospitals demanded this incentive and a further, more complex strike ensued.

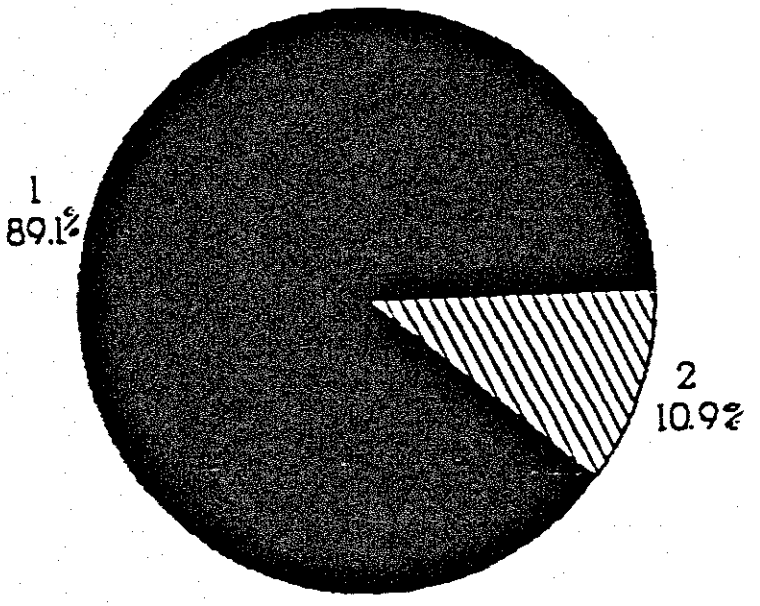
Discharging and transferring patients to other hospitals, mentioned as one of the plans by 20% (5) and 48% (12) respondents respectively was previously highlighted as some of the undesirable experiences of nurse managers during the strikes in item 29. This option should however be used when it becomes impossible to continue nursing care and treatment in the striking hospital. Evacuation of patients should be well planned in consideration of their conditions. This should be done co-operatively by the medical and nursing personnel. Respondents also highlighted that high costs were incurred through paying for patients who were transferred to private hospitals. Some respondents stated that personnel in the non-striking hospitals threatened or later got involved in strikes protesting against receiving and caring for patients from the striking hospitals because this added to their workloads. It is clear therefore that the problem tends to complicate when patients are transferred to other hospitals.

Some respondents, 24% (6) indicated 24-hour protection by police from the Safety and Security department to maintain order and safeguard those who wanted to work against intimidation. Such intimidation was mentioned as one of the undesirable consequences in item 29. Gerber at al (1987:395) state that police involvement should be avoided as much as possible because their presence usually leads to an inflamed situation. However these authors agree that management should liaise with the police and request their intervention if there is violence and intimidation.

ITEM 32 VIEWS ON WHETHER THE STRIKE(S) COULD HAVE BEEN PREVENTED IN ANY WAY

In this item respondents were to indicate if they thought the strikes could have been prevented in any way. Responses to item 21 showed that some threatening strikes were successfully prevented from becoming actual strikes. Responses are presented in Figure 7.6.

FIGURE 7.6 VIEWS ON WHETHER STRIKES COULD HAVE BEEN PREVENTED



KEY: 1 = YES
2 = NO

According to figure 7.6 the majority of respondents, 89,1% (49) stated that the strikes could have been prevented while 10,9% (6) stated that this was not possible. It is vitally important that nurse managers identify strategies which might be taken to prevent ensuing strikes.

ITEM 33. REASONS FOR THINKING THAT THE STRIKES COULD OR COULD NOT HAVE BEEN PREVENTED

TABLE 7.31 WHY STRIKES COULD NOT HAVE BEEN PREVENTED

Response N=55	Frequency	Percentage
No notification therefore the strikes were not expected	2	3,6
Reasons cited for the strikes too general therefore too difficult to address	3	5,5
Difference between legal and illegal strikes not known	2	3,6
Reasons for strikes political eg demanding to be allowed to vote and assurance about safety of pensions	4	7,3
People no longer believed in negotiation	3	5,5
No Response	2	3,6

(Respondents could give more than one response)

The majority of respondents in this category 7,3% (4) expressed a feeling that strikes were politically based and therefore could not be stopped while 5,5 %(3) cited lack of confidence in negotiation and an equal percentage 5,5% (3) stated that it was difficult to negotiate because reasons stated for the strikes were too general.

TABLE 7.32 WAYS IN WHICH THE STRIKES COULD HAVE BEEN PREVENTED

	First Level Managers		Middle Managers		Top Managers		Total	
N=55	F	%	F	%	F	%	F	%
Authorities could have followed the grapevine, called staff meeting and address the grievances promptly	3	5.4	0	0	0	0	3	5.4
Management positive and co-operative to bargaining structures	4	7.3	0	0	0	0	4	7.3
Prompt response by Head Office when notified of grievances and imminent strike	4	7.3	0	0	2	3.6	6	10.9
Personnel with problems to notify their immediate supervisors	1	1.8	0	0	0	0	1	1.8
Workers committees formed of different categories to continue negotiating while the work goes on	2	3.6	3	5.4	2	3.6	7	12.7
Grievances forwarded in writing and deadline given	0	0	2	3.6	0	0	2	3.6
Equal treatment of personnel no nepotism	5	9.1	0	0	0	0	5	9.1
Political groups not allowed to operate in the hospital	6	10.9	0	0	3	5.4	9	16.4
Compromises between management and personnel and -	4	7.3	1	1.8	2	3.6	7	12.7
- between the younger and older generation	2	3.6	0	0	0	0	2	3.6
Attention to salary dissatisfaction and avoid unexpected high deductors	11	20	2	3.6	2	3.6	15	27.3
Nurse managers not to ignore nurses reports of salary dissatisfaction	3	5.4	0	0	0	0	3	5.4

(Respondents could give more than one response)

A wide diversity of strategies that could have been used to prevent the strikes were mentioned but the highest percentage 27,3 % (28) referred to attention to salary dissatisfaction and preventing unexpected high deductions. This is in keeping with the high percentage of respondents among the nurse managers and nursing personnel who indicated salary dissatisfaction as an important cause of strikes. Prompt attention to grievances including addressing the grapevine was also highlighted and might have deterred the nurses from striking. The issue of preventing political parties from operating in the hospital was highlighted by 16,4 %(9) of the respondents. This was seen as significant if one considers the highly volatile political situation in the 1990's during the transition preceding, during and after the government elections.

It was also noted that the strategies mentioned were directed at the employers and management. What management cannot handle, for example salary issues, should be referred promptly to the appropriate authority. Follow up and feedback to staff is of utmost importance when it comes to prevention of strikes.

ITEM 34 EFFECTS OF STRIKES THAT OCCURRED IN THE HOSPITALS

This was a Likert scale item to which respondents had to agree or disagree to statements indicating effects of the strikes. Responses to agree and strongly agree are grouped together as "agree " for analysis and responses to disagree and strongly disagree are grouped together as "disagree".

TABLE 7.33 EFFECTS OF THE STRIKES EXPERIENCED

EFFECTS OF STRIKES	First Level Managers				Middle Managers				Top Managers						Total				Total No. Of	
	Agree		Disagree		Agree		Disagree		Agree		Disagree		No Response		Agree		Disagree		Respondents	
N=55	F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%	F	%
34.1 Patients lives were put at risk during nurses strikes	27	49	9	16,4	11	20	1	1,8	7	12,7	0	0	0	0	45	81,8	10	8,2	55	100
34.2 Patients supported the nurses for their strike action	6	10,9	30	54,5	0	0	12	21,8	1	1,8	5	9,1	1	18	7	12,7	47	85,5	55	100
34.3 The public condemned nurses for striking	25	45,5	9	16,4	9	16,4	2	3,6	5	9,1	1	1,8	4	7,3	39	70,9	12	21,8	55	100
34.4 Some nurses expressed coercion and intimidation as reasons for their participation in the strikes	31	56,4	5	9,1	9	16,4	3	5,4	4	7,3	1	1,8	2	3,6	44	80	9	16,4	55	100
34.5 The nurses appeared to enjoy involvement in the strike	7	12,7	27	49,1	2	3,6	10	18,2	2	3,6	4	7,3	3	5,5	11	20	41	74,5	55	100
34.6 The nurses demands were conceded to as a result of the strike	8	14,5	28	50,9	1	1,8	11	20	2	3,6	5	9,1	0	0	11	20	44	80	55	100
34.7 Relations between management and nursing personnel were strained after the strike	32	58,2	4	7,3	8	14,5	4	7,3	6	10,9	1	1,8	0	0	9	16,4	46	83,6	55	100

(Respondents could give more than one response)

34.1 PATIENTS LIVES WERE PUT AT RISK DURING NURSES STRIKES

The majority of respondents in all categories 81,8% (45) agreed that patients lives were put at risk during the strikes. This was in keeping with the responses to item 29 where the majority 41,8%(23) indicated that their most undesirable experience during the strikes was the suffering and neglect of patients. The same trend was noted in responses of nursing personnel 90%(139) who agreed that the patients suffer more than the employer when nurses strike (item 20.3 Chapter 6).

These findings indicate that nurses of all categories are committed to their ethical responsibility of providing continuous safe patient care. The challenge of preventing or minimising nurses strikes is therefore highlighted. Ncayiyana (1994:2) referred to reports of dire misery and death of patients across the country while nurses had abandoned them in pursuit of better service conditions. He maintains that though nurses have a good cause for striking "no cause can ever be good enough to justify a health care professional walking away from his or her trusting patients leaving them to suffer or die". He suggested that such nurses "ought to be called to book".

34.2 PATIENTS SUPPORTED THE NURSES FOR THEIR STRIKE ACTION

The majority of respondents in all categories 85,5% (47) disagreed that patients supported the nurses for their strike action. It is the patients who suffer therefore it is unlikely that they would support nurses strikes which lead to their suffering. Ncayiyana (1994:2) described striking nurses as abdicating their professionalism whereby they declared publicly their unqualified loyalty to the patients whom they serve.

34.3 THE PUBLIC CONDEMNED NURSES FOR STRIKING

The majority of respondents in all categories 70.9% (39) agreed that the public condemned nurses for striking. There is correlation between responses of 14% (11) of nursing personnel who identified stigma and loss of public trust (Chapter 6:80) and 78.9% (80) nurse managers who identified lack of confidence , mistrust and poor image (Chapter 7:120)

34.4 NURSES EXPRESSED COERCION AND INTIMIDATION AS REASONS FOR THEIR PARTICIPATION IN THE STRIKE

34.4. The majority of respondents 80% (44) agreed that some nurses were coerced and intimidated to join the strikes. In item 15 (Chapter 6) the majority 40 % (10) of nursing personnel expressed fear and intimidation as reasons for their unwilling participation in the strikes. This highlights the challenge facing employers and managers to develop mechanisms for protecting non-striking nurses so that they can continue to provide nursing care.

34.5 THE NURSES APPEARED TO ENJOY INVOLVEMENT IN THE STRIKES

The majority of respondents 80%(44) disagreed that the nurses demands were conceded to as a result of the strikes. 20% (15) of nursing personnel in item 10 (Chapter 6) indicated that there were no benefits gained, however a diversity of responses were given indicating lack of agreement regarding results of the strikes.

34.6. THE NURSES DEMANDS WERE CONCEDED AS A RESULT OF THE STRIKES

The majority of respondents 80% (44) disagreed that nurses' demands were conceded to as a result of the strikes. 20% (15) of nursing personnel in item 10 (Chapter 6) indicated that there were no benefits gained, however a diversity of responses was given indicating lack of agreement regarding results of the strikes.

34.7. RELATIONS BETWEEN MANAGEMENT AND NURSING PERSONNEL

The majority of respondents in all categories 83,6%(46) agreed that relations between nursing personnel and management were strained after the strikes. This is in line with the hostility and mistrust expressed in item 16 of this chapter as consequences of strikes. Gerber et al. (1987:397), while highlighting that managers can do much to prevent strikes and manage strikes when in progress, emphasize that the biggest responsibility starts when the strike is over. Management has to re-establish relations with the workers and the union. It also has

to investigate and eliminate the issues which caused the strike.

ITEM 35 ADDITIONAL COMMENTS ON STRIKES BY NURSING PERSONNEL

This item was included to tap further information which might not have been catered for in the questionnaire. Most of the responses to this item were repetition and further reinforcement of responses to other items in the questionnaire and will therefore not be discussed in this section. Only responses which indicate new information are discussed. Responses were from the total sample of 109 respondents who had, or had not experienced strikes.

TABLE 7.34 ADDITIONAL COMMENTS ON STRIKES BY NURSING PERSONNEL

N=55	Frequencies	%
Management should stop general assistants strikes because:	16	14,8
-they are just as disruptive to patient care		
-nurses have to do general assistants' work		
-nurses are forced to join general assistants' strikes		
Strikes have long-term demoralising effects	9	8,2
Strikes should never go on for more than 7 days	3	2,7
Strikes will continue if management and employers persist in neglecting nurses needs and problems	12	11,0
Scientific planning of strikes so that only one portion of the hospital goes on strike at a time	4	3,6
Professionalism must be maintained even during strikes	8	7,3
No responses	21	19,3

(Respondents could give more than one response)

The findings showed that 14 out of 16 respondents who expressed concern about general assistants' strikes came from one hospital which was said to have had strikes by general assistants and no nurses' strikes. This emphasizes to challenge for nurse managers and employees to strive to maintain overall stability because of the importance of the multidisciplinary team approach in nursing services. It was also highlighted that strikes would continue if management and employers continued to neglect nurses' needs and problems.

7.5 CONCLUSION

In this chapter information on strikes obtained from nurse managers has been analysed. Although differences of opinions were marked, there was more correlation on many aspects between nurse managers at various levels. The analysis also revealed shared perceptions with nursing personnel on more aspects of strikes, for example, causes and consequences as well as need and ways of preventing strikes.

In chapter eight (8) a summary, conclusions drawn from these findings, limitations and recommendations will be presented.

CHAPTER EIGHT

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

This study examines strikes by nursing personnel as a challenge for the nurse manager. Literature consulted confirmed that this is a problem on which people, including providers and consumers of health care, hold conflicting views either in support or opposition to nurses' strikes. Various nursing and non-nursing authors address the challenges facing employing authorities and management in preventing or minimising strikes because they result in varying degrees of disruption of health services.

8.2 SUMMARY

A descriptive study was conducted in selected hospitals in KwaZulu- Natal Province. The subjects comprised nursing personnel of various categories and nurse managers. It was considered important to include both groups to prevent the bias which might be introduced if only one of these groups was included in the sample.

Objectives of the study were:-

-To identify reasons for nurses' involvement in the strikes.
-to detect nurse managers' views on strikes by nursing personnel.
-to detect nurse managers' views on effects of strikes by nursing personnel
-to identify the role of the nurse manager in minimising the need to strike
-to determine the degree of preparedness for continuation of patient care during strikes of nursing personnel.

Objectives of the study were achieved as it is indicated in the section on conclusions. Conclusions are discussed according to assumptions made in chapter one of this report.

8.3 CONCLUSIONS

8.3.1 ASSUMPTION 1

'Nurses in South Africa are increasingly getting involved in strike action, particularly in the 1990's.'

Findings indicated that the majority of nurse managers 77.1% (84) were aware of the increasing incidence of nurses' strikes in the 1990's in South Africa. Responses from nursing personnel in Hospital C, indicated that strikes had occurred in 1990, 1993 and 1994. In Hospital D strikes had occurred in 1990 and 1994. Duration of the strikes ranged from 6 days to 2.5 months.

On the basis of these findings it was concluded that nurses' strikes are occurring with increasing frequency in the 1990's, that is from 1990 to 1994 when the data for the study was collected. The strikes involved large numbers of nurses in various categories. Some strikes lasted for long periods of two or two and a half months (2 or 2.5) months and in other cases resulted in total closure of the hospitals. Pratt and Bennett (1989:305) refer to strikes of long duration, that is, several weeks to months, as a 'trial of strength' where the employee attempts to establish his rights while the employer jealously defends his prerogatives.

According to these findings assumption one was confirmed.

8.3.2 ASSUMPTION 2

'The majority of nurses in South Africa are against strikes but are forced to adopt the strike strategy because of employer and management policies which they perceive as unfair.'

The majority of nursing personnel 75% (57) participated in the strikes. This included both the professional and sub-professional categories. Of these respondents 42%(32) indicated

that they participated willingly while 33% (25) indicated unwilling participation. Based on these findings the researcher concluded that there was no consensus amongst nurses on the use of the strike strategy. The main reason cited for unwilling participation was fear and intimidation. From this it was deduced that those 33% (25) nurses could have joined the 25% (19) who did not strike because of their commitment to uninterrupted patient care. These findings are supported by Uys (1992:35) who states that nurses consistently claim that they were intimidated to join the strike. She suggests that it would be ideal if nurses who do not want to strike are made part of the skeleton staff that maintains essential services.

This might lessen their feelings of depression and guilt after strikes expressed by 58.8% (39) respondents in item 1 (Chapter 7:86) and supported by Makunga (Chapter 3:45). It was also concluded that nurses are divided on their right to strike. Amongst the nursing personnel 50.4% (78) disagreed while 49.6% (77) agreed with the nurses' right to strike. Amongst the nurse managers 55,9% (61) disagreed while 42.2% (46) agreed with this right. It is important to consider the nurses' right to freedom of expression , however there should be consensus or the nurses' right to strike. This would lead to consistency in policies and procedures. It would also prevent the confusion created by lack of consensus on the right to strike. From these findings it is clear that nurses in the KwaZulu-Natal province, as indicated by those employed in hospitals under study, are divided on whether they should strike or not.

When asked for additional comments, both nursing personnel and nurse managers were divided in their views on nurses' strikes. Some indicated that strikes by nursing personnel must be prevented at all costs while others indicated that strikes would continue if employers and managers continued to neglect nurses' needs and grievances. These views are supported by Gerber et al (1989:305) who emphasize the importance of satisfaction of personnel needs according to Maslows Hierarchy of needs. According to these authors one of the implications of Maslow's theory is a need for workers to control their environment so that they can manipulate it in accordance with their needs. If they feel controlled by the environment and thwarted in satisfaction of their needs they become frustrated and vulnerable to undesirable employee behaviours which include strike action.

From these findings it was concluded that strikes would be preventable if employers and managers showed sensitivity to personnel needs or problem and communicated openly and timeously when certain needs could not be satisfied. Compromises that are acceptable to both nursing personnel and management could then be worked out.

The study revealed that employing authorities were perceived by 75.2% (82) of nurse managers as being responsible for issues that lead to nurses strikes while 42,9% (49) respondents referred to top management. Responses from both nurse managers and nursing personnel highlighted employer and management-related issues as reasons for strikes. Regarding salary dissatisfaction it was deduced from the findings that top managers are not as grossly affected by this factor as the lower categories because, out of 54.5% (30) of nurse managers who referred to it as one of the causes of the strikes only 1.8% (1) top manager referred to it and the majority 47.3% (26) were first level managers. Amongst the nursing personnel salary dissatisfaction was indicated by the majority 67% (88) of respondents. This calls for urgent thorough analysis of nursing personnel salary structures especially those in clinical situations.

The issue of uncertainty about the future was indicated as an important transitional problem related to imminent changes in government which led to fear of the unknown. The strike wave in South Africa in the early 1990's occurred at a time when the country was undergoing rapid, significant socii-political changes in the pre- and post- 1994 national government elections period. From these findings it was deduced that there is a need for transparency during times of change. The change in government in South Africa led to changes and restructuring of health services. This resulted in some modification or changes in policies and procedures due to integration of certain health authorities, for example KwaZulu Health Department and Natal Provincial Health Services Department. The findings revealed that lack of information on how nursing personnel would be affected contributed to nurses' strikes. An example was uncertainty about safety of pension funds of Government employees after elections which was mentioned by 76.3% (42) nurse managers and 31% (24) nursing personnel.

Mellish and Lock (1992:317-318) agree with Daughtrey and Ricks (1989:530-531) who state

that "management has a responsibility to communicate to employees their rights as individual employees and their responsibilities as individuals to the organisation especially when changes are made in company policies, procedures and rules that will affect employees."

On the basis of these findings, assumption two of this study was confirmed.

8.3.3 ASSUMPTION 3

'The standards of nursing care are lowered by the proliferation of strikes in health services.'

The study revealed that lowering of standards of nursing care was observed by 34.2% (26) of nursing personnel and 41.3% (45) of nurse managers. This concern is in keeping with the ultimate responsibility and accountability for quality patient care. Specific reference was made to patient suffering and neglect as well as psychological trauma due to feelings of insecurity. 97.2% (106) of nurse managers and 90% (139) of nursing personnel agreed that patients suffer more than the employer when nurses strike.

Responses to the item on feelings after the strike indicated that 51.3% (39) nursing personnel felt guilty and depressed. Amongst reasons expressed for these feelings patient suffering due to failure to remain with them and render nursing care was indicated. This is supported by Tschudin (1987:30) who emphasized the need for caring in a helping, counselling relationship which is also an important part of the nurse-patient relationship. In Tschudin's view, caring can be expressed by merely 'being there', giving time and attention, and fulfilling the patients needs. At times of emotional stress the nurse gives care, 'not by solving problems but by being available through listening.'

The findings indicated that 70.9% (39) of nurse managers were aware that the public condemned nurses for striking. These findings are supported by some media reports which demonstrate resentment of the public to nurses' strikes for example:-

- Steenkamp (Daily News 14/09/94:7) remarked that nurses go against their pledge which commits them to unconditional service. She blames this on some militant

workers and union officials who lack understanding of what 'conscience' and 'dignity' means, for example, one nurse had her arm broken by other workers because she refused to abandon her patients.

- Turner (1994:7) in the same edition of the Daily News expressed a wish to see strikers heavily fined for their action.

These public messages are in line with the South African Nursing Council ruling that striking nurses should be disciplined for abandoning patients. However the findings of this study revealed that nurses were divided on the issue of South African Nursing Council discipline of nurses for neglecting patients or clients whilst involved in strikes. This could be in accordance with the fact that this regulatory body was not acceptable to the majority of nurses at the time of this study. This led to establishment of an Interim Regulatory Body at the time of completing this research report (1995)

From these findings it was deduced that patients were denied access to acceptable standards of nursing care during nurses' strikes. The various categories of nursing personnel and nurse managers indicated concern over lowered standards of nursing care.

8.3.4 ASSUMPTION 4

'Nurse managers lack the ability to handle striking nurses and fail to make adequate alternative plans for the provision of patient care during strikes.'

The adverse effects of strikes highlighted by the respondents pointed to lack of ability of employing authority and the whole management team, including Medical Superintendent, Hospital Administrator and Nursing Service Management , to handle strikes. Patient suffering and deaths, smuggling and theft of equipment in wards, poor staff control and protracted periods of strikes, intimidation and even deaths of some members, all lead to the conclusion that the strikes were not handled effectively.

Finnemore and van der Merwe (1992:207) describe strikes as a challenge to the autonomy of managerial control. Therefore management response to a strike has a direct bearing on

how the strike will proceed. If management is seen to be harsh to strikers, for example, resorting to threats, interdicts, lock-outs, dismissals or police intervention, worker tactics become equally antagonistic.

Gerber et al (1989:394) warns that strikes are a fact of life in South Africa and the world over. Managers and employers therefore need to be prepared for them, know how to handle them by making adequate contingency plans, and know what to do after the strike.

The study revealed that nurse managers were divided on the issue of adequate contingency plans for continued patient care during strikes. 52.7% (29) indicated that there were no plans while 45.5% (25) indicated that adequate plans were made. Lack of adequate plans could be associated with lack of notification of strikes as indicated by 40% (22) of nurse managers. One of the reasons stated by 70% (35) nurse managers for the need of strike notification was that it would give time to make and implement alternative plans for patient care.

Adverse effects of nurses' strikes on patient care were highlighted by both nursing personnel and nurse managers. This led to the conclusion that it was not possible to continue rendering good quality patient care during the strikes. This confirmed the challenge of proper handling of strikes by employers and management since patients who come to their organisations for health care entrust their lives to them.

Searle and Pera (1992:104 and 208) emphasized that nursing is a critical element in all health care and it must be characterised by a sound philosophy of service. The professional code of ethics for nurses sets parameters of the responsibility that the nurse owes to her patient. She must consider at all times that his life is fragile and she is entrusted with the responsibility for human well-being.

Mabe (1993:9), sharing her views on the challenging era of change in a League of Nursing Associations of South Africa (LONASA) assembly, reminded nurses that they cannot afford to withdraw their services from their patients when they need them most. She warned that this would happen if nurses adopted the industrial model of trade unionism which uses the

strike weapon.

Respondents who were aware of contingency plans for patient care mentioned plans which were identified as effective in literature cited in Chapter 3. A question which arises is why patient care suffered so highly if appropriate strategies were adopted. It was therefore concluded that the plans mentioned by nurse managers in table 7.2.7 were weakened by other factors, for example:-

- management was caught unaware due to lack of strike notification or, in some cases, period of notification was too short.
- the skeleton staff provided was not enough to give adequate nursing care. It was also mentioned that some were prevented from continuing to work by the strikers.
- the 24-hour protection of staff mentioned might not have been enough to deter strikers from intimidating those who wanted to work.

Both nursing personnel and nurse managers agreed that strikes could be prevented if

- fair and just policies were adopted
- no corruption in management
- more attention and strengthening of the bargaining process
- more transparency and worker participation in decision making

A diversity of ways to prevent or minimise strikes was suggested by the nurse managers. It is therefore deduced that the respondents held the perception that strikes by nursing personnel can be prevented. This is supported by Roy's Adaptation Theory which states that mediating factors in the environment have an effect of controlling the effects of stimuli to levels where adaptation is possible.

On the basis of assumption 4 it was concluded that appropriate plans for continuing patient care during strikes were made. What remains is to find means of controlling factors which make these plans ineffective during strikes.

8.4 LIMITATIONS

8.4.1 The study was done in only 4 hospitals in the KwaZulu-Natal province whereas nurses strikes are currently widespread all over South Africa. Generalisation of these results for the whole country may create problems if factors that affect health care delivery are different. However, it has been observed by the researcher that a concern on the conditions of service, especially salaries, for South African nurses is a national issue.

8.4.2 Access to specific literature and previous research on nurses' strikes in South Africa was limited thus making it difficult to make meaningful comparisons with other findings.

8.4.3 Ethical implications posed serious problems which resulted in a delay in completing the study. These included the following:

8.4.3.1 Two health departments existed in KwaZulu-Natal at the time of initiating the research project. Permission was granted by one authority and refused by the other. This meant exclusion of all hospitals under the jurisdiction of the authority which did not give permission. Some authorities of hospitals selected for the research were reluctant to give permission in spite of the employing authority having given permission. This posed a limitation especially because researcher was refused access to hospitals known to have had strikes.

8.4.3.2 Some nursing personnel who could have been subjects in the sample refused to complete the questionnaires. They expressed fear of victimisation in spite of repeated assurances of confidentiality and anonymity. The problem being investigated was said to be very sensitive especially at a time when nurses' strikes were escalating. In terms of purposes of research this was all the more reason for a need to conduct the research in an attempt to find answers to the problem.

8.5 RECOMMENDATIONS

In terms of the findings and conclusions of this study the researcher makes the following recommendations:-

8.5.1 ROLE OF THE EMPLOYING AUTHORITY

Since the employer was seen by most respondents as being responsible for issues leading to strikes, it is recommended that the employer pays immediate attention to those issues according to priorities, for example:-

- salary dissatisfaction must be addressed without delay
- transparency and consistency in policies
- prompt attention to all grievances referred to them through well-defined grievance procedures
- attention to adequacy and fair distribution of human and material resources in health services
- should work co-operatively and be supportive to management as the findings revealed that nurse managers felt abandoned by both employers and personnel (employees) during strikes.
- should take responsibility for ensuring security and safety of personnel who want to work during strikes, including nurse managers.

8.5.2 ROLE OF MANAGEMENT

Management plays a dual role representing the employing authority on one hand and the personnel rendering the service on the other. They are close enough to personnel to be aware of their problems. It is therefore recommended that:-

- managers should show sensitivity to personnel needs and problems. Minor complaints must not be ignored
- grievances should be handled according to official grievance procedure to ensure consistency
- there should be prompt referral of staff requests and grievances to higher authority and no delays in feedback to staff

- line and staff managers should observe transparency and openness to prevent accusations of corruption
- managers should be able and willing to change and move away from traditional bureaucratic management styles, be democratic without losing control and show more awareness of personnel rights

These recommendations are in keeping with Roy's Adaptation Theory which specifies a need for secuiring adequate information to enable the person to maintain his autonomy.

8.5.3 ROLE OF NURSING PERSONNEL

It is recommended that nurses:-

- should consider patient suffering that results from strikes.
- they should avoid 'bottling up' grievances but forward them promptly and assertively to management and seek feedback.

This will minimise and/or prevent the need to strike. Nursing personnel should be guided by propositions from Roy's Adaptation Theory which state that adaptation is neither a total triumph over the enviroment nor a total surrender to it. They should therefore be prepared to compromise when some of their requests cannot be met.

It is further recommended that through the effective collective bargaining process and representation from the Democratic Nursing Organisation of South Africa (DENOSA) nurses needs and grievances be attended to by employing authorities and management. The fact that the union leg of the organisation will be controlled by the profession itself should ensure that patients' rights as well as nurses' rights will be catered for.

8.5.4 ROLE OF THE PUBLIC

The public who are the consumers of nursing care should show interest and concern for conditions under which nurses work. They should have input and influence policy-making at local, regional and national levels. There should be platforms which bring together nurses and the public whom they serve so that there is agreement on needs and problems of each group as well as strategies to address them. The negative attitudes of nurses towards input from the public, as revealed in this study, will then be corrected. There should be accurate and positive reporting on the media aimed at preserving a positive image of the nurse.

Positive aspects or results of collective bargaining must be highlighted instead of paying attention to the negative aspects only.

8.5.5 STAFF DEVELOPMENT

It is recommended that Industrial Relations teaching be given a priority in health services by:-

- including a module of industrial relations in the curriculum for basic nursing courses
- short courses of minimum 2 weeks duration run on a continuous basis as was done during the introduction of the Nursing Process in nursing services in South Africa. All nurse managers and the various categories of nursing personnel should be given a chance to attend these courses. It is of utmost importance that nurse managers in charge of nursing services attend Industrial Relations courses. The content of the courses should be adapted to include aspects that are specific to health care services.
- regular in-service education programmes to keep staff up-to-date with current trends in industrial relations.
- strike handling should be included in these courses to enable nurse managers to face strikes with confidence and manage them effectively to minimise disruption of nursing services.

On-going training programmes on general personnel management should be given to nurse managers with emphasis on management of change during then transition period.

8.5.6 CONTINUITY OF SAFE PATIENT CARE DURING STRIKES

Long-term plans for management of patient care during strikes should always be in readiness, publicised and trial runs done for mock strikes as for disaster plans. This will prevent unnecessary suffering and deaths of patients due to strikes. This will provide guidelines which can be modified to suit prevailing circumstances. The system, of reshuffling duties and off-duties should be discussed with personnel beforehand to ensure acceptance instead of waiting until the strike occurs.

Protection of personnel wishing to continue rendering patient care during strikes should be ensured through liaison between employing authority, management and recognised protective or secuirity services of the country.

8.5.7 FUTURE RESEARCH

It is recommended that this study be replicated in the other eight provinces of South Africa to enable generalisation of findings. This is important to facilitate formulation of appropriate national policies on nurses' service conditions in an effort to prevent or minimise strikes.

Research on strikes by student nurses needs urgent attention to establish causes for their escalation and to establish means of addressing the problem so as to maintain a stable, quality nursing workforce.

8.6 CONCLUSION

The findings of this study have highlighted concerns of both consumers and providers of nursing care on strikes by nursing personnel. In the light of rapid changes taking place in the country and in health services nurse managers and nursing personnel will continue to face new challenges. Changes will have to be managed effectively to prevent undesirable personnel behaviours such as strikes. Nurses' strikes are a contemporary problem therefore employing authorities and management must encourage research into this problem.

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ANNEXURE 1

RESEARCH TOPIC: **STRIKES BY NURSING PERSONNEL: A CHALLENGE FOR THE NURSE MANAGER**

Dear Colleague

REQUEST FOR COMPLETION OF A QUESTIONNAIRE FOR RESEARCH PURPOSES

Kindly complete the attached questionnaire. Information is required solely for research purposes. Strict confidentiality will be ensured. Please do not write your name or the name of your institution anywhere in this questionnaire.

Please answer all questions. There are no right or wrong answers. Your own views and opinions are important.

Please indicate your responses by placing a tick (✓) in appropriate spaces and/or by giving explanations where needed. Ignore the numbers on the right hand side of the page. They are for computer purposes.

Thank you for your co-operation.

P.J. KUNENE

ANNEXURE 2

QUESTIONNAIRE FOR NURSING PERSONNEL

SECTION 1 - PERSONNEL PARTICULARS

1. Gender

Male		1
Female		2

2. Age group in years

16-25		1
26-35		2
36-45		3
46-55		4
56-65		5

3. Nursing Category

Senior professional nurse		1
Professional nurse		2
Enrolled nurse		3
Enrolled nursing auxilliary		4

4. Length of service in this institution in years

1-10		1
11-20		2
21-30		3
31-40		4
Other		5

SECTION 2 - EXPERIENCE OF STRIKES

5. Has there ever been strike(s) by nursing personnel in this hospital ?

Yes		1
No		2

6. If yes, when did the strike occur ? (State year(s).....

7. How long did it last

No. of days		1
No. of weeks		2
No. of months		3

8. Categories of nurses involved in the strike (s)

Chief professional nurses		1
Senior professional nurses		2
Professional nurses		3
Enrolled nurses		4
Enrolled nursing auxilliaries		5
Student/pupil nurses		6

9. State reasons given for the strike(s)_____

_____

_____

10. What benefits were gained as a result of the strike ?_____

_____

_____

11. What adverse effects occurred as a result of the strike ?_____

_____

_____

12. Did you participate in the strike ?

Yes		1
No		2

13. If "no" to item 12, give reasons for not participating

_____

_____

14. If "yes" to item 12, how did you participate

Willingly		1
Unwillingly		2

15. If you did not participate willingly, indicate your reason(s)

Fear and intimidation by the strikers		1
Influence of friends		2
Obligation of trade union membership		3
Solidarity not associated with union		4

16. Give an indication of your feelings after the strike

Happy		1
Depressed		2
Guilty		3
Other		4

17. Give reasons for your feelings as indicated under 16.

_____

_____

_____

18. If circumstances that led to the strike were to be repeated would you still opt for a strike ?

Yes		1
No		2

19. If you did not opt for the strike what alternative action would you take ?_____

_____

_____

20. The statements below reflect some conflicting views on strikes by nursing personnel. Indicate your own views by placing a tick ( ) in appropriate column.

KEY TO ABBREVIATIONS:

S.A. = **Strongly Agree**

A. = **Agree**

D. = **Disagree**

S.D. = **Strongly Agree**

		4	3	2	1
		SA	A	D	SD
20.1	Nurses have the right to strike				
20.2	Strikes by nursing personnel are an effective strategy to influence the authorities to grant nurses' requests.				
20.3	If nurses strike, the patient suffers more than the employer.				
20.4	Strong disciplinary action should be taken for neglect of patients during nurses' strikes.				
20.5	Opinions of the public should be sought before nurses go on strike				
20.6	Strikes by nursing personnel can be prevented by fair and just management policies.				

21. Any other comments on strikes by nursing personnel

_____

_____

_____

ANNEXURE 3

QUESTIONNAIRE FOR NURSE MANAGERS

SECTION 1 - PERSONAL PARTICULARS

1. Gender

Female		1
Male		2

2. Age Group

21 - 30		1
31 - 40		2
41 - 50		3
51 - 60		4
61 - 70		5

3. Present designation

Professional nurse in charge		1
Senior professional nurse in charge		2
Chief professional nurse		3
Nursing service manager		4
Senior nursing service manager		5
Chief nursing service manager		6

6.	Have you attended any industrial relations course	Yes		1
		No		2

7.	If "yes" to item 6 state duration of course	No. of days		1
		No. of weeks		2
		No. of months		3

8. Indicate aspects covered in the industrial relations course

Industrial relations in South Africa		1
Industrial Relations Act		2
Trade Unionism		3
Disciplinary procedure		4
Handling of grievances		5
Collective bargaining		6
Dispute resolution procedure		7
Strikes in general		8
Strikes in health services		9
Health worker concept		10

SECTION 2. AWARENESS OF STRIKES

9. What is the incidence of strikes by nursing personnel in the KwaZulu-Natal region in the 1990's

Very frequent	☐	1
Frequent	☐	2
Seldom	☐	3
Never	☐	4

10. Has the incidence of strikes increased or decreased in the 1990's as compared to previous years ?

Increased	☐	1
Decreased	☐	2
No change	☐	3

11. Indicate any factors which, in your, opinion, have resulted in the change mentioned in item 10_____

_____

_____

12. Which types of health services are more prone to strikes by nursing personnel in the KwaZulu-Natal region ?

Private hospitals	1
KwaZulu/Natal Provincial hospitals	2
Big hospitals (500 + beds)	3
Small hospitals (less than 500 beds)	4
Rural hospitals	5
Urban hospitals	6

13. Who is usually said to be responsible for issues that lead to nurses' strikes ?

Employing authorities	1
Top management	2
1st level supervisors	3
Other nurses	4
Other (specify)	5

14. In your opinion do nurses have the right to strike ?

Yes	
No	

15. If "no" to item 15, how should nurses express their dissatisfaction ?_____

_____

_____

16. What are the consequences of strikes by nursing personnel?

16.1 On patients_____

_____

16.2 On the community_____

_____

16.3 On management_____

_____

16.4 On the employing authority_____

_____

16.5 On nursing personnel_____

_____

16.6 On the nursing profession_____

_____

17. In your opinion what can be done to minimise or prevent strikes by nursing personnel? _____

_____

18. Nurses are subject to disciplinary action by the South African Nursing Council for neglect of patients during strikes. What are your views on this ?_____

_____

_____

SECTION 3. PERSONAL EXPERIENCES OF STRIKES BY NURSING PERSONNEL

19. Has there ever been a threatening strike by nursing personnel which was prevented from becoming an actual strike in this hospital ?

Yes ☐ 1

No ☐ 2

20. If "yes" to item 20, what measures were taken to prevent the strike ?_____

_____

_____

21. If "no" to item 20, what proactive measures could have been taken to prevent the strike ?_____

_____

22. Has there ever been a strike(s) by nursing personnel in this hospital ?

Yes ☐ 1

No ☐ 2

23. If "yes" to item 22, what reasons were given for the strike(s) ?

_____

_____

24. List categories of nurses who were involved in the strike

Senior professional nurses	☐	1
Professional nurses	☐	2
Enrolled nurses	☐	3
Enrolled nursing auxilliaries	☐	4
Student/pupil nurses	☐	5
Other (specify)	☐	6

25. Was there notification of the strike ?

Yes	☐
No	☐

26. If "yes" to item 25, state how many days'notice was given ?___

27. Do you think notification of strikes is essential

Yes	☐	1
No	☐	2

28. Give reasons for your answer to item 27._____

_____

_____

29. State the most difficult or undesirable experiences in your work during the strike(s)

_____

_____

_____

30. Was there adequate planning for effective patient care during the strike(s) ?

Yes ☐

No ☐

31. If "yes" to item 30 briefly state the plans that were made._____

_____

_____

_____

32. Do you think the strike(s) could have been prevented in any way ?

Yes

No

33. Give reasons for your answer to item 32._____

_____

_____

34. The following statements reflect effects of the nurses' strike(s) that you have experienced. Indicate your answer by placing a tick ( ) in the appropriate column.

KEY TO ABBREVIATIONS

S.A = Strongly agree

A = Agree

D = Disagree

S.D. = Strongly disagree

		4	3	2	1
		SA	A	D	SD
34.1	Patient's lives were put at risk during the nurses strike(s)				
34.2	Patient supported the nurses for their strike action				
34.3	The public condemned the nurses for striking				
34.4	Some nurses expressed coercion and intimidation as reasons for their participation in the strike(s)				
34.5	The nurses appeared to enjoy involvement in the strike(s)				
34.6	The nurses demands were conceded to a result of the strike(s)				
34.7	Relations between management and nursing personnel were strained after the strike(s)				

35. Any additional comment on strikes by nursing personnel

_____

_____

_____