J. INDIVIDUAL EMPLOYMENT RIGHTS, Vol. 2(1) 29-37, 1993-94

AUSTRALIAN OCCUPATIONAL THERAPY ACADEMICS' ATTITUDES TO COLLECTIVE BARGAINING*

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ABSTRACT

This article presents the results of an investigation of the attitudes of Australian occupational therapy academics toward collective bargaining for themselves and clinical therapists. Data were collected using a mailed survey instrument which included scales measuring attitudes to collective bargaining and collecting demographic data. In general, Australian occupational therapy academics are supportive in principle, of collective bargaining for both themselves and clinical therapists to achieve a range of outcomes. However, in practice, less than 50 percent are members of a union and less than 25 percent are involved in any way beyond basic membership.

Industrial relations and, therefore, unions have begun to play an increasingly important role in health services. This is due to an increasing dissatisfaction with working conditions due to the rationalization of health services [1]. Also contributing to the increased need for representation to employers is what Brocket termed the socialization of health professionals into bureaucracies and away from more independent, autonomous practice [2]. The salaried professional requires collective bargaining with other employees to ensure that the professional's good will is not exploited by employers.

The occupational therapy literature has called for occupational therapists to become more involved in lobbying, challenging decision makers, and power broking to secure the future of the profession within an increasingly tight financial

*This research was supported by a grant from the Occupational Therapists' Vocational Branch of the NSW Public Service Association.

doi: 10.2190/LKRP-C8T8-AE9C-Y9VA
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climate for health care [3, 4]. Occupational therapists also express dissatisfaction with salaries, working conditions and other organizational factors that affect their work, such as staffing levels, poor facilities and equipment [4, 5]. In 1990, a two-day workshop for occupational therapists in New South Wales provided a forum for these issues to be discussed and strategies for therapists to use to influence decision making and maintain positions and working conditions.

An industrial union is one organization that can assist and support occupational therapists to address or redress some of these issues and the changes that are occurring in health care delivery. At the 1989 Federal Council meeting of the Australian Association of Occupational Therapists, a number of issues were discussed relating to working conditions, expectations of employers and a request for the council's support of industrial action occurring in one state. It would seem informally, at this level, that there is support for industrial unions. There have been no studies, however, to determine the attitudes of occupational therapists toward unions and their activities.

Conflict may arise for the health professional with respect to union membership due to the perception of unions as supporting and involving open hostility. The union is interested in its individual members' well-being, while the professional is interested in the well-being of the client and may see the two being incompatible due to union methods such as the strike [2]. Similarly, the issue of a professionalism/unionism conflict is raised for academics. "One of the major concerns about unionism is the idea that it is not "professional" and, therefore, outside the realm of professors" [6].

A number of other factors are discussed in the literature as affecting union membership. These include gender, age, income [7], level of knowledge about unions [8], socialization during undergraduate education [9], and the influence of supervisors and mentors. Students may be exposed to the concepts of unions during their undergraduate studies via the students' union. For some students this provides the opportunity to experience the process of collective bargaining in relation to students' study and education concerns when dealing with the administration and faculty of a tertiary institution. No information is available on whether these experiences affect future union involvement.

A review of the literature indicates that no studies have been conducted to specifically determine the attitudes of Australian occupational therapy academics toward industrial unions and union activities. The question addressed in this study was what the attitudes of Australian occupational therapy academics are toward industrial unions.

METHOD

The sample consisted of fifty-nine of the 100 (total population at the time of the study) occupational therapy academics employed in Australian universities offering an undergraduate occupational therapy program who were in tenured positions

or on short-term contracts of one year or longer. Both full-time and part-time faculty were included.

Instrument

The data collection instrument for this investigation was a questionnaire based on the Nursing Faculty Collective Bargaining Attitudinal Survey Instrument developed by Crisci, Fisher, Blixt, and Brewer [10]. The survey instrument was modified to relate to occupational therapists in academic and clinical settings. The instrument determines attitudes toward collective bargaining, including strike action and unionism/professionalism conflict. The content validity of the questionnaire was determined by having faculty and clinical occupational therapists review the items to ensure their appropriateness for occupational therapists in Australian clinical and academic settings.

Demographic data collected to determine factors that may influence attitudes toward collective bargaining included information concerning age, gender, academic position held, tenure status, years of experience as an academic and a clinical occupational therapist, union membership, most influential source of information about unions, level of education, family attitude toward unions, and level of involvement in a union.

Procedures

The questionnaire was distributed to the sample academics via the university school/department in which they were employed. Envelopes were addressed, "Occupational Therapy Academic" and mailed in bulk to the school/department. These were distributed to the personal mail boxes of each academic occupational therapist by the schools'/departments' secretarial or administrative staff. Opportunity for coercion to participate or not to participate was minimized, as the decision to participate was made independently by each respondent and questionnaires were mailed by the respondent directly to the researcher in the stamped and addressed envelope supplied.

The questionnaire was accompanied by a cover letter explaining the purpose of the research, stressing the voluntary nature of participation, the fact that all information collected was confidential, and that consent to participate was implied upon return of a completed questionnaire.

A follow-up letter was sent to the total sample thanking those who had returned the questionnaire and reminding those who had not to do so if they wished to respond.

Analyses

Descriptive statistics were calculated on all variables. Chi square analyses using a significance level of .01 were used to determine the statements where more

respondents agreed than disagreed with an item. A *t*-test was performed on the total collective bargaining scores for each of the subscales to determine whether a difference existed between the attitudes of faculty toward collective bargaining for themselves and for occupational therapists in clinical positions. A simple regression equation was calculated using the totals for the academic subscale and each of the following demographic variables: gender, age, tenure, academic title, full-time experience as an academic and a clinical therapist, highest education level, union membership, family attitude toward unions, major source of influence about unions and knowledge of unions.

RESULTS

Chi square results (Table 1) indicate that for only two of the thirteen items on the clinical subscale was there no difference between the number agreeing or disagreeing at the .01 level. These were: 4. "There are circumstances where striking would be a legitimate means of collective action by OT's"; 7. "When OT's are not treated as professionals, unified action is the only way to achieve professionalism." The other eleven statements were significantly different from what would be expected by chance.

On all but one of the items in the faculty subscale there was a significant difference (at .01 level) between those agreeing and disagreeing than would be expected by chance. The item on which there was no difference was item 24: "When faculty are not treated as professionals, unified action is the only way to achieve professionalism."

The *t*-test revealed no significant difference between the academics' attitudes toward collective bargaining for themselves and for clinical therapists. In fact the means on the two subscales were identical at 58.4 ($t = -.01$, $DF = 115$, $p = 1.0$).

For the regression equations only one of the predictor variables was significantly related to the score on the academic subscale. This was knowledge about unions ($F = 5.61$, $p = 0.021$), which accounted for 9.0% of the variance. Title correlated significantly on preliminary analysis but failed to do so when adjusted for extreme results.

Table 2 summarizes the demographic data obtained about the sample.

DISCUSSION

Australian occupational therapy academics believe there is a place for collective bargaining in both the Australian health care and higher education systems. They are also supportive of collective bargaining in principle for both academics and occupational therapists. However, in practice, less than 50 percent of those sampled are members of the union, the body which is able to bargain collectively on their behalf.

Table 1. Percentages of Agreement and Chi Square Tests

	Clinical Sub-scale		Academic Sub-scale	
Items in Questionnaire	Percent	Chi	Percent	Chi
Coll. barg. has a place (1 & 15)	91.5	43.1034	91.5	43.1034
Coll. barg is a threat to professional image (2 & 18)	16.9	27.5862	13.6	35.5263
I support coll. barg. (3 & 16)	91.5	43.1034	93.2	46.6207
Strike is legitimate (4 & 21)	69.5	8.96610	81.4	28.5714
Coll. barg. increases voice in decision making (5 & 19)	89.8	39.7241	86.4	35.5263
Most effective way to influence decisions is to negotiate (6 & 14)	77.9	19.9310	81.3	24.8966
Unified action to achieve professionalism (7 & 24)	49.5	9.93103	66.1	8.64286
Coll. barg. safeguards rights (8 & 17)	88.1	38.7544	88.1	38.7544
Coll. barg. results in more equitable decisions in prof. issues (9 & 22)	79.7	27.6545	77.9	21.4912
Coll. barg. brings higher salaries and benefits (10 & 20)	84.7	30.4138	88.0	38.7544
Right to strike over serious issues (11 & 23)	81.4	24.8966	79.7	25.7857
Coll. barg. safeguards prof. freedom (12 & 26)	76.3	19.1053	88.1	41.1429
Coll. barg. results in more equitable decisions in economic issues (13 & 25)	79.7	24.0175	79.7	24.0175

Academics are supportive of the strike as a legitimate means of collective bargaining for faculty but not for clinical therapists generally. However, over serious professional issues they feel clinical therapists should have the right to strike. This may reflect the professionalism/unionism conflict for health professionals described by Brockett [2]. It does not support previously found concern by academics about unions being unprofessional. Further support for this is the fact that significantly more academics disagreed than agreed that collective bargaining was a threat to the professional image either for themselves or for clinical

Table 2. Demographic Data of Sample

Gender:		Membership:	
Male = 4	6.78%	Member = 28	47.46%
Female = 54	91.53%	Nonmember	
Missing = 1	6.78%	past member = 21	35.59%
Age:		not past mem. = 9	15.25%
20-25 = 1	1.69%	Missing = 1	1.69%
26-30 = 7	11.86%	Family Attitude:	
31-35 = 12	20.34%	Pro-union = 14	23.73%
36-40 = 11	18.64%	Anti-union = 26	44.07%
41-45 = 12	20.34%	Neither = 17	28.81%
46-50 = 5	8.47%	MIssing = 2	3.39%
51-55 = 8	13.56%	Most Influential Source:	
56+ = 2	3.39%	Family = 9	15.25%
Missing = 1	1.69%	Undergrad educ. = 4	6.78%
Tenure:		Colleagues in	
Tenured = 43	72.88%	first job = 4	6.78%
Nontenured = 15	25.42%	Colleagues gen. = 22	37.29%
Missing = 1	1.69%	Mentor = 1	1.69%
Rank:		Senior work coll. = 0	0%
Professor = 2	3.39%	Union info. source = 4	6.78%
Associate prof = 2	3.39%	Postgrad. educ. = 4	6.78%
Reader = 1	6.78%	Other = 10	16.95%
Senior lecturer = 10	16.95%	Missing = 1	1.69%
Lecturer = 38	64.41%	Knowledge of Unions:	
Senior tutor = 4	6.78%	Uninformed = 4	6.78%
Tutor = 1	1.69%	Somewhat uninf. = 7	11.86%
Missing = 1	1.69%	Somewhat inform. = 31	52.54%
Percent Appointment:		Informed = 11	18.64%
Full time = 40	67.80%	Well-informed = 4	6.78%
Part time = 19	32.20%	Missing = 2	3.39%
Highest Education Level:		Union Involvement:	
Undergrad dip. = 2	3.39%	Union executive = 1	1.69%
Bachelors degree = 23	38.98%	Union rep. = 11	18.64%
Postgrad dip. = 8	13.56%	State exec. = 0	0%
Coursework MA = 13	22.03%	Federal exec. = 0	0%
Research MA = 8	13.56%	Federal council = 1	1.69%
PhD = 4	6.78%	State council = 1	1.69%
Missing = 1	1.69%	(should not total 100%)	

occupational therapists. However, they did not agree that unified action was the only way to achieve professionalism if they themselves or clinicians were not treated professionally.

Those sampled more often agreed than disagreed that collective bargaining increased the voice of the average occupational therapist in decisions related to professional practice and academic governance and that the most effective way to have meaningful influence over decisions was to negotiate via collective bargaining. This would seem to auger well for occupational therapists becoming more involved, as they have been challenged to do in lobbying and challenging decision makers to secure the future of the profession in tight fiscal times [3, 4]. However, one is left with the question of "who will lobby" and represent the interests of occupational therapy faculty when less than 50 percent are members and only 23.71 percent of the sample have been involved at anything beyond membership level in both the past and the present.

Faculty surveyed significantly agreed that collective bargaining safeguarded rights and professional freedom and resulted in more equitable decisions in both professional and economic decisions, plus higher salaries and benefits. Some of these areas are concerns previously expressed by occupational therapists [4, 5]. Again one is forced to consider who therapists believe will contribute to these collective bargaining outcomes on their behalf. Low membership and involvement in union structures suggests a helpless "do-it-for-me" attitude on the part of occupational therapy faculty.

Faculty who perceived themselves as being better-informed about unions and their activities were more favorable toward collective bargaining. Knowledge of unions has been shown to influence union membership in previous research [8].

It is interesting to note that colleagues generally and in the first job (47.04% combined) were the most influential source about unions for respondents. Family were the next most influential source (15.25%). This may bear further investigation, as 44.07 percent of those surveyed indicated that their family's attitudes had been anti-union.

CONCLUSION

The aims of this research to investigate the attitudes of Australian occupational therapy academics toward collective bargaining were met. It would seem that faculty are supportive of collective bargaining, in principle, for both themselves and clinicians to achieve a range of outcomes, including better access to and more equitable decision making, improved salaries and benefits, protection of rights and professional freedom. However, in practice, less than 50 percent of those surveyed were currently members of their union and less than 25 percent had been involved in a union at a level beyond that of member, either in the past or the present.

Previous research has shown that occupational therapists are concerned about a range of issues for which a union can represent them. Similarly, there is

recognition in the professional literature about occupational therapists' need to become more involved in lobbying and influencing decision makers. Such involvement is relevant for both clinical and academic occupational therapists. However, it seems unlikely that effective involvement will be achieved if faculty do not support one of the major organizations, namely the union, that can bargain collectively on their behalf to achieve a range of desired outcomes. Unfortunately, it seems that the majority of occupational therapy faculty are prepared to leave the task of accessing and influencing decision makers to others.

Further research is needed to investigate more directly the reasons for this attitude, the factors that have favorably disposed those who do become involved in unions to do so, and the attitudes of occupational therapy clinicians toward unions and their activities.

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