

III. Collective Bargaining and Economic Transition – Industry Studies

Nurses' Unions Efforts to Give RNs a Greater Voice in Patient Care

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Abstract

This paper will examine the efforts of nurses' unions to give registered nurses (RNs) a greater voice in the delivery of patient care in acute-care hospitals. Collective bargaining provides a forum in which nurses can voice their concerns about patient care issues and influence how care is delivered. Within the context of bargaining, nurses' unions use two different strategic approaches to address these issues—traditional bargaining and collaborative/cooperative programs. Both approaches, and the mechanisms used in each, will be discussed, as will the outcomes generated by these approaches.

Introduction

The American healthcare system is in critical condition. Although it spends much more per capita on healthcare than any other system in the world (see Figure 1), the quality of care trails that of many other nations (see Table 1; Kaiser 2007). These two factors—quality and cost—are the central challenges facing U.S. healthcare today.

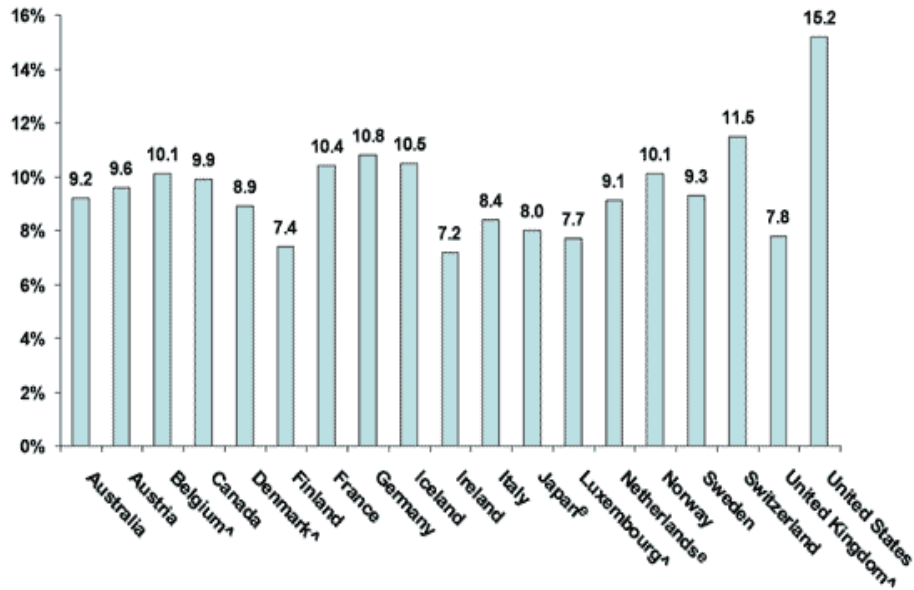
Acute-care hospitals typically provide immediate treatment for moderate to serious illnesses and injuries. Costs associated with these hospitals represent the largest category of costs incurred by the U.S. healthcare system. Registered nurses (RNs) play a critical role in these facilities as they serve as the primary, day-to-day caregivers. They also are the largest occupation category in the healthcare system and account for a significant proportion of the total labor costs incurred. For these reasons they have considerable potential to impact, in a positive or a negative way, the cost and the quality of healthcare.

In recent years, an increasing number of nurses working in acute-care hospitals have experienced unsatisfactory working conditions. Many nurses believe that understaffing, mandatory overtime, and floating, caused by an ongoing shortage of RNs, prevent them from providing appropriate patient care. As a result, more and more nurses have chosen, or are considering, union representation. The evidence suggests that nurses, in part, base their vote in a representation election on the degree to which they believe the union can give them a greater voice in how patient care is delivered (Clark et al. 2001). Accordingly, nurses' unions have increasingly focused on strategies for doing so. This presents nurses, and their unions, with a somewhat unique opportunity to use collective bargaining to help address the core challenges facing acute-care hospitals in the U.S.

This paper will examine the reasons why nurses are increasingly turning to unions and the efforts of nurses' unions to influence working conditions and the delivery of patient care in acute-care hospitals. Collective bargaining provides a forum in which nurses can voice their concerns about patient care issues and influence how care is delivered. Within the context of bargaining, nurses' unions use two different strategic

approaches to address these issues—traditional bargaining and collaborative/cooperative programs. Both approaches, and the mechanisms used in each, will be discussed, as will the outcomes generated by these approaches.

FIGURE 1
Total Health Expenditures as a Share of GDP in the U.S. and Selected Countries, 2003



Source: Organisation for Economic Co-operation and Development. *OECD Health Data 2006*.
<http://www.oecd.org/health/healthdata>.

TABLE 1
World Health Organization's Ranking of the Most Effective Health Systems

1.	France	19.	Ireland
2.	Italy	20.	Switzerland
6.	Singapore	22.	Colombia
7.	Spain	23.	Sweden
8.	Oman	25.	Germany
9.	Austria	26.	Saudi Arabia
10.	Japan	27.	United Arab Emirates
11.	Norway	28.	Israel
12.	Portugal	29.	Morocco
13.	Monaco	30.	Canada
14.	Greece	31.	Finland
15.	Iceland	32.	Australia
16.	Luxembourg	33.	Chile
17.	Netherlands	34.	Denmark
18.	United Kingdom	36.	Costa Rica
		37.	United States

Source: *The World Health Report 2000—Health Systems: Improving Performance*. World Health Organization, 2001.

Problems Facing Nurses in Acute Care Hospitals

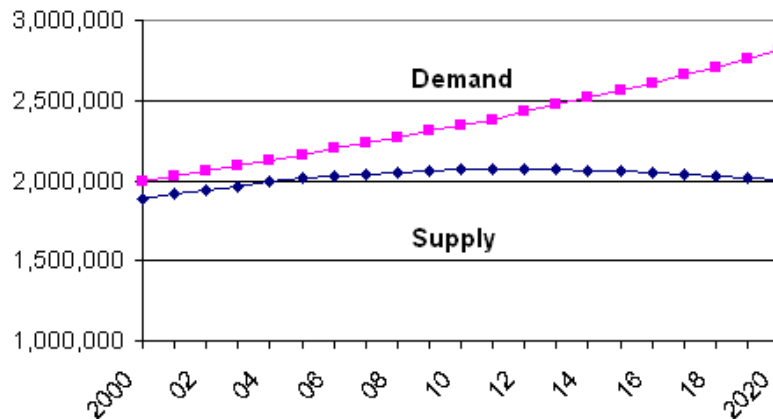
Nurses occupy a unique and strategically vital place in the healthcare delivery system. For this reasons, nurses' unions believe that RNs should be full partners in the American healthcare system, along with the other key players—physicians, administrators, insurers, and policymakers. They believe nurses' voices should be heard and valued in discussions about how healthcare in this country is made available, delivered, and funded.

Many nurses working in the U.S. healthcare system face dysfunctional work environments that prevent them from providing high quality care to their patients, undervalue their contributions, cause debilitating stress and frustration, and have contributed to a national nursing shortage that threatens the system's ability to meet society's needs in the short and the long term. Few RNs have a meaningful voice in the way care is delivered. Some receive the respect, recognition, and material rewards they merit; many do not. And as a profession, nursing's influence remains limited to traditional "nursing" issues.

In a 2001 survey of RNs, approximately 75% of the respondents reported that both their working conditions and the quality of nursing care in their facilities had declined in recent years. Of the nurses in this study, 38% reported that they felt "exhausted and discouraged" upon leaving work; 34% said they were "discouraged and saddened by what they could not provide their patients." And 29% felt they were "powerless to affect change" (Michigan Nurses Association 2001).

This dissatisfaction, and an accompanying sense of powerlessness, has contributed to the national nursing shortage (see Figure 2). The anxiety and guilt that result from not being able to provide appropriate care mount to the point that many RNs voluntarily leave acute-care nursing to work in less stressful occupations inside and outside the healthcare system. And of course, the inability of the system to stem the exodus of nurses sets a damaging dynamic in motion—as more nurses quit, fewer are available to care for the steady stream of patients who come and go, forcing the remaining nurses to take on a larger number of patients, which inevitably increases their stress and dissatisfaction, causing more nurses to leave, and on and on. Providing adequate, let alone optimal, patient care under these conditions becomes exceptionally difficult.

FIGURE 2
National Supply and Demand Projections for FTE Registered Nurses, 2000 to 2020



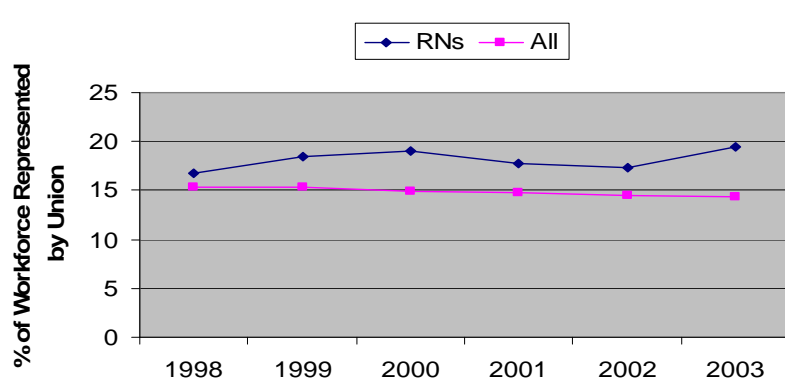
Source: Bureau of Health Professions, RN Supply and Demand Projections

Many nurses, however, have chosen to stay and use their voices to address the workplace problems and other employment-related issues they face. In many cases they have done so because, as the healthcare system's first-line care providers and patient advocates, they feel an obligation to do everything in their power to ensure that their patients receive the best care possible. All too often, however, they learn that the administrative hierarchy in their facility does not value their input and resists change at every turn. And they confront the reality that as individuals they have little power or influence to effect change for the better. At

this point, many RNs have begun to consider unionization in an effort to gain a greater voice in the workplace.

Over the last 10 to 20 years, nurses' unions have become the most effective vehicle for giving RNs a greater voice in their workplace and in the national healthcare system. As a result, union density among nurses has risen to approximately 20% (see Figure 3).

FIGURE 3
Union Density 1998 to 2003: RNs Compared to All Workers



Nurses have used that voice to win improvements in their working conditions, their economic situation, and the quality of patient care through collective bargaining. They have used it to influence state legislatures to pass laws mandating safe nurse–patient ratios, outlawing mandatory overtime, and protecting whistleblowers who draw attention to practices that put patients and healthcare employees at risk. And they have used it to lend weight to the push to reform our national healthcare system (Clark and Clark 2006).

Most nurses believe that they have an obligation to make sure their patients get the best care possible. Increasingly, they appear to recognize that this kind of care is most likely to be provided in a work environment where nurses are valued commensurate with their contributions and where they have a voice in how care is delivered. They also recognize that for the nursing profession to assume a role in the broader healthcare system, it needs to use its collective power to make its voice heard and to be recognized as full partners with other professionals in the American healthcare system.

Nurses as Patient Advocates

Nurses willingly assume the role of patient advocate and take this responsibility very seriously. The American Nurses Association Code of Ethics, and most state nurse practice acts, lists patient advocacy as one of the primary responsibilities of RNs. While many definitions of patient advocacy exist, most include a key theme—acting to ensure that the patient's welfare is paramount in any medical setting, procedure, or treatment.

Trying to live up to this obligation while caring for more patients than one can reasonably handle is a source of great stress for many working RNs. Often, when they leave work, nurses are physically, mentally, and emotionally exhausted. It is not unusual for nurses to mentally replay their work day in the hours after their shift ends and question whether they did all they could have or should have done for their patients. The real or imagined shortcomings in care they identify, and their belief that they are powerless to change a system that institutionalizes such suboptimal care, are the source of the guilt and the stress that many nurses carry around.

The conditions RNs are often forced to practice under, and the negative impact on patient care that results, suggest that the profession has fallen well short of the maximum potential as caregivers and patient advocates. One of the reasons for this is that individual nurses, or even a group like the ANA that represents 150,000 RNs, cannot be an effective advocate.

The concerns, views, and interests of patients are underrepresented in today's American healthcare system. They need a concerned and knowledgeable advocate to speak for them at both the hospital and the

national levels. RNs have the public's confidence, as evidenced by the fact that the nursing profession regularly tops the annual Gallup poll that rates the honesty and ethical standards of major occupations and by the fact that a 2002 Vanderbilt University survey found that 95% of Americans trust, respect, and admire RNs and view their opinions on health matters to be credible (Sigma Theta Tau 2002). There is little doubt that the public would prefer to have nurses rather than insurance executives, politicians, or even physicians represent their interests at the hospital and at the national level.

RNs today have a better, broader, and more comprehensive education than previous generations of nurses. They have strong backgrounds in a number of physical sciences; a detailed knowledge of hundreds of drugs, their side effects, and their interactions with one another; a familiarity with computer software and the ability to operate an array of high-tech equipment; a solid grasp of myriad laws and ethical standards; and the kind of people skills that require a highly developed understanding of the human psyche. And they need to be able to apply this knowledge and expertise, with grace under pressure, as human lives literally hang in the balance, day after day.

This background, combined with the accumulated knowledge of an experienced nurse workforce, suggests that nurses have a tremendous amount to contribute to the American healthcare system. For the sake of their patients, the healthcare system in general, the nursing profession, and themselves, RNs must assume a larger role in discussions regarding how patient care is delivered, whether those discussions occur at the bedside or in the national arena.

Winning a Greater Voice for Nurses

Today's RNs are well equipped to assume full partnership in the American healthcare system. Their broad and extensive knowledge, experience, and skill, and the fact that they are on the front lines delivering care and interacting with patients day in and day out, attest to their potential to advocate for patients and for patient care.

All professions and occupations evolve over time as the skills and knowledge required change and technology advances. But the nursing profession has undergone a more dramatic metamorphosis than most other professions. The nurse working in the modern American healthcare system is as different as could possibly be from the nurse of 150 or even 50 years ago. The role of nurse evolved from the domestic role that women had for centuries played in the home as wives, mothers, and daughters or as domestic servants. The role required little formal education, depending more on instinct, intuition, and information passed down from one maternal generation to the next.

As suggested earlier, nursing today is, in every sense of the word, a profession. The education, breadth and depth of knowledge, and independent judgment required compare favorably with other science-based professions. And the responsibilities nurses accept on the job every day exceed those of many other professional occupations. Yet nurses, collectively, are not perceived as full partners by healthcare decision-makers. While nursing, as a field, has made some progress in recent decades, nurses are often still relegated to a narrow and limited role in the healthcare system that is not commensurate with the vital and critical patient care duties they perform.

Overcoming Management Resistance

Contemporary nurses have the expertise, the skill, and the knowledge to play a bigger role in the healthcare system than they are presently accorded. And the evidence suggests that they desire to make a bigger contribution. However, employers appear to be reticent to tap into the profession's collective experience and energy.

One possible explanation for this reticence is that most healthcare administrators, health insurance executives, policymakers, and, to a lesser degree, physicians, believe that they are in the best position to reform and reshape the American healthcare system, despite the fact that these groups bear significant responsibility for creating the present, which, at best, is viewed as underperforming and, at worst, is seen as largely dysfunctional.

In most cases, these individuals resist efforts to broaden the role that RNs play in the healthcare system not because they hold any deep animosity toward nurses or do not share the goal of quality patient care, but because they have been socialized by their training, their mentors and colleagues, and the culture of

the system to believe that nurses exist to perform a limited and specific function in the healthcare system and have little to offer in terms of workable ideas and strategies for improving the delivery of care. And because they have been trained to believe that control and decision-making are zero-sum commodities, they are concerned that if they share control with nurses or involve them in decision-making, their own position in the system will be diminished.

The American healthcare system appears to be in desperate need of new ideas, approaches, and new voices. Nurses can bring a fresh, informed, and patient-centered perspective to the effort to redesign a workplace or an entirely new healthcare system; however, the system's present leadership is unlikely to voluntarily offer them a seat at the table. To ensure that both nurses and patients have an advocate in any reform process and that better working conditions and greater voice for nurses and improved quality of care for patients are priorities in any such effort, nurses will need to speak as one voice and insist that they be heard.

Nurses' Unions and Nurses' Voice

The importance nurses place on having a greater voice in patient care issues appears to be reflected in the attention nurses' unions pay to these issues. In recent years virtually all nurses' unions have used the collective bargaining process to provide opportunities for nurses to influence the quality, and to a lesser extent, the cost, of patient care. As we have suggested, these efforts have taken two strategic forms—the traditional bargaining approach and a more consultative, cooperative approach. The former has resulted in explicit contract language designed to improve working conditions for nurses and the quality of care they can provide, and the latter has created numerous mechanisms for nurses to actually participate in discussions and decisions about how care is provided. Both of these approaches have been utilized to address three of the major care-related issues of concern to RNs—staffing, mandatory overtime, and floating.

Collective Bargaining—Contract Language

Staffing Levels

As hospitals have tried to cut costs by reducing the number of nurses they employ, understaffing has become a chronic problem. In recent years, most negotiations between nurses' unions and acute-care facilities have included discussions about staffing levels (Clark and Clark 2006). Nurses' unions have used bargaining to try to win contract language that ensures adequate staffing levels.

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; Service Employees International Union 2005a).

The Health Professionals and Allied Employees (HPAE)/AFT has negotiated such ratios for the nurses at the Bayonne (NJ) 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, an 8:1 ratio for the evening 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 (Health Professionals and Allied Employees 2004b).

Some unions have also negotiated contract language requiring that staffing disputes be resolved by neutral third parties. For instance, HPAE Local 5004 and the Englewood (NJ) Hospital and Medical Center have negotiated staffing levels for all units of the hospital. The contract requires that any dispute over staffing be settled by a mediator chosen by the American Arbitration Association (Health Professionals and Allied Employees 2004a). 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 (Service Employees International Union 2005b).

Lastly, some unions have successfully negotiated provisions that give nurses the final say on appropriate staffing levels. A contract between the Minnesota Nurses Association (MNA) 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 if staffing is not sufficient (Minnesota Nurses Association 2005).

Mandatory Overtime

The efforts of many hospitals to cut their workforces to the bare minimum, combined with a national nurse shortage that has developed over the last several years, has meant that facilities often operate with the absolute minimum nurse workforce possible. When a nurse calls off sick or a hospital experiences a higher-than-normal census, administrators often turn to mandatory overtime to meet their staffing needs. Because of the disruption mandatory overtime causes in its members' lives, and the danger presented by nurses working excessively long hours, many nurses' unions have negotiated contractual limits on mandatory overtime.

The goal of most nurses' unions is a complete ban on mandatory overtime, and an increasing number of contracts contain such language. The MNA 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 Nurses 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 2002).

When not able to win a complete ban on overtime, many nurses' unions have settled for language that limits mandatory overtime to emergency situations. 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” (Service Employees International Union 2005c).

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 12-hour shifts may not be scheduled for more than three consecutive days without their approval” (Service Employees International Union 2005c). The contract also requires management to make every effort to post schedules four weeks in advance to give nurses an opportunity to adjust schedules according to their needs (Service Employees International Union 2005c). 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 (Service Employees International Union 2005d).

One additional approach that is sometimes combined with limits on mandatory overtime is to try to increase the compensation for overtime work to discourage its use by hospitals. A contract between SEIU and hospitals in upstate NY requires double pay for all hours employees work in excess of their regularly scheduled shifts (Service Employees International Union 2005e).

Floating

Floating is the practice of moving nurses from their regularly assigned areas to parts of the hospital with a greater need. Many RNs believe this practice is problematic, particularly where an RN is required to work in an area of the hospital in which she or he has insufficient experience or knowledge to deliver the kind of care required. This is an additional issue that nurses' unions are trying to address through collective bargaining. Since a complete ban on floating is in most cases unrealistic, unions have worked to place restrictions on it. The most common language negotiated on this issue is a prohibition on 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 (Service Employees International Union 2005f).

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

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 a part of 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 and receive a \$5 per hour wage differential (Service Employees International Union 2005f).

The California Nurses Association has also negotiated language that prohibits “double floating” (the practice of moving nurses a second time midshift; California Nurses Association 2005b).

Collective Bargaining—Consultation/Cooperation

A second strategy unions have employed to increase nurse voice in decisions involving patient care is forming consultative mechanisms through which nurses have regular opportunities to discuss patient care-related issues with management. These committees are often established through bargaining and operate throughout the life of a contract. In some hospitals they are simply termed “labor–management committees”; in others they take the form of “Professional Practice Committees,” “Joint Nursing Practice Councils,” “Patient Care Committees,” or “Staff Ratio Oversight Committees.” They usually meet on a regular schedule (e.g., biweekly, monthly, quarterly) and often include equal numbers of representatives from the union and from hospital administration.

From the union perspective, these mechanisms are based on the belief that RNs, as the healthcare professionals who provide direct patient care around the clock, are in a unique and critical position to contribute to decisions about how to maintain and improve the quality of care, as well as how to minimize its cost. And there is evidence to suggest that these mechanisms have great potential in these regards.

In a study of 14 hospitals in the Minneapolis–St. Paul area over 10 years, a researcher found that “labor–management committees improve communication and ease the process of implementing new hospital practices in response to changing market demands in a manner that protects the quality of patient care” (Preuss 1999:1).

The report finds that labor–management committees lead to higher nurse staffing ratios for patients (Preuss 1999), a practice that has been shown to have a positive impact on the quality of patient care (Aiken et al. 2002). In addition, the institution of such committees was found to be directly linked to better hospital financial performance (Preuss 1999). In this regard the author of the report indicates that

the development of cooperative relations between management and just two occupational groups is correlated with an increase of \$26 in income per patient day. . . . Comprehensive cooperation across all union groups is correlated with nearly \$80 more in income per patient-day when compared to hospitals with no cooperative relations with unions. Either way this is a dramatic economic benefit, since hospital income . . . ranged from –\$147 to \$284 per patient day over the course of the study (Preuss 1999:27).

Nurses’ unions across the country have used the bargaining process to establish various forms of consultative/cooperative mechanisms in their members’ hospitals. The Massachusetts, Minnesota, and California Nurses Association, for example, include language in all of their contracts with acute-care hospitals that require the formation of such groups. They often focus on four general issues—staffing, mandatory overtime, floating, and safety and health.

Staffing

Staffing issues are a primary topic of discussion for these committees. In the absence of established staffing ratios, a committee might gather data and study staffing patterns and problems as a first step toward establishing ratios. They might then set staffing guidelines or even specific staffing levels (Clark and Clark 2006; Service Employees International Union 2005b). Where such guidelines or ratios are in place, these committees often monitor compliance and resolve disputes over staffing. Some contracts provide for an arbitrator to determine whether the level of staffing is adequate if the hospital implements ratios lower than those endorsed by the labor–management committee.

Mandatory Overtime and Floating

Where mandatory overtime or floating is restricted or banned by contract language or legislation, joint committees can serve to monitor compliance. In the absence of such restrictions, committees can gather information about such practices and begin to work toward solutions.

Workplace Safety and Health

Nurses in acute-care hospitals face numerous safety and health problems, ranging from exposure to communicable diseases and toxic substances to injuries resulting from lifting patients and equipment to workplace violence. Meetings of working nurses and administrators provide a useful forum for discussing hazards that either side may identify in the workplace. Because avoiding on-the-job injuries is beneficial to both sides, these issues can often be effectively addressed by joint committees.

The formation of such groups, however, does not guarantee that the union and employer representatives involved will be able to shift from an adversarial mode to a cooperative one. The effectiveness of existing collaborative efforts in bringing about change in patient care practices appears to vary considerably.

Different nurses' unions approach the issue of consultative/cooperative programs differently. One of the most notable approaches in this regard is that of the California Nurses Association (CNA). CNA, and its national arm—the National Nurses Organizing Committee (NNOC), is the fastest growing nurses' union in the country. CNA/NNOC has 80,000 members in 50 states and has a reputation of being very aggressive, both in organizing and in bargaining. It has 14,000 nurse–members working in 70 Kaiser Permanente (KP) facilities in northern and central California. KP has established one of the largest, and most high profile, labor-management partnership ever undertaken in the U.S. It includes over 86,000 employees and more than 25 local union partners from eight international unions. However, CNA has chosen not to participate.

When the partnership was proposed in the late 1990s, CNA stated that their opposition to the initiative was, at least in part, based on an unwillingness to accept the quid pro quos Kaiser required of all partnership unions. These included the following:

- not opposing Kaiser's business plan, which included hospital closures, restructuring that included nurse layoffs, and cuts in preventive care and other services
- actively marketing Kaiser's "preferred health plan"
- agreeing to a "confidentiality" clause that required members of the partnership to refrain from criticizing Kaiser (California Nurses Association 2008b)

CNA's opposition also seemed to have roots in the turbulent relationship with KP that predates the partnership and, later, with its equally turbulent relationship with SEIU, the other major union representing KP employees. However, CNA's past and current opposition to the KP partnership suggests a less idiosyncratic basis for their refusal to participate in the KP initiative. Conversations with top CNA officials suggest that a major reason for its commitment to a more adversarial approach to employers is grounded in its broader, long-term, vision for the nursing profession (Clark and Clark 2008).

CNA's ultimate goal appears to be a nurse workforce that plays a significantly greater role in decisions about how patient care is delivered. The union believes that RNs serve as the chief advocate for patients in a dysfunctional healthcare system and that they have an obligation, as well as the expertise and experience, to fulfill this responsibility. This is reflected in a CNA policy statement:

CNA RNs will never join a partnership where the price of admission is the silencing of the voice of patient advocacy. The price is too high and would subject their patients to a market which clearly values crude economic cost benefit analysis over alleviating human pain and suffering (California Nurses Association 2008c).

CNA's commitment to an adversarial approach to collective bargaining appears to be based on the belief that administrators will not voluntarily relinquish any control over the decision-making process and that the only effective way to wrench this power from employers is to use the unions' collective power. Interestingly, while CNA vehemently opposes the KP partnership, it does negotiate quasi-consultative/cooperative mechanisms into all of its contracts, including the one with KP. These mechanisms, called Professional Practice Committees (PPC), are committees of elected staff nurses who meet on company time in the hospital to address practice issues. Their first priority is monitoring staffing levels. Another PPC focus is the introduction of technology and its impact on nursing practice (California Nurses Association 2008a).

The difference between the KP partnership and CNA's PPCs appears to be that PPCs do not place the kind of restrictions on participants that the partnership did. Provisions for the PPCs are negotiated into the contract, and CNA insists on preconditions of its own, among them the right to take disputes over staffing to binding arbitration.

CNA's more adversarial approach, and the success they have experienced employing it, is intriguing because it appears to fly in the face of the conventional wisdom about nurses and the culture of the profession. An integral aspect of the culture of nursing is selfless devotion to patients. This selflessness has often led to passivity and conflict avoidance on the part of nurses when it comes to their role in the healthcare system. One manifestation of this has been the view that nurse unionization is irresponsible and unprofessional. CNA has challenged this inherent discomfort with unionism by turning the view on its head and arguing that nurses, as patient advocates, have a duty to use their collective power on behalf of their patients to improve the quality and efficiency of care. In other words, they have argued that it is irresponsible and unprofessional *not* to organize a union and use collective bargaining to improve patient care (Clark and Clark 2008).

Compared with other nurses' unions, CNA's consultative/cooperative initiatives are much more of an integral part of adversarial bargaining than a mechanism separate and distinct from bargaining. However, like other approaches, much of the focus of these efforts is the key issue of concern to RNs—the quality of patient care (Clark and Clark 2008).

Conclusion

The American healthcare system significantly underperforms given the resources invested in the system. In particular, its costs are the highest in the world, while quality of care lags behind that of many countries. Nurse collective bargaining in the U.S. acute-care hospital sector is unusual given that a significant part of the focus of bargaining is quality of patient care. And because of the critical role that nursing plays in the delivery of healthcare in hospital settings, the outcomes of bargaining in this sector have significant potential for improving the quality of patient care, and to a lesser extent, the cost of care.

Given the high priority the nursing profession places on nurses' role as patient advocate, nurses' unions have made patient care a high priority in bargaining. Using both traditional collective bargaining and negotiated collaborative/cooperative programs, unions have effectively addressed workplace practices such as staffing, mandatory overtime, and floating that have significant patient care implications. These approaches are consistent with the objectives of nurses' unions, particularly CNA, to give the nursing profession a greater voice in the delivery of care.

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