Union Strategies for Improving Patient Care: The Key to Nurse Unionism

Paul F. Clark and Darlene A. Clark

Abstract

Over the past ten years the healthcare industry has become a main target of union organizing efforts. While registered nurses represent the largest group of healthcare professionals, union efforts to organize nurses have met only limited success. Evidence suggests that nurses are more inclined to join a union if they believe the union can help them address one of their most important concerns—the quality of patient care. This paper discusses the significant workplace problems nurses currently face in acute care hospitals and how those problems negatively impact nurses’ abilities to provide effective patient care. The paper also identifies, examines, and analyzes strategies that unions have developed and employed to increase nurse voice and involvement in patient care/nursing practice decisions in acute care settings.

Over the past ten years the healthcare industry has become one of the main targets of union organizing efforts. This has occurred, in part, because healthcare is one of the few growth industries in the United States, and occupations in this industry are among the fastest growing in our economy. It is also a promising target for organizing because healthcare employees have been adversely affected by the many problems facing the industry and because healthcare jobs are less subject to outsourcing than jobs in other sectors.

While the labor movement has experienced some success in organizing healthcare workers, progress in this industry, from the union point of view, has been less significant than might have been expected. One explanation for the limited success unions have experienced is that the industry presents the labor movement with a unique set of challenges. One of the most significant of these is the traditional reticence of healthcare professionals to join unions (Zerwekh and Claborn 1997; Gordon 2005). If the reservations of these workers can be addressed, the labor movement might be able to substantially increase their numbers.
Registered nurses (RNs) represent the largest group of healthcare professionals, and anecdotal and empirical evidence suggests that they might be a particularly fertile target for union organizers (Clark and Clark 2005; Department of Professional Employees [DPE] 2005; Gordon 2005). Recent research, however, suggests that their openness to unionization is greatly influenced by the degree to which they believe a union can help them address one of their most important concerns—the quality of patient care (Clark et al. 2000; Clark et al. 2001). Winning a greater voice in this area appears to be one of the keys to organizing this critical segment of the healthcare industry.

This paper discusses the significant workplace problems nurses currently face in acute care hospitals and how those problems negatively impact nurses’ abilities to provide effective patient care. The paper also identifies, examines, and analyzes union strategies to improve patient care and increase nurse voice and involvement in patient care decisions in this sector of the healthcare industry. The research linking nurse support for unionization to a union’s ability to win greater voice is reviewed and the range of strategies unions employ in this regard are identified and discussed. Finally, examples of union success in winning greater nurse involvement in decisions affecting patient care are presented.

The Healthcare Industry

The U.S. healthcare industry is a large and growing segment of the American economy. In 2003, national health expenditures in the U.S. totaled almost $1.7 trillion. This represented 15.3 percent of the nation’s gross domestic product (GDP) (Centers for Medicare and Medicaid Services [CMMS] 2003). By 2010, total expenditures are expected to increase to $2.75 trillion, with 17.4 percent of the GDP going to healthcare, and healthcare expenditures per capita are expected to rise from roughly $5,000 in 2001 to over $9,000 by 2010 (see Table 1).

In addition, the healthcare industry is one of the U.S.’s leading employers. In 2002, 6.59 million people worked in health-related professional and technical positions (e.g., physicians, registered nurses, pharmacists, therapists, lab technologists, radiology technicians, etc.) and an additional 3.31 million were employed in support, service, and ancillary jobs (e.g., nurse aides, home health aides, medical secretaries, etc.). These numbers are expected to grow to 8.29 and 4.45 million respectively by 2012. There were 2.28 million RNs employed in 2002; that number is projected to grow to 2.91 million in 2012 (Hecker 2004).

The U.S. healthcare industry is also an industry in crisis. Among the factors contributing to this crisis are rising healthcare costs, declining government
spending, increasing pressures on public and private budgets, changing demographics, growing personnel shortages, and accelerating scientific and technological advances. These issues have resulted in significant changes in the structure, organization, financing, and delivery of healthcare over the past twenty years. Many of these changes are the result of the introduction of managed care and the growth of health maintenance organizations (HMOs) (Wunderlich, Sloan, and Davis 1996; Harrington and Estes 2004).

These developments have had a significant and, in many cases, adverse impact on healthcare employees, resulting in their increased interest in unionization (United American Nurses [UAN] 2004). Collective bargaining in the healthcare industry, particularly for professional employees in the nonpublic hospital sector, is at a relatively early stage of development compared to many other industries in the U.S. (Clark 2002). However, it is steadily becoming an important part of the healthcare system and, if the labor movement can increase its effectiveness in organizing healthcare professionals, unionism and collective bargaining could become an integral part of this key industry.

Problems Facing Nurses

Managed care is a market-based approach to the delivery of healthcare services. At the heart of this approach are cost-control strategies. Since healthcare is a labor-intensive industry in which personnel constitute the largest

Table 1

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<th>National Health Expenditures Per Capita 1986-2010</th>
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Source: CMMS 2003.
single expense for care providers (hospitals, nursing homes, etc.), labor costs have been one of the prime targets of managed care’s cost-containment efforts (Kangas, Kee, and McKee-Waddle 1999).

Managed care has attempted to reduce labor costs in healthcare in two ways: by consolidating hospitals and healthcare systems through mergers and closings and by reorganizing work within their facilities (Wunderlich, Sloan, and Davis 1996). As a result, hospitals are forcing a reduced nurse workforce to care for more patients. In addition, health maintenance organizations (HMOs) and insurance companies have restricted access to hospital care to only the sickest patients, causing acuity levels (a measure of how sick patients are) to steadily increase. The result is that nurses are not only caring for more patients than in the past, but their patients are sicker (Clark and Clark 2005; Gordon 2005).

The end result is that managed care has greatly changed the healthcare workplace and negatively impacted the workplace experience of nurses, particularly for those working in acute care hospitals where increased pressure and stress have greatly reduced job satisfaction (Clark and Clark 2005; Gordon 2005).

In recent years, managed care’s impact on the nursing profession has been exacerbated by a significant shortage of nurses willing to work in the U.S. healthcare system (Lafer 2005). It is estimated that in 2005 there are 150,000 vacant nursing positions in this country. The number of vacant positions is expected to grow to 275,000 by 2010, and to over 800,000 by 2020 (see Table 2) (U.S. Department of Health and Human Services [DHHS] 2002).

While the difference between the nurses needed and the nurses available is commonly referred to as a shortage, the United States actually has a sufficient number of RNs. In 2000, for example, there were almost 500,000 nurses not working in healthcare, many more than needed to fill every position in every healthcare facility in this country. While nurses choose not to work in the healthcare industry for numerous reasons (e.g., family concerns, financial considerations, etc.), evidence shows that working conditions, particularly in the acute care sector, are a significant factor (Clark and Clark 2005, Lafer 2005; Gordon 2005).

Whatever the cause, the lack of available nurses has exacerbated the problems that nurses experience in the workplace. Combined with the managed-care-driven push for labor cost savings, the shortage has resulted in understaffing in many acute care facilities. Recent research has found direct evidence of a link between understaffing and increases in nurse errors in patient care (Aiken et al. 2002). The added stress and increased liability that nurses experience as a result of understaffing is often cited as one of
the reasons nurses are leaving the acute care sector (Clark and Clark 2005, Gordon 2005). Of course, the phenomenon of nurses leaving creates more understaffing, increasing the stress on the remaining nurses, and resulting in even more nurses opting out of the field.

The shortage also has led to other problems that negatively impact the experience of nurses in the workplace. Mandatory overtime, the practice of forcing nurses to continue to work additional hours after their normal eight hour shifts, has become a common practice in acute care hospitals (Institute of Medicine [IOM] 2004; Services Employees International Union [SEIU] 2005f). This practice has serious implications for both patient safety and the quality of nurses’ work life.

Forcing nurses to work twelve- or even sixteen-hour shifts results in fatigue. Tired nurses are much more prone to commit errors than are well-rested nurses. The evidence suggests that mandatory overtime reduces the degree to which nurses are alert to changes in patients’ medical condition, leading to increases in medication errors, bedsores, and patient infections (Michigan Nurses Association 2001). A 2004 study concluded that “both errors and near-errors are more likely to occur where hospital staff nurses work twelve hours or more during a shift” (Rogers et al. 2004, 205). This study also reported that “working overtime increased the odds of making at least one error, regardless of how long the shift was originally scheduled” (Rogers et al. 2004, 205).
Related to these patient care/nursing practice concerns is the impact of mandatory overtime on the work lives and the personal lives of nurses. Not being able to provide appropriate and safe care to patients results in greater stress and decreased job satisfaction. Greater potential for errors increases nurses’ potential liabilities, as well as risks of losing their license to practice. In addition, mandatory overtime wreaks havoc on a nurse’s personal and family life (American Association of Critical Care Nurses [AACN] 2005). These factors, again, increase the dynamic of nurses leaving the acute care sector, exacerbating the shortage, and leading to even more short-staffing and forced overtime.

Working nurses experience another problem as a result of the nurse shortage: “floating.” Floating is the practice of moving nurses from one department or area of a hospital to another where there is a greater need. Nurses see this practice as a potential problem when they are moved to an unfamiliar part of the facility where they have little experience with the patients or the procedures or where they lack sufficient education or experience in the type of nursing practiced there. As with mandatory overtime, nurses believe that this practice sometimes puts patients at risk. Nurses also see this practice as adding additional stress and pressure to an already stressful job (Clark and Clark 2005; SEIU 2005e).

Managed care, the nursing shortage, and the working conditions they have spawned, have had significant and negative effects on the workplace experiences of nurses in the U.S. The impact has been particularly significant and negative in the acute care sector, causing a sizable proportion of the nursing workforce to conclude that "hospitals have become lousy places to work" (Jaklevic and Lovern 2000).

This conclusion is supported by a 2001 survey of RNs in which approximately 75 percent of the respondents reported that both their working conditions and the quality of nursing care in their facilities had declined in recent years. Thirty-eight percent of the nurses in this study reported that they felt "exhausted and discouraged" upon leaving work. Thirty-four percent said they were "discouraged and saddened by what they could not provide their patients." And 29 percent felt "powerless to affect change" (Michigan Nurses Association 2001).

Efforts to Organize Nurses

Aware of the increasingly serious problems nurses were experiencing on the job, healthcare unions stepped up their organizing efforts beginning in the 1990s. While progress has been made, organizing RNs presents significant challenges.
Unions first gained footholds in acute care hospitals by organizing non-professional employees such as housekeeping personnel, maintenance employees, nurse aides, and orderlies. Healthcare professionals were slow to join unions, in part because many believed that union involvement was inappropriate and unprofessional. Nurses, in particular, have historically struggled with the conflict they see between union representation and their obligation to their patients. Nurses are socialized to be selfless caregivers and advocates for patients’ well-being, and many perceive unions to be solely concerned with winning greater salaries and benefits for their members, regardless of the impact on the employer or the customer/client (in this case, the patient) (Miller, Mansen, and Lee 1983; Zerwekh and Claborn 1997; Clark and Clark 2005).

A 2001 study by Clark et al. suggested that unions could overcome the ambivalence of RNs toward unions by focusing their organizing campaigns on patient care issues. Specifically, the research found that nurses were much more likely to vote for a union in a representation election if they believed the union could give them a greater role in patient care/nursing practice decisions.

The findings of a 2005 survey of six hundred non-union nurses underscored the importance nurses place on voice and professional issues, relative to economic issues. As Table 3 indicates, when nurses were presented a list of reasons to support unionization, the top four reasons they chose had to do with promoting professional quality and skills and increasing nurse voice in the workplace. Gaining better salaries and benefits was the fifth most often-cited reason to support unionization (Department of Professional Employees [DPE] 2005).

Most unions that attempt to organize nurses understand the importance RNs place on patient care and make these issues a central part of their campaigns. Less clear, however, is the extent to which unions actually are successful in winning a greater voice for nurses in patient care/nursing practice decision-making.

Despite the inherent difficulties in organizing RNs, unions have had some success in bringing nurses into the labor movement in recent years. In fact, between 1998 and 2003, the percentage of the nurse workforce represented by unions increased from 16.8 to 19.5 percent. This occurred during a period when the percentage of the overall American workforce represented by unions fell from 15.4 to 14.3 percent (see Table 4). The fact that the rate of union representation is higher among nurses than for the overall workforce, and that it has been increasing as overall union representation falls,
is a positive sign for nurses’ unions (United American Nurses [UAN] 2004; Hirsch and Macpherson 2005).

**Union Strategies for Impacting Patient Care/Nursing Practice Issues**

In response to the concerns of their members, unions representing nurses have made patient care/nursing practice issues a priority. Unions have used three different strategies to address these issues. First, unions have bargained contract language regarding staffing, mandatory overtime, and floating. Most notably, they have used negotiations to push for minimum staffing levels and greater nurse input into decisions related to patient care by establishing nursing practice committees or councils. Second, nurses’ unions are working in the political and legislative arena to establish nurse-to-patient staffing ratios and to ban mandatory overtime. Third, they have turned to regulatory bodies to address unsafe nursing practices.

These multiple strategies are interconnected. For example, where unions have been able to establish legislated staffing ratios, these ratios have become the minimum standards for staffing. However, unions can use the collective bargaining process to negotiate even lower ratios. In addition, where legislation resolves an issue to the union’s satisfaction (e.g., the banning of mandatory overtime), the union is not forced to spend any of its “bargaining capital” on that issue. It can, instead, substitute a demand for some other desired contract provision in its place.
Table 4

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<th>% of Workforce Represented by Union</th>
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<td>1998</td>
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<td>RNs</td>
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Source: UAN 2004

Bargaining Language

Staffing Levels

Anecdotal evidence suggests that almost every set of negotiations involving a nurses’ union and an acute care facility includes discussions about staffing levels (Clark and Clark 2005). As suggested earlier, understaffing has become a chronic problem in hospitals across the country. The most common response by nurses’ unions is to try to negotiate contract language in two related areas.

First, unions have had some success winning contract language that establishes minimum staffing ratios for different departments in a hospital. Such language is based on having one nurse on duty for a certain number of patients. This ratio is different for different parts of the hospital and generally is smaller the more intensive the care becomes (e.g., a general medical/surgical floor might have one nurse for every seven patients, while an intensive care unit might have one nurse for one to two patients) (SEIU 2005a).

The Health Professionals and Allied Employees (HPAE)/AFT has negotiated such ratios for the nurses at the Bayonne (New Jersey) Medical Center.
For example, on the medical/surgical floors, the hospital must maintain a 7/1 patient-to-nurse ratio during the first shift of the day (normally 7 A.M. to 3:30 P.M.), an 8/1 ratio for the 3 to 11:30 shift, and a 9/1 ratio on the night shift. In the pediatric unit, the ratios are 5/1 for all three shifts, and in the intensive care unit the ratios are 3/1 around the clock (HPAE 2004a).

Second, many unions have negotiated some form of joint committees with management to discuss and monitor patient care/nursing practice issues. These committees take many forms, including “Professional Practice Committees,” “Joint Nursing Practice Councils,” “Patient Care Committees,” and “Staff Ratio Oversight Committees,” and often include equal numbers of representatives from the union and from hospital administration. In terms of staffing issues, these committees perform a number of functions. Where specific staff levels have not been negotiated into the contract, the committees might set the levels (Clark and Clark 2005; SEIU 2005b).

One of the most significant functions of such committees is to monitor staffing to ensure that agreed-upon levels are being met. Because the staffing needs of hospitals change constantly as both the number of patients and the specific type of care they require change, significant potential exists for disputes over whether sections of a hospital are being adequately staffed. In many contracts, the committees are charged with resolving such disputes. Some contracts specify how these disagreements are to be resolved if the joint committee cannot come to an agreement.

For instance, HPAE Local 5004 and the Englewood (New Jersey) Hospital and Medical Center have negotiated staffing levels for all units of the hospital. The contract requires that any disputes over these staffing levels be settled by a labor mediator chosen by the American Arbitration Association (HPAE 2004b). SEIU negotiated a similar arrangement at the Health Corporation of America’s Sunrise Medical Center in Las Vegas. Under their contract, Sunrise’s nurses first take their staffing concerns to a staffing committee. If the concern is not resolved to their satisfaction, the issue can be appealed to a special review panel (both the committee and the review panel are made up of equal numbers of staff nurses and managers). An arbitration provision is invoked if the parties cannot resolve the issue (SEIU 2005b).

Some unions have successfully negotiated provisions that give nurses the final say on appropriate staffing levels. A contract between the Minnesota Nurses Association and Fairview Hospitals gives charge nurses authority to determine whether sufficient staffing resources are available to meet patient care needs and to close the unit to further admissions for a designated period if not (UAN 2005).

While numerous examples illustrate that unions have made significant
progress on this issue, many show that progress has been slow. The case of Kaiser Permanente suggests how difficult the staffing issue can be. Kaiser Permanente is one of America’s largest integrated health care organizations. It serves the health care needs of members in nine states and Washington, D.C. In 1997, Kaiser Permanente created a Labor Management Partnership with twenty-six local unions representing its employees. The Partnership is one of the most ambitious programs of its kind and has accomplished a great deal in a relatively short period (Labor Management Partnership 2005). However, its efforts to address staffing problems in its facilities have yielded only mixed results (Kochan et al. 2005).

Kaiser Permanente and the Coalition of Kaiser Permanente Unions negotiated a joint staffing process as part of their 2000 labor agreement. The process was to be system-wide but, initially, it focused on a number of pilot projects. In some cases the projects developed joint staffing plans, but in other instances the efforts stalled. In 2003, the unions and Kaiser Permanente agreed to set the issue aside at the national level, while still encouraging local unions to pursue the issue at their workplaces (Kochan et al. 2005).

Mandatory Overtime

Given the increase in the use of mandatory overtime as a means of meeting the staffing needs of facilities, nurses’ unions have made this problem a bargaining priority. Contractual limits on mandatory overtime take a number of forms.

Most nurses’ unions strive to completely ban the use of mandatory overtime, and an increasing number of contracts contain such bans. The Minnesota Nurses Association has effectively eliminated forced overtime in most hospitals in the Minneapolis-St. Paul area by including contract language stating that “no nurse shall be disciplined for refusal to work overtime” (Minnesota Nurse Association 2004, 5). And the contract between Kaiser-Permanente and the California Nurses Association (covering the largest number of RNs in the U.S.) includes a ban on mandatory overtime (California Nurses Association [CNA] 2002).

When nurses’ unions have not been able to win a complete ban on overtime, many have settled for language that limits it to emergency situations only. SEIU has negotiated such language into their contract with the University of Iowa hospitals and clinics. While the language does not eliminate forced overtime, the hospital can no longer force nurses to work overtime instead of hiring more staff to fill vacant positions. At Mercy Hospitals in Scranton and Wilkes-Barre, Pennsylvania, a new contract negotiated by SEIU insures that mandatory overtime “can only be used as a last resort, when a comprehensive
process of seeking volunteers has been exhausted” (SEIU 2005g).

Another approach to reducing mandatory overtime is to place limits on the amount of overtime employees can be forced to work. SEIU has included language in their contract with Jackson Memorial Hospital in Miami that “nurses who work twelve-hour shifts may not be scheduled for more than three consecutive days without their approval” (SEIU 2005g). The contract also requires management to make every effort to post schedules four weeks in advance. This gives nurses an opportunity to adjust schedules according to their needs (SEIU 2005g). And at the Boston Medical Center, SEIU has negotiated a contract that limits the number of times the Center can force an individual nurse to work overtime to six times per year (SEIU 2005c).

One additional approach is sometimes combined with limits on mandatory overtime: an effort to increase the compensation for overtime work to discourage its use. A contract between SEIU and hospitals in upstate New York requires double pay for all hours employees work in excess of their regularly scheduled shifts (SEIU 2005h).

Floating

Nurses are also using collective bargaining to address the practice of moving nurses from their regularly assigned areas to other parts of the hospital. Of particular concern are situations where nurses are assigned to areas where they are unfamiliar with the personnel and the environment (layout, equipment, etc.) or where they feel unqualified to provide good care.

Since a complete ban on floating is, in most cases, unrealistic, unions have worked to restrict this practice. The most common language negotiated on this issue is to prohibit moving nurses to areas that are outside their areas of expertise. For example, SEIU’s contract with hospitals in New York City includes comprehensive floating policies that guarantee that nurses cannot be floated to areas where they do not have appropriate qualifications and training and where they have not had an up-to-date orientation (SEIU 2005i).

Another approach is negotiating contract language providing for nurses to be cross-trained to work in multiple areas and limiting floating to those specially trained nurses (SEIU 2005c). Nurses represented by SEIU at Laurel Regional Hospital in Maryland have a contract provision that requires cross-trained nurses to be floated before other nurses. Cross-trained nurses are to be paid a “float differential” in addition to their regular pay (SEIU 2005h).

Where they can, unions may try to bargain “float differentials” requiring hospitals to pay such floating nurses a wage premium above and beyond their normal rate. And in some hospitals, contract provisions are included that mandate the creation of special “float pools.” This arrangement is included
in an agreement negotiated by SEIU at Swedish Health Services Hospital in Seattle. At that facility, floating is handled by a special group of nurses who receive extensive, wide-ranging training. These nurses also receive a $5 per hour wage differential (SEIU 2003c).

The California Nurses Association has also negotiated language that prohibits “double floating” (the practice of moving nurses a second time in mid-shift) (CNA 2005a).

**Legislation**

In addition to addressing patient care/nursing practice concerns through bargaining, nurses’ unions are also using the political/legislative process to bring about change. The quality of patient care is a potentially potent political issue that touches the lives of many politicians and voters. And nurses have a very positive public image, which makes them a formidable political force (Gallup 2004).

Legislation that sets minimum staffing levels or bans mandatory overtime has a significant advantage over the negotiation of clauses in collective bargaining agreements in that such legislation could cover every healthcare workplace under the legislature’s jurisdiction. Thus, legislation would do across the board what might take nurse unions a very long time to achieve on an individual contract-by-contract basis.

**Staffing**

The most effective way for unions to address patient care/nursing practice would be the passage of federal legislation. A coalition of nurses’ unions successfully lobbied to have “The Nurse Staffing Standards for Patient Safety and Quality Care Act,” a bill establishing minimum staffing levels, introduced in Congress in 2005. However, the bill is opposed by the American Hospital Association, the industry’s employer group, and has little chance of being enacted by a Republican-controlled Congress in the near future. State legislatures, at least in some parts of the country, appear to be more open to such legislation (SEIU 2005d).

The most significant effort to date in this regard has been in California where a ten-year campaign by nurses’ unions resulted in the 1999 passage of a law mandating RN-to-patient ratios in California hospitals. Hospitals in the state fought the legislation, arguing that its passage would cost them $500 million annually and might force them to shut down some of their facilities if they were unable to find sufficient nurses due to the ongoing shortage (CHA 2003). At their behest, Governor Schwarzenegger raised legal challenges that delayed the implementation of the mandated ratios. However, in early 2005,
the court challenges were dismissed and hospitals in that state were ordered “to implement ratios of no more than one RN for every five patients in general medical units” and to restore safe staffing in emergency rooms (CNA 2005b). The ratios required by the act are significantly better than those found in most American hospitals (such ratios vary from 1/7 to 1/10 or even more) and nurses’ unions expect the law to attract more nurses to California and to have a positive impact on patient care (Lafer 2005).

Although no other state has passed safe staffing legislation, bills are being considered in a number of state legislatures, including those in Illinois, Florida, Iowa, Kentucky, Massachusetts, Missouri, Nevada, New Jersey, Oregon, Pennsylvania, Rhode Island, Colorado, New York, and others (SEIU 2005a).

**Mandatory Overtime**

Legislation has also been introduced at the federal level to address the problem of mandatory overtime in healthcare settings. The Safe Nursing and Patient Care Act of 2005 would allow “a nurse to refuse mandatory overtime in excess of the regular work shift or beyond 12 hours a day or 80 hours in a two-week period... [and] prohibit discrimination or retaliation against a nurse for refusing overtime assignments” (SEIU 2005e). Like the federal safe staffing bill, the political reality is that this legislation has little chance of passing in the near future.

At the state level, however, unions representing nurses have made much more progress in addressing the problem of mandatory overtime. To date, nine states—California, Connecticut, Maine, Maryland, Minnesota, New Jersey, Oregon, Washington, and West Virginia—have won restrictions on mandatory overtime. Most ban compulsory overtime after a nurse has worked twelve hours, although the New Jersey law prohibits it after eight hours, except in the case of an emergency (SEIU 2005e). Similar bills have been introduced in a number of states.

**Floating**

Nurses’ unions have made little legislative progress on the issue of floating. Their efforts to address this issue have focused largely on the negotiation of collective bargaining provisions restricting this practice.

**Regulation**

Healthcare is a regulated industry in the sense that various government agencies insure that medical facilities and practitioners provide certain standards of care to their patients. State nursing boards are responsible for establishing the standards for competencies of RNs and also for insuring that
nurses provide care in a professional and appropriate manner.

Another regulatory agency that impacts the quality of patient care/nursing practice is the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), a private agency operated and funded by the health care industry. It is responsible for certifying that the quality of care provided by hospitals meets acceptable standards.

Nurses’ unions are trying to use the regulatory power of these agencies to help them address patient care concerns. One approach has been to encourage state nursing boards to permit nurses to refuse work assignments they believe will place patients at risk. Currently, when nurses feel that short-staffing, mandatory overtime, or floating might result in unsafe conditions for patients, they have the right to file an “assignment despite objection” document that notifies the hospital about the nurse’s concerns. However, nurses are not generally permitted to refuse such assignments (unless they have relevant language in their contracts). If they do, they could be subject to discipline for “patient abandonment.” Unions have been lobbying state nursing boards to allow nurses to refuse assignments when, for example, they have a good faith belief that working a mandatory second shift would put patients at risk. It is not clear at this point if any boards have agreed to endorse such a policy.

Nurses’ unions also have been working to reform the system of hospital inspection used by JCAHO to evaluate the quality of care. SEIU, for example, has called on JCAHO to address more aggressively understaffing and other practices that reduce the quality of care nurses can provide. Specifically, SEIU has encouraged JCAHO to drop its practice of warning hospitals of inspections in advance, a practice that SEIU claims allows hospitals to mask many unsound practices in which they normally engage (SEIU 2005f).

Conclusion

Unions provide workers with an opportunity to influence, or have a “voice,” in the policies and practices in their workplace. Because of the central role they play in the delivery of patient care in our healthcare system, nurses are particularly concerned about patient care/nursing policies and practices. Not surprisingly, considerable anecdotal and systematic evidence indicates that nurses are much more inclined to support union representation if they believe the union can give them a greater role in patient care/nursing practice decisions (Clark et al. 2000; 2001).

In response, nurses’ unions are devoting considerable time and effort to restricting or eliminating practices their members see as having a negative impact on patient care. Specifically, they are using contract language,
legislation, and, in some cases, regulation, to address understaffing, the use of mandatory overtime, the practice of floating, and other patient care/nursing practice issues. Unions are also giving nurses a greater voice in the workplace by establishing joint committees that provide nurses with an opportunity to directly influence patient care/nursing practice policies. These multiple strategies are not separate and distinct; rather they are interconnected and mutually supportive. For this reason, this multifaceted strategy appears to have significantly more potential for giving nurses greater influence over the workplace and the patient care process then any single strategy.

Ultimately, it is difficult to measure, with any precision, the actual extent to which these strategies increase nurse voice in the workplace. Systematic research is needed to establish the degree to which unions’ efforts to increase nurse voice are effective and the extent to which increasing nurse involvement in decision-making leads to tangible improvements in patient care/nursing practice. Research is particularly needed to determine the potential that joint committees and councils have for influencing patient care/nursing practice. Such on-site workplace committees may provide one of the most effective means for rank-and-file nurse input in these areas. Finally, work is needed to determine whether increased nurse involvement in patient care decisions actually translates into increased nurse/member commitment to the union.

Note

1 Acute care is care related to short-term medical conditions requiring immediate attention. Such care is usually provided by specialized, highly trained personnel and is usually provided in a hospital or medical center setting.

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