Title

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Journal

Medical Care, 52(5)

ISSN

0025-7079

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Publication Date

2014-05-01

DOI

10.1097/mlr.0000000000000124

Peer reviewed

HHS Public Access

Author manuscript

Med Care. Author manuscript; available in PMC 2024 May 13.

Published in final edited form as:

Med Care. 2014 May ; 52(5): 393–397. doi:10.1097/MLR.0000000000000124.

What do health care unions do? A response to Manthous

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Abstract

In response to Manthous (2014) we discuss the role of unions in health care. The ethical quandary that Manthous perceives in health care worker unions is overstated because patient and worker interests are frequently aligned. The search for a "selfless" union overlooks the importance of adequate compensation for providing excellent care. The collective actions employed by health care workers' unions need not include strikes or slowdowns and can be consistent with patient safety and well-being.

1 Introduction

Manthous (2014) has written a provocative and potentially constructive analysis of the role of collective action by health care workers, recognizing challenges to patient safety posed by corporate health care's profit motive. He argues that physicians, registered nurses (RNs), and other health care workers can play a crucial role in protecting patient safety through collective action, but worries that health labor unions' pursuit of their workers' self-interest puts patients at risk. His proposed alternative for empowering health care workers to protect patients, but not to pursue their own self-interest, is out of touch with the law, structures, and practice of labor relations, and how these institutions function in U.S. health care.

Manthous's essay shows little familiarity with the state of unionization or the institution of collective bargaining. Manthous describes health care as having low union density (p. 2), but the 20-percent unionization rate for RNs, compared to 7 percent in the private and non-profit sector (Bureau of Labor Statistics, 2013b), is notably high (although rates varies enormously across the U.S., with unions representing over half of RNs in some regions and none in others). The proposed structures and functions already exist within health care labor unions and the alternative institutions are neither feasible nor desirable. Empowering workers to use their familiarity with the workplace to pursue policy goals is more likely to achieve Manthous's aims.

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We first consider Manthous' ideas regarding physicians, then turn to labor-market institutions for RNs and less-credentialed health care workers. We make three main points: (1) because health workers' working conditions are patients' care conditions, their interests often align on issues of staffing, scheduling, and process; (2) RNs' main methods for advocacy have been workplace and policy campaigns that protect or enhance patient safety; and (3) the concentrated power of health care employers requires strong equalizing institutions to protect workers and patients.

2 Physicians' unions

Manthous focuses his discussion on physicians' unions, including a description of the short-lived Physicians for Responsible Negotiation. Physician unionization has an interesting history in the United States (Budrys, 1997). However, the fact that U.S. physicians are most often self-employed or employed in group practices limits the prospects for their unionization.

Budrys (1997) argues that physicians' unions could become important, particularly at the intersection of physician concern for patient well being and diminishing physician autonomy as corporate entities increasingly control health care. Yet (as Manthous describes), physician unionization has not taken off. The Department for Professional Employees at the AFL-CIO estimated that only 5.5 percent of practicing US physicians in 1999 (42,000 of 755,000) belonged to unions, with perhaps as many as 20% of this small number being resident physicians employed by hospitals (Carlson, 1999) who rapidly leave unionized positions for practice. Given the limited importance of physicians' unions in U.S. health care, Manthous' plea (to pursue patient well-being rather than self-interest) would be better directed at physicians' professional organizations than to their unions.

3 Nurse Caring Conditions are Patient Care Conditions

Just as teachers' unions define common ground with students and parents with the observation that "teacher working conditions are student learning conditions," the working conditions of RNs are, largely, patient care conditions. RNs' bargaining, regulatory, and legislative goals typically protect both working conditions and patient care; conflict over staffing ratios, scheduling, and overtime, as well as wages, dominate RN collective bargaining.

Our most important objection to Manthous is that the complaint against nursing unions perpetuates the dangerous fallacy that physically and mentally demanding, high-quality work can be supported other than through good pay and good working conditions. These are necessary for attracting and retaining skilled practitioners and enabling good work.

Manthous' "selfless" union (p. 10) is the institutional analogue of the selfless nurse whom Heyes (2005) celebrates in "The economics of vocation or 'why is a badly paid nurse a good nurse'?" Both rely on gender-stereotyped, "angel of mercy" nurses, an image rooted in the free services offered by churches and other charitable institutions until the rigorously scientific Florence Nightingale (not her mythic "lady of the lamp" persona) invented the profession of nursing and lobbied it into existence (Hott and Garey).

In responding to Heyes, Nelson and Folbre (2006) argue that high RN salaries contribute to high-quality care by enabling hospitals to select RNs from larger pools of highly-skilled workers. Earlier (2000) they had observed that nurses' commitment to patient well-being can lead them to stretch themselves to compensate for inadequate staffing. Hospitals can – and do – exploit this excess commitment; U.S. health care relies on substantial unpaid contributions from RNs who forego breaks or continue to work after "clocking out." The U.S. Department of Labor recently ordered a Texas hospital to reimburse nurses for unpaid overtime and meal breaks (Clark, 2011).

Eventually, however, the cynical strategy of exploiting selflessness unwinds, as would-be RNs pursue alternative careers, reducing the stock of highly qualified workers, or take second jobs, to make ends meet (Khazan, 2010). Gordon (1998) describes the reluctance of older RNs to encourage young people to pursue an undervalued profession.

Manthous's ideal organization would exclude "wage issues or work conditions that do not impact the quality of care or patient safety" (p. 10). Yet workplace conditions—staffing, cleanliness, security, exhaustion—manifestly do affect patient care (Stimpfel and Aiken, 2013). The health care shop floor is experienced collectively by workers, frontline managers, and patients alike, albeit with substantial variation in intensity, privacy, and power. Thus, the form, conditions, and control of the workplace matters greatly for providers, managers, and consumers. Mandatory overtime or inadequate staffing, for example, can create an unpleasant and dangerous situation for patients and RNs alike.

Even the desire for a middle-class wage, which might seem removed from the immediacy of the workplace, affects care quality. Health care workers who feel the need for second jobs, or are anxious about their own health insurance, child care, or mortgage, may be more prone to errors. Ultimately, wages contribute importantly to staffing availability in the short run, to recruitment and retention in the medium term, and to the long-term sustainability of a high-quality workforce.

The institutions that treat patients and employ health workers focus on profit and costs as well as care. Whether led by physicians (Pauly and Redisch, 1973) or hospital administrators (Newhouse, 1970), both non-profit and for-profit hospitals are large health-care labor buyers and act similarly (Spetz et al. (1999); Seago et al. (2004)). Hospitals have substantial control over the price, quantity, and quality of their inputs and products. Especially in isolated markets, RNs often face a single, monopsonist buyer, able to enforce a below-market wage, to provoke excess turnover and to be slow to fill vacancies (Staiger et al., 2010).

The classic complaint against unions is that by controlling the labor supply they can demand higher wages than would occur in a competitive labor market. And, indeed, hospital unionization can increase costs (Wilson et al., 1990; Morey et al., 2008). Manthous worries that higher wages may constrain hospital activity in dimensions that benefit patients, for example, by reducing the number of patients served or the quantity or quality of nursing and other inputs. But there is a health-care exception. Expensive equipment is a likely marketing point, and Spetz and Baker (2000) and Rosenthal (2012) observe that in the "medical arms race" among competing hospitals, buying expensive but underused equipment often takes

precedence over ongoing operational costs like nursing. The strongest incentive is to cut the quantity and quality of nursing labor at the margin where it is least likely to generate an actionable mistake (Currie et al., 2005); union rule enforcement, rather than wage advocacy, matters most here.

Hospitals may not face adequate market discipline for safety consequences because many patients have only one realistic choice, dulling their sensitivity to hospital quality and safety information. As hospitals become more profit-focused, the tendency to exploit the twin advantages of monopoly on the patient side and monopsony on the worker side, grow. Health care workers' unions provide counterweights to these hospital advantages.

Health care products are often complex, involving affect and communication, such as in pain management. The work often requires complex decision-making and attentiveness to physical and emotional needs, and the relations between effort and outcomes are uncertain. Worker engagement and cooperation is needed for effective care, but such efforts are neither fully observable by managers nor enforceable by contract.

Realistic models for organizing worker contributions to patient well-being must consider US law and institutions of collective bargaining, with the efficiency case for collective bargaining principally deriving from the shared workplace. Workers must coordinate among themselves and with employers in establishing workplace forms and conditions. This sometimes produces trade-offs between employers and workers, for example, employers agree to higher wage rates in exchange for increased discretion in setting hours. In other cases, coordination may mean aggregating disparate worker preferences. For example, some workers prefer higher pay rates for overtime while others prefer to limit overtime altogether. But today's workplace collective action goals are more likely to involve resisting *mandatory* overtime and demanding adequate staffing than higher wages.

4 Communication and control

We agree with Manthous that worker autonomy and open communication can contribute to patient safety. Power is important in any workplace, as managers give workers both explicit and implicit instructions. Hospitals add the wrinkle of physicians, who are neither hospital employees nor managers yet provide labor and also manage the labor of other health care workers; indeed, hospitals are noteworthy for their highly structured and hierarchical array of occupations.

Because RNs have specific institutional and case-based knowledge, effective communication between health care workers and hospital management is good for patients. Unions institutionalize this communication, through their "voice" function (Hirschman 1970 and Freeman and Medoff 1984). Labor law (Section 8(a)2 of the National Labor Relations Act) prohibits negotiations between management and non-union employee organizations. The idea is to prevent management from creating "company unions" that would exploit opportunities for enhanced communication and cooperation without adequate reward or true participation. Employers may hesitate to initiate shared governance or collaborative committees because working with employee organizations without the collective-bargaining

relationship violates labor law. Also, employees may be reluctant to participate in potentially co-opted employee organizations. Thus, the collective bargaining relationship is in a unique position to facilitate other formal modes of communication between RNs, hospital management, and the medical staff, such as quality circles. Baskin and Shortell (1995), Shortell and Hull (1996), Shortell et al. (2000), Shortell et al. (2001), and Ferlie and Shortell (2001) have shown that these improve patient outcomes. We (Seago and Ash, 2002; Ash and Seago, 2004), have also found positive associations between the presence of RN unions and favorable patient outcomes.

Decades of studies show that hierarchical hospital employment structures can inhibit communication between RNs and MDs. (e.g., Stein 1967, 1968, Stein et al. 1990, Goodwin and Taylor 1977, Murray 1986, Marsden 1990,and Gjerberg and Kjolsrod 2001.) Unions can improve communication in several ways. Longer RN tenure, enabled by higher wages, may increase trust between RNs and MDs as respect for the judgment of particular individuals increases with years of experience.

In a much-cited article, surgeon-journalist Atul Gawande (2007) argues that checklists can significantly reduce medical errors. While checklists are tools for managing information, they can also be tools for redistributing power. An essential paragraph describes how a health-services researcher

> …persuaded the hospital administration to authorize nurses to stop doctors if they saw them skipping a step on the checklist…This was revolutionary. Nurses have always had their ways of nudging a doctor into doing the right thing, ranging from the gentle reminder (“Um, did you forget to put on your mask, doctor?”) to more forceful methods (I’ve had a nurse bodycheck me when she thought I hadn’t put enough drapes on a patient). But many nurses aren’t sure whether this is their place, or whether a given step is worth a confrontation…The new rule made it clear: if doctors didn’t follow every step on the checklist, the nurses would have backup from the administration to intervene. (Gawande, 2007)

The essay describes reduced infections, deaths, and costs attributable to this innovation. One possible interpretation is that good administrators can empower the right people (without labor unions). However, labor unions provide an efficient, institutionalized way to transfer power - and a significant improvement on “nudging.” Checklists may be particularly effective in the highly-structured operating room, but open communication can help anywhere. Unionization may encourage RNs to speak up in ways that improve patient outcomes, but that might jeopardize a non-union career (Gordon et al., 1996; Gordon, 1998). By protecting RNs from arbitrary dismissal or punishment, RN unions help offset the hierarchical relationship between RNs and medical staff or hospital administrators.

Many managers resist RN unionization, assuming that it is difficult to manage in a union environment (Harper et al., 1994; Flarey et al., 1992). Breda (1997) and Flarey et al. (1992) report some RNs view union activity as adversarial and unprofessional (Flarey et al., 1992). Breda (1997) and Flarey et al. (1992. Unionization is associated with lower employee morale and job satisfaction (American Organization of Nurse Executives, 1994; Sherer, 1994; Harper et al., 1994; Seago et al., 2011), but why? Do unions make RNs dissatisfied?

Do RNs dissatisfied with a workplace incline towards unionization? Do unionized RNs feel freer to complain? In truth, we do not know.

Increased staffing levels may improve care quality and, thus, patient outcomes (Kovner and Gergen, 1998; Needleman et al., 2002). Staffing levels have been a particular focus of RN union activism. In California, RN unions started turning to government regulation to mandate staffing ratios in all – not only unionized – hospitals (Coffman et al., 2002). These efforts, with variable success (Seago et al., 2012), have spread to other states and to broad efforts to mobilize regulators, legislatures, and the public to give RNs a voice in staffing levels.

5 Tactics of Health Care Unions

Even with shared goals, the means employed by RN unions can jeopardize patient well being. Manthous is concerned that health workers' unions will use strikes or slowdowns to enforce higher wages through the workers' monopoly on hospital labor. In fact RN unions more typically use non-traditional workplace tactics including work-to-rule, regulatory interventions, lobbying, and community, patient, and stakeholder mobilization. RN strikes are highly regulated, requiring advance notice and other patient safeguards.

While RN strikes can affect care quality (Gruber and Kleiner, 2012), strikes and slowdowns are rare in health care. The Bureau of Labor Statistics (2013a) identified only eight health care work stoppages involving 1,000 or more workers; seven involved nurses. Unlike the other eleven large work stoppages in 2012, all eight were short; five lasted for five days and three, just one day each. Shorter actions are often symbolic rather than intended to shut down the activity of the hospital. With over 3 million RNs in the US, this is not a lot of nurse-related work stoppages. Furthermore, BLS does not distinguish between strikes and employer lock-outs, so it is not clear how many were union-controlled.

In health care, non-cooperative job actions, the union's "stick" in negotiations with management, are unlikely to involve strikes or slowdowns, with their potential to jeopardize patient health; more likely, they employ work-to-rule, to seek enforcement by the state or accreditation agencies of regulations (especially concerning staffing ratios and mandatory overtime), and to inform patients and communities about safety concerns or hospital shortcomings. Indeed patient mobilization in the interest of both RNs and patients is an important strategy. Budd et al. (2004) tells how a union local applied both traditional and non-traditional means to secure gains for patients and workers.

In summary, in US health care today, the means that health care workers' unions actually use to force hospital management's hand do not deny care to advance self interest, which limits the relevance of the ethical quandary that concerns Manthous.

6 Success and vulnerability: RN unions and less-credentialed health care workers

Last we examine an area of health care labor relations that Manthous has overlooked: the sometimes fraught relations between RNs and health care workers with lower formal qualifications.

RN organizing success —for both patient- and self-interest — has been based on integrating a craft-union model, in which control over the supply of skilled labor is the basis of workplace power, and a professional model, in which workers adopt and internalize ethics and norms.

Nurse managers often resist integrating professional and worker identities; as RNs they are drawn to a professionalist ethic, but as managers, they may be unfavorably disposed towards unions (see for example American Organization of Nurse Executives (1994)).

RNs have struggled to address the tension between the craft- and professional- union models. In 1995 the California Nurses Association (CNA), then the nation's largest labor union for RNs, severed its ties with the American Nurses Association (ANA), the leading professional association, because of the ANA's ambivalence towards unionization and CNA's collective bargaining strategies (Sherer, 1994; California Nurse, 1994). By 2006, following two decades of transition in health care and union organization by RNs, ANA forcefully denounced the National Labor Relations Board (NLRB) attempt to reclassify RNs so as to exclude them from unions. The President of the ANA called the NLRB's position:

> … an assault on the rights and preferences of nurses regarding whether or not they choose to join a union. We recognize that collective bargaining may not be the choice for everyone, but protecting and preserving that right is fundamental to the safety and well-being of both nurses and the patients they serve. (Patton, 2006)

An underappreciated concern is that RNs are firmly within the craft-union model, with ongoing tensions between their unions and those of less-credentialed health care workers - certified nurse assistants, nurses' aides, orderlies, attendants, food-service workers, custodial staff, and other hospital workers. For example, SEIU represents many types of healthcare workers, but RNs can feel that their power is diluted when SEIU negotiates as a single group. CNA itself faces this problem when negotiating for highly credentialed nurse practitioners, a relatively small group within their union.

Less-credentialed health care workers are usually excluded from RN unions. But while the craft-professional hybrid model of RN unions has clearly defended patient well-being and helped make nursing a middle-class profession, over time it may undermine their ability to transform health care to benefit patients and workers. Forging constructive relations with less-credentialed health care workers presents a key challenge for RN unions that could bring substantial benefits for both workers and patients.

Acknowledgments

We thank the Agency for Healthcare Research and Quality (AHRQ) for support under grant R01 HS014207 and Arlene Ash for comments and suggestions.

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