The Impact of Nursing Unions on Job Satisfaction and Patient Outcome

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The nursing shortage is proving to be a serious public health issue. Nurses who feel unappreciated, overworked, stressed and underpaid are expected to remain professional and deliver caring and competent care despite personal frustrations (Gordon, 2002). Realistically this is difficult even among the most professional of nurses.

Some nurses believe that one alternative to the current slide in morale is to join together as a collective voice to facilitate change within the healthcare profession (Forman & Davis, 2002a). Although union membership in the private sector is declining (Cherry & Jacob, 2002), participation in nursing unions is increasing (“As shortages,” 2002) and may lead to improved patient outcomes because of increased job satisfaction among nurses and increased safety measures designed to protect both nurses and patients (Grady, 2002).

A national survey by the Federation of Nurses and Health Professions found that “one in five nurses plans to leave the profession within five years because of unsatisfactory working conditions” (“New Survey,” 2001). The survey suggests that some of the main reasons nurses are leaving the profession is the result of severe understaffing when patient loads and acuity are at their highest. Many stated the job was too stressful and physically demanding in addition to issues involving mandatory overtime, irregular hours, low morale and worsening work conditions (“New Survey,” 2001).

These frustrations are not only felt at a particular hospital or in a specific community but also nationwide. Leaving the profession should not be the only alternative for thousands of nurses who love taking care of patients but are discouraged by the increased demands placed upon them by management and the public.
Many nurses believe unionization would help elevate the profession and encourage more young people to consider nursing as a career (Forman & Davis, 2002a). However, there are other nurses who believe that the introduction of unions into an institution undermines the independent authority of the nurse and puts the patient at risk for substandard care (Brengman & Shields, 2000).

Both sides make valid points and are related to the public’s perception of nurses and the perception among nurses themselves. Although the National Labor Relations Act was passed in 1935 to allow workers to collectively bargain against long working hours and unhealthy conditions, nurses were exempt from this protection and were not legally allowed to form a union until 1974 (Cherry & Jacob, 2002; Forman & Davis, 2002a).

The nurse is an advocate for her patient, a caring and compassionate individual who puts the needs of others above her own. It’s an accurate perception but also a double-edged sword when trying to balance the needs of the patient with that of the nurse. Ann Shields, RN (2000) used a portion of the Florence Nightingale Pledge to support her anti-union argument, “[As a nurse,] I will devote myself to the welfare of those committed to my care.” She continues to state that, “All healing professions are first and foremost servants of the patient.” Shields continues to explain that an ethical and moral person puts the needs of the patient above his/her own needs.

What is missing from Shields’ argument is the rest of the Florence Nightingale Pledge, which continues by stating that as a nurse, “I will do all in my power to maintain and elevate the standard of my profession” (Donahue, 1996). Those who are anti-union and try to follow in Nightingale’s footsteps may be surprised to learn that although she is not the author of the pledge written in her name, it does indicate that she may have supported the unionization of nurses. In fact, she was one of the original feminists constantly striving to change the image of the nurse. A
nurse is not a “servant” with menial skills simply following the orders of the physician but a knowledgeable professional with unique skills that are important to a patient’s outcome (Donahue, 1996).

Part of the commitment involved in improving a patient’s outcome is supporting reduced nurse-to-patient ratios (Brengman & Shields, 2000). Nurses are expected to take care of more patients than ever before, nine or more at a time (Seago, 2002). The result of this heavy patient load is nurses forced to skip lunch and breaks which has a secondary result of fatigue and increased errors. Patients benefit from nurses who are working reasonable schedules and are able to take lunch or a break during the 8 or 12-hour workday (Brengman & Shields, 2000).

More than 1,700 patients have died and 9,548 have been injured in the five years between 1995 and 2000 due to poorly trained or overwhelmed nurses according to the Chicago Tribune (“Nursing mistakes,” 2000). A nurse was quoted in the same article as saying; “I wake up every day and hope I don’t kill someone today.” A sobering comment considering nurses are programmed wanting to help their patient not cause harm. An analysis of 3 million state and federal computer records showed that hospitals are sacrificing patient safety for a better bottom line (“Nursing mistakes,” 2000). If a hospital will not take the issue of nurse-to-patient ratios seriously, then another entity will have to pick up the fight.

Unions who feel that this is the most important issue facing nurses have assumed the battle. Lynne Brengman, BSN (2000) believes union representation promotes quality patient care by fighting for decreased nurse-to-patient ratios, safer working conditions, mandates on mandatory overtime and required lunch and rest breaks. Unions help with these issues by lobbying legislators to adopt mandatory limits on the number of patients a nurse can be assigned, which ultimately increases job satisfaction and improves patient safety (Bruder, 1999a).
In fact, unions are the only organizations actively trying to persuade legislators to pass laws limiting maximum nurse-to-patient ratios. The California Nurses Association (CNA) sponsored Bill AB394, which was passed in 1999. It was the nation’s first law mandating nurse staffing ratios for acute-care settings. The law requires the state department of health to enforce minimum nurse-to-patient ratios and adds a requirement for hospitals to adopt written procedures for training and orienting nursing staff (Seago, 2002). Adding additional laws is not always the best solution to a problem but in this particular case it was necessary to ensure public safety.

The nurse-patient relationship is similar to a contract. The nurse receives report at the change of a shift with the understanding that s/he is assuming full responsibility of the patient and will not relinquish responsibility of their care until another licensed nurse takes report. If the nurse’s replacement doesn’t arrive for one reason or another, a nurse would never abandon the patient just because the shift is over. It is not only illegal but also immoral (Shields, 2000).

However, some organizations take advantage of this requirement by mandating that the nurse work a double shift when short-handed instead of the alternative of calling an expensive agency nurse to take over patient care (Seago, 2002). The only recourse the nurse has with this, or any safety issue, is to file a complaint with the organization.

Filing a complaint in a non-union hospital may not be wise, especially in Indiana. Indiana is an “at will” state meaning that the employment relationship is presumed to be at-will and can be terminated at any time, by either party, with or without cause, with certain limited exceptions such as those created by state and federal anti-discrimination laws which prohibit actions based on sex, race, age, religion, national origin, disability, and union activity (Baker & Daniels, 1998).
A nurse who too frequently complains about safety concerns such as an unreasonable patient load or mandatory overtime could be fired without recourse. This is another important issue addressed by unions. Again, California is the front-runner in sponsoring legislation tackling this issue but other states are also fighting to have laws passed that to address these issues (Gordon, 2002).

New Jersey introduced a Mandatory Overtime Bill, which would have banned mandatory overtime for health care workers but was vetoed in 2000. Both New York and Wisconsin have passed Whistleblower Protection laws meant to protect healthcare workers from retaliation if they report unsafe conditions or care (American Teachers Association [ATA], 1998). Employees need to feel confident that they will not lose their job when trying to uphold standards in safety. Unfortunately, Indiana does not currently have legislation affording healthcare workers this type of protection.

Shields continued to argue in the article published in *Maternal-Child Nursing* (2000), that union guidelines do not allow managers the flexibility to develop work assignments that must adapt to the ever-changing needs of nursing staff or to adequately provide patient care. The translation is that when a staff member calls in sick or is late to work, the remaining nurses must increase their patient load. The problem is that the decision to increase the remaining nurses workload is based on financial reasons (Seago, 2002). The department can save money by not calling in additional staff.

Unions have made a significant impact on the formation of various regulatory agencies. Life for executives of large companies would be easier if governmental regulations and agencies such as the Occupational Safety and Health Administration (OSHA), Department of Labor, or the National Institute for Occupational Safety and Health (NIOSH) did not exist. However, for
the greater good of society corporations cannot always be trusted to make the welfare of their workers and the public more important than their pocketbook (Forman & Davis, 2002a).

Unfortunately, it is the same in the healthcare industry. Although it would be difficult to compare a nurse’s current environment to the sweatshops of the early 20th century, some of the issues involved in the formation of the unions in the manufacturing industry can still be applied to the healthcare industry. Financial issues frequently override public safety, which is an unacceptable prospect when dealing with life and death. If the administrators of an organization will not take responsibility for putting the health and welfare of their employees and patients first, and the employees do not have enough power individually to effect change within the organization, then a mediator may need to step in and bargain for the needs of the individual.

The mediator is the union bringing both sides together, not always in agreement but at the least creating a forum for discussing the issues. Forman and Davis (2002b) stated, “Unions don’t create the climate in which organizing activity thrives; they simply take advantage of it. The roots lie in the fertile soil of poor relationships between employees and their leaders.” A mediator attempts to establish an environment where employees can have impact and a “voice” in the day-to-day operations of the facility.

This voice is an important issue for nurses (Bruder, 1999b). Their nursing license is on the line. Their career is on the line. The prospect of making a mistake while having a person’s life entrusted to her care weighs heavy on the mind of an overworked nurse. In the past, nurses have been viewed as the “doctor’s handmaiden,” simply carrying out the orders of other healthcare professionals. But court cases have supported the fact that nurses are independent practitioners, responsible for decisions, working side-by-side with physicians and responsible for the actions of unlicensed personnel assisting with patient care (Cherry & Jacob, 2002).
The issue of nurses being viewed as independent practitioners is critical because a nurse can be sued and lose his/her license if unable to properly assess a patient, failure to catch an incorrect physician’s order or by not researching the side effects of a medication given in haste ("Nursing mistakes," 2000). Considering the seriousness of this implication, nurses should have input on standards of nursing care that affect their ability to properly perform the duties that are required by law.

A parallel concern related to a nurse’s independence and frequently addressed by union critics is that nurses have struggled to be viewed as professionals, an entity unto their own. Instead of individualism and independent excellence, they believe unions promote mediocrity and employment of sub-standard nurses (Forman & Davis, 2002a). They are afraid that under the protection of a union, nurses will become satisfied with just “good enough” and abandon attempts for improvement because of the difficulty within union organizations in rewarding exceptional individuals (Shields, 2002).

Unfortunately, even in a non-union environment, the requirements placed on nurses have not only lead to mediocrity but degraded further to indifference and disgust. The current atmosphere does not promote individualism and excellence.

For example, nurses employed in critical care settings are required to obtain specialized certifications but are not rewarded with extra compensation for these certifications. All floor nurses are paid exactly the same. Unless the nurse moves into a management position, the only compensation received for additional education or training is the pride of having obtained these skills.

Pressures on department managers to reduce costs, lead to raises barely above the cost of living. Shields (2000) believes that unions discourage individual initiative. However, Bruner was
quoted in Hospital Topics (1999) stating that “the average unionized facility recorded productivity higher than in non-union environments.” Unions are not discouraging individual initiative any more than it is already being discouraged by management, and the article by Bruder states that it actually leads to improved productivity.

An advantage to union negotiations is that it creates a forum where discussion of professional practice issues can be discussed (Bruder, 1999a). It forces management normally far removed from bedside care to consider the input of staff nurses who have direct insight to both the positive and negative aspects of the current healthcare environment (Brengman, 2000). Negotiations also give nurses insight to the difficulties of running a hospital during financially difficult times when staying up to date with technology is an expensive prospect for institutions (Bruder, 1999a).

Although patient safety is the most important argument for the endorsement of nursing unions, the issue perceived by critics as being the most important is the financial aspects of unionization. They argue that nurses in favor of unions are greedy, selfish and unconcerned with the needs of the patient (Bruder, 1999b). This could not be farther from the truth. Nurses pride themselves on constantly improving their skills and studying the newest breakthroughs in medical technology and pharmacology.

Improving skills and gaining knowledge isn’t done with the ulterior motive of increasing income but done to give the patient the most accurate information and perform the job to the best of the nurse’s ability. The commitment to their patient cannot be underestimated by the fact that the financial rewards of nursing should be brought in line with the responsibilities and the difficulties of the career.
Most states do not have strong union support among nurses (Seago, 2002). Brenda Meyer is a registered nurse who has worked in the healthcare field for over 25 years and a nursing instructor at Indiana-Purdue University in Fort Wayne, Indiana. She believes the reason unions have had such a hard time taking hold in the nursing profession is due to the subservient attitude of nurses in the past. Indiana does not support union membership, although organization has been tried several times in the past. Meyer was personally involved in two out of four attempts in the Fort Wayne area over the last twenty years. Two attempts for unionization occurred at Lutheran Hospital and two at Parkview Hospital (personal communication, April 10, 2003).

All were unsuccessful, not only because of the difficulty gaining the support of nurses afraid of losing their jobs but also because of the expensive campaign waged by the administration to influence voting. The American Nurses Association (ANA) supported and assisted the nurses in the last union attempt approximately six years ago. The law requires at least 30% of the employee group show interest (Forman & Davis, 2002b) but the ANA required a 60% approval vote by the nurses employed by the hospital. A 55% approval vote was obtained and union membership was defeated (B. Meyer, personal communication, April 10, 2003).

The case has been made regarding the benefit to nurses who work in a hospital where unionization is supported. A more important analysis of the benefit of nursing unions is whether actual patient outcomes have been improved in states with strong nursing unions. This would be a definitive sign of the benefits of nursing unionization. Unfortunately there as been limited investigation to whether a hospital employing union nurses have better outcomes than non-union hospitals (Seago, 2002).

One study is available however, and researchers interested in the effect of unionization on patient outcomes used California as the source for their research. Although Indiana has not been
successful in gaining strong support for union membership, California has been doing well in this area (“As shortages,” 2002). California has two strong unions, California Nurses Association and the Service Employees International Union (SEIU). Approximately thirty-five percent of nurses in California belong to one of these unions (Seago & Ash, 2002).

In this study researchers looked at the outcome of acute myocardial infarction (AMI) patients treated in union hospitals versus non-union hospitals. This is a difficult project to undertake because of the many factors involved in ensuring a positive patient outcome. Not only did the researchers have to consider union membership in these hospitals, but the wages and experience of the nurses, the technology available within each institution, expertise of the physicians, the comfort level of the staff with this particular disease process and patient characteristics (Seago & Ash, 2002).

What they found was an interesting testimonial to the benefit of union membership. The researchers attempted to take into consideration all of the above issues in making a fair and even comparison of union vs. non-union hospitals. During the study period, they collected data at 343 of the 385 eligible hospitals. Seago & Ash (2002) found that:

Having an RN union significantly predicted lower risk-adjusted AMI mortality in all models except [a few]…The significant finding in this study is that hospitals in California with RN unions have 5.7% lower mortality rates for AMI after accounting for patient age, gender, type of MI, chronic disease and several organizational characteristics. (p. 148-149)

Although this was a small study, it opens the door to further studies regarding patient outcome.

The researchers acknowledge that the findings are preliminary and nurses should not rush to join a union based on one study, however having a nursing union may have additional benefits
such as promoting respect and stability among staff, better communication with physicians, and increased confidence in decisions that may have a secondary consequence of better patient outcomes than in non-union hospitals (Seago & Ash, 2002).

Another important aspect of this study is that it may give nurse executives insight into the characteristics of a union that increase job satisfaction and improve patient outcomes (Bruder, 1999a). Having open communication between management and employees may be enough to increase job satisfaction among nurses. By giving them the “voice” that is so desperately needed, nurses may then decide to stay in nursing and encourage young people to consider nursing as a profession eventually relieving the shortage that is causing the current problems in staffing (Bruder, 1999b).

In a recent Letter to the Editor in The Journal Gazette, Tina Dearing (2003) a union member in a manufacturing industry making aircraft controls addressed the issues of unions and commented, “We are highly trained and constantly reminded that our job means someone else’s safety.” Not only true of airplane manufacturers but of nurses as well. Unions would not be necessary if employers recognized the importance of their employees and compensated them appropriately, not just monetarily but with reasonable working hours and safe conditions (Dearing, 2003).

Unionization may not necessarily be the only solution to the crisis that nurses are facing, however, unions are the only organizations willing to tackle the tough issues by lobbying for change to improve job satisfaction and patient safety.
References


