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Nursing Education: Unions and their place in the curriculum

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Abstract

Nursing unions are currently on the rise in the United States and therefore their implications to the Nursing profession are becoming more relevant. This paper will explore the history of unions in the profession of Nursing, the goals of nursing unions, and evidence regarding the impact nursing unions have on patient outcomes. This background will give Nurse Educators (NEs) the information needed when considering including the topic of nursing unions into nursing curricula. Finally, the implications for NE practice when adding nursing unions into curricula will be outlined.

Keywords: nursing, unions, education, unfair labor practices, collective bargaining

There is currently little to no inclusion of the topic of nursing unions and their implications for the profession of Nursing in nursing school curriculums. The absence is likely due to the very polarizing views of unions in general with some people finding their presence a detriment while others see them as invaluable. Including the topic of nursing unions into the curriculum is strongly related to the lack of reliable and unbiased sources of information (Cherry, 2014). While reliable and unbiased sources are not readily available, educating future nurses to understand the concept of unionization within the context of their professional role as a registered nurse is important.

As healthcare systems continue to change and challenge all professionals caring for those they serve, assuring that our workforce can and does make informed decisions about their participation in established unions is vital. In this paper the history of unions in the profession of Nursing, the goals of nursing unions, and evidence of the impact nursing unions have on issues concerning nursing professionals, patients and systems will be described. The paper will conclude with a discussion of the pros and cons of including the topic of nursing unions in nursing curricula and implications for Nurse Educator (NE) practice.

Background and Significance

History of Unionization in the United States

There are unions representing American workers across many different industries such as government workers, factory workers, truck drivers, janitors, healthcare workers, clerical workers, and teachers. There are two main goals of unions in general with the first being to improve wages and the second is to improve working conditions (Moody, 2014; Spetz, Ash, Konstantinidis, & Herrera, 2011). The lack of fair wages and a safe working conditions are frequently reasons that workers seek unionization, however unions also give groups of workers a

collected and unified voice when discussing concerns with employers. The height of union membership in the United States occurred in the 1950s when 35% of eligible workers unionized (Bureau of Labor Statistics, 2016). The profession of Nursing has been in a conflict over unionization since the 1940s when it began to consider it. Two of the reasons that are frequently cited in the literature as to why nurses forming unions were perceived as negative include, one, that Nursing is a profession and professionals were typically not members of unions at that time (Northrup, 1948; Raelin, 1989; Seidman, 1970), and two, many nurses felt that union tactics such as strikes were not compatible with their professional values and ethics (Northrup, 1948). The concept of professionalism versus unionism is greatly debated in Nursing, a topic that is discussed in greater detail later in this paper.

Union Membership

Nurse union membership was around 18% from 1983 to the mid-1990s, and then began to increase around 2005 (Spetz et al., 2011; p. 61). While there isn't data on nursing union membership rates prior to 1983, it is reported that healthcare union membership overall was at 13% in 1974. It is unclear how close this value reflects Nursing specifically (Hirsch and Schumacher, 1998). Current private sector union membership rates are 6.7%. This sector is the one that the Bureau of Labor Statistics (BLS) most often links Nursing to (BLS, 2016). With 21% of all nurses currently employed in hospitals reporting as union members in the United States (Spetz et al., 2011, p.61), it can be ascertained that Nursing has more than three times the union membership to that of other private industries. Arguments within the literature and Nursing community challenge that nursing union membership is at an all-time high, yet this argument is not conclusive due to the lack of accurate data from before 1983. The relative

difference of union membership between other private sector industries and Nursing does however leave room for additional questions to be asked.

Types of Unions

There are many different unions representing nurses across the United States. The largest nursing union is National Nurses United (NNU) with 185,000 members (NNU, 2016a). There are multiple other nursing unions and state associations that operate in the U.S. such as the National Federation of Nurses, Oregon Nurses Association, or Washington Nurses Association. (Moody, 2014). There are also nurses that are represented by non-nursing entities such as the American Federation of Teachers, Service Employees International Union (SEIU), and the United Steelworkers (Moody, 2014). In addition to unions representing Nursing issues there are many professional organizations representing the diverse specialties of Nursing. The leading professional organization in the United States is the American Nurses Association (ANA). Each union is unique, however the founding principles of creating a unified voice, improving working conditions, and improving wages are inherent in all of them.

Nursing unions are on the rise in the United States and this growth has many implications for the profession of Nursing. Currently, there is little to no inclusion of nursing unions in nursing school curricula. There are many aspects to the rise of nursing unions which could be utilized by NEs when designing assignments relevant to the changing healthcare environment. Nursing unions have financial, ethical, professional, and personal implications for nursing students and the Nursing profession as a whole.

Literature Review

History of Unions in Nursing

Collective bargaining and the ANA. Nurses have been using *collective bargaining* since World War II (WWII) to improve wages and working conditions. Collective bargaining is when a group of workers, often represented by an organization, negotiate with an employer to improve wages and working conditions (ANA, 2016b). Collective bargaining is frequently done by unions but it is also done by professional organizations. For instance, the ANA is a professional Nursing organization whose primary goals are to advance the profession of Nursing, represent the interests of nurses, and improve the health of America (ANA, 2016a). They also participate in collective bargaining. Northrup (1948) describes that in the 1940s there were many concerns in Nursing regarding wages, working hours, and working conditions. The ANA's action to begin collective bargaining was a deliberate step to assist nurses in resolving these issues, and to also prevent nurses from turning to unions. Seidman (1970) explains that the ANA used collective bargaining to raise wages and it also funded a large media campaign to improve working conditions. This media campaign was to gain nurses a forty hour work week, whereas previously nurses worked whatever hours each hospital required (Northrup, 1948).

These successes were important for the ANA as it was feared that if their economic improvement plans failed then unionism would begin to spread into Nursing. During this time period, the ANA was very clear that it did not support unions for Nursing for various reasons, with the number one reason being that Nursing is a profession and its ethics were not compatible with union tactics (Seidman, 1970). However, it must be considered that the ability of unions to increase the wages of their members and improve working conditions is a significant achievement for the profession of Nursing (Spetz, Ash, Konstantinidis, & Herrera, 2011).

Professionalism versus Unionism. The topics of professionalism versus unionism are greatly debated in Nursing literature. Two schools of thought are pervasive, including 1) that professionals do not need and should not form unions and 2) that professionalism and unionism can be synonymous in some form (Realin, 1989). The ideas both seem to have validity which is why nurses continue to struggle with this debate even today.

For many nurses their professional ethics, standards, and morals are the pillars of their field and the concern with unionism is that it will negatively impact these. Many authors note the ethical conflict when nurses choose to strike (Cherry, 2014; Kany, 2007; Realin, 1989). There is this sense that striking nurses have abandoned their patients. In addition to striking, the process of forming a union can be perceived as negative as it creates a divide among nurses who should be a unified profession (Kany, 2007). Cherry (2014) describes the unionization process as emotionally taxing on nurses as they endure a variety of emotions from the discord in the workplace. Believers of professionalism want to see all nurses working together to gain advancements to Nursing as a whole. They view unionism as a dividing force among nurses.

Nurses that lean more towards professionalism believe that there are alternative methods to unions which could be used to advance the profession such as education, political lobbying, and public campaigns (Kany, 2007; Realin, 1989). Those nurses that do not believe in unions may or may not believe in collective bargaining, even when it is done by a professional organization (Seidman, 1970). Some of these nurses think professional organizations are acting too much like a unions at times stating that, “the difference between a professional association and union has become blurred over the years as many associations have adopted trade union tactics and functions” (Seidman, 1970, p. 103). Nurses focusing more on professionalism would hope to see Nursing organizations such as the ANA focus on advancing the profession of

Nursing through increasing the education of current and future nurses, and less on the economic issues facing Nursing.

One organizational behavioral theorist by the name of Realin (1989) poses the question, “Is it possible for nurses to be professionals and a union member?” To attempt to provide an answer to this question, Realin begins by explaining how professions become deprofessionalized from natural causes or the result of outside forces. He gives examples of these natural causes as social trends, economic trends, demographic trends, political trends, and situations where the profession becomes less necessary to people. Realin also addresses the many outside forces that can impact the profession of Nursing, including but not limited to the healthcare industry itself. The healthcare industry continues to put pressure on nurses to change in manners that are seen as undesirable and is one reason nurses may turn to unions for help. Unions can also be seen as an outside force causing deprofessionalization. By removing individualization, a paramount factor in professions, and creating standardization in its place, unions do not allow for members to earn individual achievements for there is a need to be equal and fair among the members (Realin, 1989). While there are ways in which unionism can be seen as contrary to professionalism, Realin (1989) also suggests that unionism can be a method to reintroduce professional qualities back into Nursing. While reintroduction is possible, the author challenges that Nursing unionism can only gain back some of the attributes of professionalism which were lost, however, it’s also possible that without unionism there would have been no regaining the lost professionalism of Nursing at all (Realin, 1989).

The debate about whether unions support or deter Nursing professionalism does not have a black and white answer. Despite previous counter maneuvers to deter nurses unionizing, the ANA uses language today that describes their current support for the right of each nurse to be a

union member or not and engage in collective bargaining in both their position statement and their *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2016b). Understanding the evolution of thought and support for or against unionization in Nursing warrants further examination.

The rise of unions in Nursing. A discussion of the rise of nursing unions would be incomplete without including the ANA even though they are not a nursing union. Both actions and inactions by the ANA have had historical and current impacts on nurses' choice to join a union. When the ANA began to collectively bargain for groups of nurses in 1950 it created a no-strike policy (Seidman, 1970). This policy was meant to set a standard for the profession of Nursing that union striking was incompatible with Nursing ethics and standards (Northrup, 1948). The no strike policy did lead to the ANA, nurses and state nursing associations putting pressure on employers using other methods including informational picketing, media campaigns, sick calls, and mass resignations (Seidman, 1970, p. 342). The ANA specifically focused on the media campaigns whereas state associations employed the other methods more frequently. While there were successes associated with the collective bargaining and media campaigns launched by the ANA, some state associations were not satisfied with these results. Thus, by the mid-1960s these state nursing associations and some unions representing nurses began to hold strikes to pressure employers. In response, the ANA removed its no strike policy in 1968 (Realin, 1989). Some believe that the reluctance of the ANA to use more aggressive methods during bargaining led to more nurses joining unions in the 1960's, however there isn't concrete evidence to support this. There is however, evidence that there was a shift of some of the state associations affiliated with the ANA to act more like unions in their representation of the nurses in their purview. The

most active of which at that time were California, Minnesota, New York, Washington, and Massachusetts (Seidman, 1970; p. 343).

Division in the ANA and formation of National Nurses United. The tension in the profession of Nursing between the ANA and other organizations representing nurses began when the ANA started participating in collective bargaining and continued through 2009 (Cherry, 2014). It is felt by some bedside nurses that ANA's leadership is not very representative of Nursing as a whole with nurse executives, managers, supervisors, and nurse educators serving as leaders of ANA instead of nurses who are actively practicing at the bedside (Kany, 2007; Northrup, 1948; Raelin, 1989; Seidman, 1970). Differing opinions of what should and should not be included in collective bargaining are evident between nurse executives and nurses at the bedside. Where executives confine collective bargaining to wages and working conditions, important issues for bedside nurses, such as staffing, are excluded. In combination with the discrepancy in leadership, there were also many members of ANA that did not support the organization participating in collective bargaining (Kany, 2007). Cherry (2014) explains that many of these nurses lived in right-to-work states and these nurses wanted the organization to focus more on professional development. Questions about whether the ANA's resources were being directed towards collective bargaining or professional development led to the desire for more financial transparency. Additional concerns about membership, collective bargaining and the representation of the board also existed. This was due to the board of directors being made up of nursing executives, some of whom were employed in places of employment involved in collective bargaining activities with the ANA (Kany, 2007). The potential ability of a board member to interfere with the collective bargaining for staff nurses within these hospitals posed serious conflicts of interest.

In response to a desire for change by its membership, the ANA formed the United American Nurses (UAN) in 1999 (Cherry, 2014). The UAN's purpose was to provide financial clarity and separation of activities associated with collective bargaining from the ANA. The UAN remained an affiliate of the ANA. Kany (2007) explains how the creation of the UAN allowed the ANA to strictly promote the professional activities of its members while the UAN is responsible for the bargaining activities.

Despite responding to its members request for separation, the ANA's actions to form the UAN proved not enough to heal the division of values in the ANA. In 2009 the California State Association and Massachusetts Nurses Association disassociated from ANA to combine with the UAN to create the National Nurses United (NNU) [Cherry, 2014]. The NNU's (2016a) describes its mission to "organize all direct care RNs into a single organization capable of exercising influence over the healthcare industry, governments, and employers." Since its inception, the NNU has grown to be the largest Nursing union in the United States with 185,000 current members (NNU, 2016a).

Laws impacting unions and collective bargaining

Understanding the laws that impact unions and collective bargaining units is necessary to better understand the complex nature of how and when unions can and should intervene on behalf of their members. A discussion of these laws follows.

National Labor Relations Act. There are two specific laws which impact collective bargaining and the everyday actions of unions. The first law is the National Labor Relations Act (NLRA) which was passed in 1935. The law describes how it protects private sector (non-government) worker's right to organize and form unions. Under this law, the right of worker's to do so are protected through a board which reviews and prosecutes *unfair labor practices*

(Cherry, 2014). National Labor Relations Board (NLRB) [2016b)] defines unfair labor practices (ULPs) as when an employer or a union violate the terms of the NLRA. Some examples of ULPs against employers obtained from the NLRB (2016b) include threats, unlawful discipline against employees for union activities, and refusal to bargain. The NLRB (2016b) also outline the common ULPs against unions which are the failure to represent an employee and failure to bargain in good faith.

The NLRB also approves and holds union elections (NLRB, 2016a). For instance, when a union is introduced or decertification of an existing union is required, and a majority vote is necessary. There are strict labor laws that prohibit coercion tactics from both the employer and the union during the time leading up to the vote (NLRB, 2016b). While both unions and employers attempt to persuade the voters to vote their platform, coercion is strictly forbidden and is punishable through this law. In the event that a union is given the majority of the vote then the employer must recognize them as the exclusive bargaining agent. This fact is significant for two reasons; one, it prevents the employer from having different unions which could lead to a weakening and division of workforce they are supposed to represent, and two, it reiterates that the employees, not the employers, are the ones that get to choose which union will represent them (NLRB, 2016a).

Taft-Hartley Act. The second law which significantly impacted early efforts of unionization in Nursing was the 1947 Taft-Hartley Act. When the law passed it excluded non-profit hospitals from having to follow the NLRA and ultimately prohibited nurses working in non-profit hospitals from being able to unite. The ANA has worked throughout the years following the passing of the Taft-Hartley Act in 1947 to have it amended. After spending a great

deal of time and money to organize a national campaign an amendment to the Taft-Hartley Act passed in 1974 removing the exemption for nonprofit hospitals (Raelin, 1989).

Right-to-work States. According to the National Right to Work Legal Defense Foundation (2016), there are twenty-six states which are *right-to-work states*. These include Florida, Wisconsin, and Texas to name some. According to Kany (2007), right-to-work states exercise provisions in the 1947 Taft-Hartley Act which allows workers to be in union shops or facilities without having to be a paying member of the unions. If a person wants to work in a union shop or facility in other non-right to work states, they must be a paying union member (Kany, 2007; Cherry, 2014). It is felt that the lack of financial support for unions from its members in the non-right-to-work states has the potential to weaken the strength of the union, and therefore membership fees are mandatory if you work in a union shop or facility. Having clear and explicit goals for each union has the most potential for improving and/or engaging new member participation.

The Goals of Nursing Unions

Goals of nursing unions are varied but most commonly include improving compensation and improve working conditions. There have already been improvements to working conditions in the past, such as gaining a forty hour work week, and currently nursing unions are focusing on lowering patient-nurse ratios. A discussion of these goals are detailed below.

Improved compensation. Since the introduction of unions in the United States, one of their primary goals has been to improve wages. This is also true in nursing unions (Northrup, 1948; Cherry, 2014; Spetz, 2011). Efforts to improve wages began in 1946 when the ANA began collective bargaining. Unions have continued using collective bargaining to improve wages, but they have also added more union tactics to achieve this goal. Today, the NNU

(2016a) outline salary goals in a document titled “*Model Contract for RNs across the Nation.*” Included in these goals are differential rates of pay for evening and night shifts which are vital in Nursing as it is a twenty-four hour, seven days a week, year round profession.

Lower nurse-patient ratios. It is widely reported that a decrease in nurse-patient ratios is often affiliated with improved patient outcomes, especially mortality (Griffith et al., 2016; Shekelle, 2013). Nursing unions use their collective voice to include patient-nurse ratios in employer negotiated contracts. The passage of lower staffing ratios in California in 2004 is an example of how nursing unions can collectively lobby to gain government mandated ratios. There was a significant amount of research done on nurse-patient ratios following the passage of California’s staffing law in 2004. Since the early 2000s, the research on this topic has shifted to clarifying that improved patient outcomes are directly related to a reduction in nurse-patient ratios and not the result of other variables (Griffith et al., 2016; Shekelle, 2013). This new research seems to be prompted by government organizations trying to justify the potential increased costs to healthcare organizations that could be incurred by decreasing nurse-patient ratios. Economists are also interested in this topic and have reported that the initial increase in cost would be offset by the benefits of lives saved, a concept discussed next in nursing union outcomes (Griffith et al., 2016, p. 218).

Nursing Union Outcomes

Compensation. A nurse’s sense of being underpaid is a leading factor to seeking unionization (Spetz et al., 2011). Today, the majority of nurses are employed in hospitals. The hospital’s dominance of the employment of nurses is an example of a *monopsony* (Hirsch and Schumacher, 2005). A monopsony exists when “individual firms face upward-sloping labor supply curves and therefore have market power that enables them to set wages” (Staiger, Spetz,

& Phibbs, 2010, p.212). This is also true in the United States where hospitals often seem to have the power to set Nursing wages. The idea of Nursing being an example of a monopsony is debated in the literature. For instance, Hirsch and Schumacher (2005) suggest that Nursing is no longer a monopsony. The authors argue that hospitals can only exercise short-term monopsony power, and that their findings indicate that in the long-term other factors lead Nursing to not be a true monopsony. For instance, the mobility of nurses to move between hospitals keeps wages competitive. Alternatively, it is possible that the potential ability of hospitals to decrease their wages could be offset due to hospitals increasing the current nurses' workload (Hirsch and Schumacher, 2005).

Newer research done by Staiger et al. (2010) concluded that hospitals do have significant monopsony power related to Nursing. Staiger et al. (2010) indicate their research is more likely to be accurate due to their ability to control for variable wages when other researchers were unable to do so in their research. Staiger et al. (2010) had exact beginning and ending nurse wages due to the records from the Veteran Health Administration (VA) hospitals. There may or may not be a monopsony in Nursing, but the evidence suggests that being in a union may deter the effects of a monopsony (Link & Landon, 1975). Evidence of alternative methods that Nursing could use to counteract the effects of a monopsony other than nursing unions was not found.

Nursing unions accomplish the counter-balance in power through their ability to create a unified voice to negotiate for a higher wage. Nurses that work in facilities that are unionized are reported to earn an average of 18.8% higher wages than non-unionized nurses (Spetz et al., 2011, p. 63). Nursing unions accomplish this increase in pay not only from a higher base pay, but also from negotiating shift differentials. For instance, according to the NNU (2016a), one of the

goals for a contract negotiation is to have a 12% evening shift differential and a 20% night shift differential. Despite nursing unions being able to negotiate higher wages for their members, some of the increase in pay is offset by the union dues required. While all nursing unions are different, an example of how these fees might offset the higher wages can be described in a common approach to dues. Nursing unions often charge \$64-\$78 per month, it could be a flat rate or based on the nurse's hourly pay (Massachusetts Nurses Association [MNA], 2009). For a nurse working 160 hours per month, and 12 months per year this would result in around 1% of a nurse's annual pay going towards union dues. These calculations suggest that despite paying for dues, there are still significant financial benefits for unionized nurses.

Patient Outcomes and Nursing Unions

While outcomes for nurses themselves are important, arguably one of the most important outcomes are those of the patient. There is limited research available directly investigating the presence of nursing unions in hospitals and their impact on patient outcomes. Interestingly only one of the articles written included a nurse as a co-author. Economists seem to be the majority of researchers looking into the impact of nursing unions on hospital quality, or patient outcomes. Most of the articles concluded that nursing unions had either a positive impact on patient outcomes or a neutral impact. Yet, of the authors that indicated a positive impact they also stated it is not possible to conclude if the relationship is a causal one (Seago & Ash, 2002; Ash & Seago, 2014; Dube, Kaplan, & Thompson, 2016). The difficulty with this question is that it is unethical to perform random-controlled studies on a topic such as this one.

In one study by Seago and Ash (2002) the authors compared acute myocardial infarction (AMI) mortality in California hospitals with and without nursing unions. In an effort to be as accurate as possible the authors deliberately accounted for variables such as, "age, gender, type

of AMI, and chronic illnesses, for acute care hospitals in California” when calculating their results (Seago & Ash, 2002, p. 143). The study finds that hospitals with nursing unions have 5.7% lower AMI mortality risk when compared to non-unionized hospitals (Seago & Ash, 2002). The authors thus reported that a positive relationship between nursing unions and AMI mortality could be established, however a causal relationship between nursing unions and patient outcomes could not. In a subsequent study, the same authors (2004) determined an overall positive relationship with nursing unions and AMI mortality. In this publication the authors also discussed the mixture of positive “outcome-improving practices (retention, quality-selection, and communication) and outcome-harming practices (adversarial workplace relations and personnel budget-squeeze)” of unions (Ash & Seago, 2004, p. 440). These were important points to address as it is often assumed by hospital management that nursing unions are a negative presence. The authors also gave hospital management some guidance on how to utilize their research recommending that management try and remain neutral while nurses’ attempt to unionize as nursing unions are not the negative entity they are often thought to be. The authors also suggest that management should continue to explore what aspects of nursing unions might contribute to improved AMI outcomes and try to replicate these traits in settings with and without nursing unions (Ash & Seago, 2004).

In a different approach to examining the impact of nursing unions in hospital settings, Dube et al. (2016) reviewed specific hospital patient outcome data for the three years before unionization and for the four years following unionization. The authors compared hospitals that had successful unionization, those that failed to elect a union, and baseline hospitals. A causal relationship was reported between nursing unions and improved patient outcomes, yet the authors emphasize that further research is needed to confirm whether it is the unionization itself,

increase in wages, changes to staffing, or work rules as the cause of the improvement in patient care quality.

In looking more broadly at unions in general, Koys, Martin, LaVan, and Katz (2015) examined the density of unions in hospitals and patient outcomes. The study was unique in that it was a national study and the previous studies were only statewide. The authors were not able to find any associations between increased union density and increased or decreased patient outcomes as measured by AMI mortality rates. The authors also looked at financial implications of unionization and reported no impact on the net income per bed, an important consideration for hospital administrators.

Lastly, in yet another approach at examining patient outcomes within the hospital setting, authors Morey, Scherzer, Lee, Wallis, and Gladney, (2011) investigated the financial implications and quality of patient care at New York State hospitals. Indicators other than AMI were used to measure quality in this study such as pneumonia mortality, hip fracture mortality, stroke mortality, and congestive heart failure mortality. The authors initially reported that the presence of nursing unions had a negative impact on overall financial and patient outcomes due to the increase in cost from higher wages and negative impact on quality of patient care. However, when adding in the variable of staffing levels, the presence of a nursing union became statistically insignificant (Morey et al., 2011). As such, the authors concluded that staffing has the greatest impact on quality of care and not the presence or absence of a nursing union.

The Impact of Nursing Strikes

The term “union” is often thought of synonymously with the term “strike.” While much of the public may believe that strikes are a choice that nurses make, nursing unions perceive going on strike as a necessity. Moody (2014) discusses the common reasons for nurses to go on

strike as concerns over working conditions, staffing, wages, or benefits. Strikes have resulted in definite gains that nurses have achieved yet there have been losses as well. Koys et al. (2015) discussed the loss in both hospital and nurse income. A recent multi-hospital strike in Minnesota lasting six weeks cost the corporation at least \$104 million dollars, and likely more for financials are not available for the entirety of the strike (Olson, 2016).

Loss of income is not the most serious result of a strike, there is also research indicating higher mortality for patients during strikes. Gruber and Kleiner (2012) studied strikes that occurred in New York and determined an 18.3% higher mortality rate compared to the hospitals' baseline (p. 155). The patients most at risk for higher mortality were the sicker patients, or those that the authors called "nursing-intensive patients" (Gruber & Kleiner, 2012). This loss of life is exactly why some nurse do believe strikes are not compatible with the ethics of Nursing.

With the potential that nursing unions can improve patient outcomes in hospitals (Ash & Seago, 2004; Dube et al., 2016) and improvements in patient care (Gruber and Kleiner, 2012), it could be also be suggested that these long term improvements offset the short-term loss of life during a strike (Gruber & Kleiner, 2012).

Nursing Education and Unions

There was no available evidence to suggest that nursing unions are or are not included in curriculums at any level of nursing education. This gap in the literature is worth noting and is addressed within the discussion.

Conclusion

There is currently little to no inclusion of the topic of nursing unions in nursing school curricula. With 21% of hospital-based nurses in unions the topic of unions and unionism is relevant to future nurses (Spentz et al., 2011). A discussion of how NEs can deliver up-to-date

content to their students, as well as the ethical, moral, financial and professional implications of nursing unions is explored next.

Discussion

The rise of nursing unions in the United States started with collective bargaining by the ANA in 1946. Today, 21% of hospital-based nurses are in unions (Spetz et al., 2011). Given that other private sector professions are currently at 6.7% union density the percentage of nurses in unions is significant (NLRB, 2016a). Increased pressures from the healthcare industry and employers are often cited as the instigators for increased unionism in Nursing. While many view unions as negative, there are positives such as improving the ability to negotiate for higher wages, improved working conditions particularly around safe staffing, and avenues that allow for creating policies for nurses who float from one unit to another (NNU, 2016a). Often times, the negativity stems from the actual or perceived hostile work environments that can occur when potential strikes are imminent and the division of non-union and union nurses are more prominent (Kany, 2007).

Without research to support the pros and cons of including the topic of nursing unionism in nursing curricula knowing the best approach will need further examination. However, it is felt that students would benefit from discussions about how unions can support and/or hinder their professional role as a staff nurse.

Nursing school can be overloaded with content at times and this is a compelling reason to not add nursing union content into an already burdened system (Dalley, Candela, & Benzel-Lindley, 2008). The nursing union content would likely have to replace existing content and the decision to change content is never easily made. However, nursing unions have demonstrated to be an increasing reality in today's healthcare environment (Spetz et al., 2011) and therefore it is

worth determining where best the content would fit. Nursing students need to be prepared when completing their degree to make an informed decision about where they will seek employment and that includes determining whether or not they will seek employment at a unionized hospital.

There are multiple possibilities of where to include nursing unions during curriculum designing. One such area is when NEs review the real-life applications of the ANA's (2016a) *Code of Ethics for Nurses with Interpretive Statements*. As previously explained the ANA (2016a) does state its *Code of Ethics* supports the right of nurses to organize. There could be an interesting debate formulated around the ideas of professionalism versus unionism, strikes versus patient abandonment, or refusing unsafe assignments. Another place nursing unions could naturally be included is in assignments to meet the American Association of Colleges of Nursing (AACN) [2008] *Essentials of Baccalaureate Education for Professional Nursing Practice*. Nursing schools design their courses and curriculum to include these essentials. The nursing union content could be included in assignments about essential VIII: Professionalism and professional values or essential V: Public Policy (AACN, 2008). There are many examples of how nursing unions are working to impact public policy. A discussion surrounding the topic of nurse-patient ratios would be relevant to today's healthcare climate. Staffing bills have been introduced in multiple states and at a federal level providing a relevant exemplar for describing the importance of professional advocacy (NNU, 2016b).

There are also practical reasons for including nursing unions into classroom discussions and curricula. Nursing students may not even consider the presence of a union prior to taking their first job, but if they do work in a union facility it will benefit them to have a general overview of how nursing union contracts operate. Union facilities have a contract which outlines the agreements the union negotiated with the employer. The frequent benefits the contract gives

to nurses are language on mandatory overtime, floating rules, ability to refuse unsafe assignments, and higher compensation (NNU, 2016a). The contract also limits or does not allow mandatory overtime, and includes rules requiring cross-training when nurses have to float off their home unit. In a non-union facilities these contract rights do not exist and nurses may be required to work passed the end of their shift due to a shortage of staff, float to a unit the nurse is not trained to work on, or the nurse could even be fired for refusing to take a patient assignment they deem is unsafe. All union contracts are different and each non-union hospitals has different rules and so the previous statements will not apply exclusively to each type of facility. The most important aspect of this education is to give nursing students a general overview union contracts and the practical uses of the contract.

Including the discussion of nursing unions in the classroom also provide students with an overview of the financial implications of unions. For instance, it has been demonstrated that union nurses make 18.8% more than non-union nurses (Spetz et al., 2011, p. 63), not inclusive of the union dues which typically amounts to 1% of the nurse's pay (MNA, 2009). The idea of paying unions dues along with the possible loss of income during a strike is an important issue to discuss with students because this may impact the decision of the nurse to work at a union facility. When considering the financial impact of union dues it will be important to cover right-to-work states.

Right-to-work states do not require employees to join the union or pay union dues to be able to work in a union facility (Kany, 2007). This legal right exists in twenty-six states (National Right to Work Legal Defense Foundation, 2016). Nursing students should understand that in non-right-to-work states they will be required to pay union dues to be able to work in a union facility, but if the facility is non-union then no dues are required. The difference between

states may be confusing to students and is very relevant to students living near state boarders *because* they may work in two different states over the course of their career.

In general, there are many academic and practical reasons for including the topic of nursing unions into nursing school curricula. If nothing else the student will be more prepared to face the ethical, moral, and professional challenges of nursing unions due to their education. Yet it may be difficult to include the topic of nursing unions in the classroom due to NEs lacking the information needed to facilitate this conversation. Nurse educator implications are discussed next.

Implications for Nurse Educators

Nurse Educators will face many challenges while leading discussions on nursing unions in the classroom due to the polarizing views of unions in general. Nursing students will come into the discussion with their own personal views of unions, and some of them may be very deeply felt. Nurse Educators will have to take steps to ensure a respectful dialogue between students because a conversation regarding nursing unions has the potential to become heated. The goal of the NE should be to guide the discussion based on the available research, and less on assumptions or emotions. Having tools to guide this difficult classroom discussion, such as suggested questions or talking points, would benefit the NE.

Along with tools to guide discussions about nursing unions, the NE will want to engage in some self-reflection of their own views on nursing unions before classroom discussions. Nursing literature often links NEs into the group of nurses who are not in favor of nursing unions, whether this information is correct today is unclear, but there is potential for NEs to have their own bias on this topic (Kany, 2007; Raelin, 1989). A self-reflection guide focused on nursing unions will be a useful tool for NEs to identify any bias and therefore prevent that bias

from entering into the classroom discussion with students. This literature review provides a resource for baseline knowledge of the history of unions, laws governing them, and current research of nursing union's impact on patient outcomes and could be an invaluable resource for NEs who consider adding this topic to the curriculum.

Conclusion

The information and data gleaned from this literature review is invaluable to NEs. The lack of quality and unbiased information on nursing unions can make it difficult to have discussions in the classroom about what, how and when unions are used and necessary, however, it is the opinion of the writer that addressing these topics are essential to knowing and understanding the role, responsibilities and resources available to the staff nurse. Continued research on the impact of nursing unions is also necessary. The historic focus by economists on the cost of nursing unions and patient outcomes in patients cared for by union nurses compared to patients cared for by non-union nurses are inconclusive and warrant further exploration (Seago & Ash, 2002; Ash & Seago, 2014; Dube, Kaplan, & Thompson, 2016). This literature review has the potential to serve as a helpful starting point for all nursing professionals who are considering researching nursing unions and their impact on the profession of Nursing, and for all Nurse Educators who consider adding the topic of nursing unions to their curriculum.

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