Convergence: How Nursing Unions and Magnet are Advancing Nursing

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PROBLEM. Historically, unions and professional associations such as the American Nurses Association have been adversaries in the fight to represent the best interests of the nursing profession.
METHODS. We reviewed the literature on the evolution of nursing unions, nursing's historical unease about unions, the Magnet designation in nursing, the tensions between the unions and Magnet, the core values and commonalities they share, and the obligations of nursing as a profession.
FINDINGS. Refocusing on the advancement of our profession provides a positive pathway in which the collective efforts of nursing unions and professional initiatives such as the Magnet designation converge during these turbulent times for our profession.
CONCLUSION. The single, central organizing idea of nursing—where nursing unions and Magnet converge—is the pivotal role of nurses in delivering high-quality patient care. The often-maligned dialectic between unions and Magnet has advanced and not hindered the nursing profession.

Introduction

In 2011, the nursing profession made history and repeated its history during triumphant, turbulent times. Just as union membership in the United States hit an all-time low (BLS, 2011; Greenhouse, 2011), a new "super union" for nurses (California Nurses Association, 2009) emerged. The union of the California Nurses Association (CNA)/National Nursing Organizing Committee with the United American Nurses and the Massachusetts Nurses Association (MNA) made the new 150,000-strong National Nurses United (NNU) the largest registered nurse (RN) union in history. According to the CNA recruitment materials (2009), the NNU is demanding and fighting for nationwide improvements in working conditions for RNs and patient protection standards, expanding the engagement of RNs in public policy, and winning "accessible, quality healthcare for every American resident as a human right" (p. 5). The NNU also plans to create a national Taft–Hartley pension plan for union RNs, and to work for the passage of National Nursing Shortage Reform and Patient Advocacy Act (Sanders & McCutcheon, 2010).

In their legal analysis of unions in health care, Sanders and McCutcheon (2010) also reported evidence that confirms a reality in nursing today—a single voice (Hirschman, 1970) for the interests and advancement of nursing remains elusive. In this article, we review the historical roots of nursing unions and the Magnet designation, tensions between them, and the core values and commonalities they share. We suggest that the often-maligned dialectic between them has actually advanced nursing.

The Unsettled Landscape

In addition to the NNU, there is now a new national nurses' labor federation—the National Federation of Nurses—which represents approximately 70,000 RNs in New Jersey, New York, Ohio, Montana, Oregon, and Washington; a new partnership and "truce" between long-standing rivals—the CNA and the Service Employees International Union (SEIU) with over 2 million members (with nearly 1 million in health care and 110,000 nurses); and the new, independent National Union of Healthcare Workers, which hopes to attract nonunionized healthcare workers and SEIU members.

Although some believe that collective bargaining interferes with employers' management rights to control and direct their workforce (Archibald, 2003), unions are competing aggressively and successfully for new members in health care. Unions claim success with many collective bargaining efforts focused on better wages, staffing levels, floating, mandatory overtime, and benefits for nurses (Albro, 2008; Breda, 1997; Chapman et al., 2009; Clark & Clark, 2006, 2009; Gaus, 2011). Commins (2012) suggested that NNU's recent success may be a result of nurses' belief that "nobody else in a position of power and influence is looking out for them" (p. 1).

Buoyed by nurses' belief that unions can give them a greater voice in patient care (Clark, Clark, Day, & Shea, 2001), unions have focused their efforts on this central concern for all nurses. Clark and Clark (2009) reported successful union negotiations about patient care—some that required arbitration for disputes and others that gave nursing leaders authority to determine whether sufficient staffing resources were available and to actually close units when staffing levels were insufficient. As suggested by Sanders and McCutcheon (2010) and Gaus (2011), common concern for patient care does not mean consensus, as evidenced by the long-standing controversy within nursing about staffing levels and patient ratios. This controversy represents the critical nexus where unions and professional associations meet—patient care (Aiken et al., 2010; Chapman et al., 2009).

The Roots of Magnet

The practice landscape of contemporary nursing has not been the exclusive province of nursing or other unions of healthcare workers, which represent approximately 20% of nurses (Albro, 2008). Almost 30 years ago, the modern Magnet movement began when McClure, Poulin, Slovie, and Wandelt (1983) identified hospitals that were unusual in their ability to recruit and retain nurses during severe nursing shortages. These institutions shared a common characteristics: low nurse turnover; adequate staffing levels; flat versus hierarchical organizational structure; flexible scheduling; strong, supportive, and visible nursing leadership; recognition for excellence in nursing practice; participatory management with open communication; good relationships with physicians; salaried rather than hourly compensation for nurses; professional development; and a rich nursing skill mix. These hospitals were similar to corporate centers of excellence where nurses had more power, higher self-esteem, and greater job satisfaction (Kramer, 1990a, 1990b; Kramer & Schmalenburg, 1991a, 1991b).

The American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), established the Magnet Nursing Services Recognition Program in 1992. Magnet designation acknowledges excellence in the management, philosophy, and practices of nursing services; adherence to national standards for the quality of patient care services; leadership of the nurse administrator in supporting professional practice and continued competence of nurses; and understanding and respecting the cultural and ethnic diversity of patients, their families, and healthcare providers.

Magnet Impact

Grounded in studies of organizational culture (Aiken & Hage, 1968), research on Magnet facilities demonstrated significant benefits from creating an organizational culture which attracts and retains professional nurses (Aiken, Havens, & Sloane, 2000; Aiken & Patrician, 2000; Aiken, Smith, & Lake, 1994). Continued research provided **e**mpirical evidence to support many nurses' first-hand perceptions that Magnet hospitals provide high quality care and achieve better patient outcomes in relation to nurse staffing (Armstrong, 2005; Graf & Halfer, 2002; Johnson, Billingsley, May, Costa, & Hanson, 2004; Kane, Shamliyan, Mueller, Duval, & Wilt, 2007; Trossman, 2002; Upenieks, 2003). As a large body of evidence accumulated, we suggested that the ANCC's Magnet program had "bent the course of modern nursing" (Johnson, 2009, p. xv).

The Business Case

The ANCC's business case for Magnet (Drenkard, 2010) was built on Magnet hospitals' achievement of significant service gains in both patient and RN satisfaction, and improvements in key quality and safety nursing outcomes such as decreased mortality rates and decreased incidence of pressure ulcers and falls. Recent changes in Medicare policies have placed a new spotlight on the economic value of these nursing outcomes which represent real benefits for patients and significant cost savings for hospitals (Kurtzman & Buerhaus, 2008). According to the ANCC (2012), there are 395 healthcare institutions that have earned the coveted Magnet designation, which US News & World Report uses as a primary measure of competence in its ranking of America's 5,000 hospitals. The ANCC reports that eight of the top 10 medical centers on the US News Best Hospitals in America Honor Roll are ANCC Magnet organizations (2011–2012); and six of the top eight hospitals in the US News Children's Hospital Honor Roll are Magnet hospitals (2011–2012).

Power Politics

Unions Versus Magnet

Tensions surrounding the uncertain power dynamic between unions and the Magnet movement are not new news. In 2004, the MNA directly addressed the intersection between union membership and the Magnet program, and re-affirmed the union's position that "any program that impacts employees' working conditions is a union matter. As a matter of law, any attempt to modify the working/practice conditions of nurses; any program that purports to seek and utilize staff nurses input; and any program that proposes to change policies and practices to boost retention and recruitment of staff is a union issue" (Twarog, 2004, p. 1). The MNA suggested that "Magnet, regardless of its purported merits and benefits, if implemented without the input of the union and without the rights and enforceability that a union provides, is yet another consultant-driven process that can circumvent the ability of bargaining unit members to define and protect their practice" (p. 1). Such a program could "co-opt staff nurses, providing the illusion of participation, and later, having been co-opted, nurses' participation is used to justify the decisions that are made," the MNA said. The MNA requires that "the union must be directly involved at all stages of discussion that relate to a nurse's 'wages, hours and working conditions' as defined by the National Labor Relations Act, and any changes contemplated must be bargained with the union" (p. 1).

In Nursing Against the Odds, Gordon (2005) suggested that the Magnet designation offers nurses the illusion of empowerment. In 2007, United Nurses United expressed similar concerns that critical hospital resources were being diverted to fund the "elaborate and expensive" Magnet application process and that the program lacked a real commitment to nurses' work environment. At that time, eight nursing unions sent a letter to the ANCC that questioned the integrity of the Magnet program and called for rule changes (p. 3). In 2008, Fagin and colleagues cited union criticism that cast the Magnet program as a promotional tool of hospitals that was similar to the Joint Commission in what was believed to be an uncomfortably close relationship with hospital management (Fagin, Maraldo, & Mason, 2008).

Nursing's Historical Unease About Unions

This tension about union membership has historical roots that date back to the post-World War II era. In 1948, the American Journal of Nursing published an analysis of collective bargaining in the engineering, teaching, and nursing professions (Northrup, 1948). The failure of these professional groups to maintain their living standards during the high inflationary, post-Depression era, fueled the rapid growth of labor unions and the expansion of collective bargaining. At the time, nursing was the only of the three professions without its own union. This was a result of the 1935 National Labor Relations Act, which allowed workers to collectively bargain against long working hours and unhealthy conditions, and which also exempted nurses from this protection until 1974 (Cherry & Jacob, 2002; Forman & Davis, 2002).

Prior to World War II, the ANA's economic security program did not include collective bargaining. In 1942, faced with long working hours and personnel shortages during wartime, the CNA successfully negotiated with the War Labor Board for a 15% salary increase for nurses. This success opened the door to the designation of CNA as the sole representative of nurses in salary negotiations and terms of employment. In 1946, the ANA adopted a policy that prohibited dual membership in unions and professional associations with active collective bargaining agreements. Some nurses had already turned to unions for

help, and by 1948, 3,000–5,000 of the 300,000 nurses in the United States had become members of unions—primarily the United Public Workers (CIO) and the Building Service Employees' International Union (AFL) (Northrup, 1948, p. 141). The marriage between unionization and professionalism was an uneasy one. According to Northrup, conflict within nursing and the other professional societies centered on two central dichotomies: whether there was consistency between collective bargaining and "professional ethics," and whether collective bargaining should be controlled by professional societies or unions (p. 141).

By 2012, the past became prologue in nursing. Collective bargaining is under siege in the United States, but union membership in health care is on the rise, the Affordable Care Act has been upheld by the Supreme Court, the national nursing shortage continues, and our country struggles with economic woes. In this environment, the tensions between nursing unions and professional practice initiatives such as Magnet represent a real dialectic in nursing—with different viewpoints and reasoned arguments on both sides. Sanders and McCutcheon (2010) suggested that the turbulence of today could be prime time for unions, although experience has shown that successful compromises in healthcare facilities are hard fought, imperfect, but palatable and possible.

Obligations of a Profession

The literature on the tensions within nursing focuses on the dangers of a "them versus us" mentality. Although the "claimed common ground" in a battle within nursing may be patient care, for example, the dynamic often has the feel of a battleground where dueling approaches, and disagreements and takeovers rule (McCloskey, 2008). Given the challenges in health care today, it is time to take a step back and reflect on the core principles and obligations of a profession. Members of a profession like nursing are considered expert, responsible, autonomous, and self-regulating (Strauss, 1963). A profession operates with a defined, formal theoretical base of knowledge gained through advanced educational preparation, shared vocabulary, clear professional identity, explicit values, commitment to ideals of public service, and a code of ethics (Hamilton, 2001a; Hamilton, 2001b; Nowling, 1981–1982; Pembertson & Pendergraft, 1998). As Morrison suggested in 1960, the responsibility of a profession . . . "entails continued study or research for advancement of status and standards" (Morrison, 1960, p. 67). Advancement involves not only conducting research, but also publishing research, monitoring the published literature, and critiquing the literature through peer review. This peer review process helps professions maintain their professional standards and intellectual rigor (Johnson, 2006; Nowling, 1981–1982; Cronin, 2001; Fenn, 1997).

Advancement Through Convergence

Refocusing on the advancement of our profession may be a path in which the collective efforts of nursing unions and professional initiatives such as the Magnet designation converge during these turbulent times. Central to this convergence is an understanding of Collins' (2001) research on great organizations. Collins suggested that great organizations are guided by a single organizing idea that unifies thinking and action. This unified view flows from the intersections of three circles: what you do best; what drives your economic engine; and what you are deeply passionate about (pp. 95–96). All three factors work synergistically to power an institution's ability to achieve its goals. The central organizing ideas of nursing—where nursing unions and Magnet converge—are the pivotal role of nurses in delivering quality patient care and the self-regulating nature of our profession.

The Importance of Leadership

Commins (2012) attributed much of the new nursing union's success to the combination of smart, tough leadership, and compelling "us-versus-them" and "patient-first" messages (p. 2).

In a working environment in which there are differing paradigms of unionization and Magnet, all nursing leaders need robust leadership skills. Developing skill in emotional intelligence—self-awareness, self-regulation, self-motivation, and social awareness (Freshman & Rubino, 2002; Goleman, 1998)—is critical because these skills will be put to the test. Nursing leaders must also embrace appreciative methods which help diverse interest groups keep their collective focus on the possibilities of collaboration (Cooperrider, Sorenson, Whitney, & Yaeger, 1999) and on keeping negotiations moving forward with total transparency and absolute fairness for all.

Shared Governance

To meet the core professional requirement of self-regulation (Strauss, 1963), nursing departments often utilize shared governance, a model adapted within hospitals in the late 1970s from university faculty governance models that reconciled different interests and developed policies through the distribution of power (Cleland, 1978). Such models may take the form of labor-management committees, professional practice committees, joint nursing practice councils, patient care committees, or staff ratio oversight committees that include equal numbers of representatives from the union and hospital administration (Clark & Clark, 2009; Porter-O'Grady & Finnigan, 1984). A large literature has shown that shared governance revolves around issues of power, control, authority, and influence.

Porter-O'Grady (2001) suggested that shared governance represented a dynamic way of conceptualizing "empowerment and building structures to support it" (p. 470) through partnership, accountability, equity, and ownership. As Archibald (2003) concluded, domination of one group to the near exclusion of the other presents an immediate danger of a conflict of interest between the public interest and the self-interest of the group that dominates the decision-making. Stated simply, shared governance answers the question, "Who rules?" (Hess, 1998). This is a critical question that must be addressed by any healthcare facility in which power and control of nursing practice are shared by a nursing union and a dedicated Magnet organization.

Beyond issues of power, shared governance models make good clinical sense. Research (Preuss, 1999) has shown that they lead to improved nurse staffing ratios, which have a positive impact on the quality of patient care (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002); better hospital financial performance (Preuss, 1999); and greater accountability, increased staff empowerment, and personal growth (Breda, 1997; Erickson, Hamilton, Jones, & Ditomassi, 2003; Larkin, Cierpial, Stack, Morrison, & Griffith, 2008). Research on Magnet hospitals (Kramer & Schmalenburg, 2003) found that the highest staff nurse ownership of practice issues and outcomes occurred where there were visible, viable, and recognized structures devoted to nursing control over practice. Kane et al. (2007) also reaffirmed that professional practice environments which enable nurses' control of practice through governance contribute to nurses' job satisfaction, positive perceptions of autonomy, improved retention, improved RN staffing ratios, and better patient outcomes.

However, as Anthony (2004) suggested, nursing and union leaders, healthcare administrators, researchers, and clinicians often come to the negotiating table with different views of shared governance, how it works, and whether, in fact, it works at all. Hess (2004) pointed out that shared governance disappeared from many healthcare institutions, the likely victim of mergers, acquisitions, and the sheer exhaustion of participants. This is not surprising because, as Clark and Clark (2009) suggested, there is no guarantee that traditional rivals will embrace the opportunity to move from an adversarial mode to greater cooperation.

Talking as Strategy

As we have learned, moving to a more cooperative stance requires a commitment to engaging in respectful, "crucial" conversations, defined (Patterson, Grenny, McMillan, & Switzer, 2002) as a "discussions between two or more people where the stakes are high, opinions vary, and emotions run strong" (p. 3). Without a doubt, discussions about the power and autonomy of nurses—and the fierce disputes in the battle for the voice of nursing—qualify as crucial, tough conversations. These are difficult because they go right to the heart of our professional identity as nurses. As Stone, Patton, and Heen (1999) suggested, these conversations can feel like threats to our competence and professional commitments. Resolving these issues has immediate, long-term implications—not only for individual nurses, but also for the nursing profession, patients, and the hospitals that care for them.

Dialogue is central to successful convergence. To promote dialogue, nursing groups must move away from perceiving negotiating as an "uneven table" (Kritek, 2002)—a term that suggests inequality in a coming together of groups in which one or the other is perceived to be more powerful and committed to "winning" at all costs versus working toward compromise and effective conflict resolution (p. 39). Whether we are working on the rules and processes for engagement, appropriate decision points, or the specified outcomes of each negotiation, we must remember that we are collectively engaged in the expert, responsible, autonomous, and self-regulating obligations of our profession. Divergent viewpoints can converge in the

provision of safe care that improves nursing outcomes through evidence-based practice and adherence to safe staffing in hospitals.

Where Unions and Magnet Meet

The experience at Robert Wood Johnson University Hospital (RWJUH), a university teaching hospital, mirrors the report from Mayes, Jansen, and Quigley (2009) that detailed the successful, sustained union–management relationship at their Florida veterans' hospital. The leaders attribute their collective success to shared governance, open communication, mutual trust and respect, and an unwavering commitment to quality patient care and continuous improvement. They have also leveraged this convergence successfully to achieve significant improvements in nursing outcomes at our hospital, most recently in reducing falls (Johnson et al., 2011). They established a highly respected brand for nursing at RWUJH—one that survived and thrived through numerous union strikes and has achieved multiple re-certifications as a Magnet institution. Their experience reflects the successful alignment of ANA and Magnet principles—focused like a laser on providing safe, quality care.

Looking Forward

Nursing remains at a crossroad. Shortages of nurses and nursing faculty persist, as union membership grows. The Institute of Medicine (2011) has asked us to seriously consider our profession's future. As we do, we cannot spend precious time fighting battles which obscure where unions and management converge—our patients' bedsides where we are improving patient outcomes. Collins and Porras (1994) found that great companies do not believe in the "tyranny of the **OR**"—i.e., that things must be either this or that, but not both. Instead, truly great companies practice "the genius of **AND**"—embracing a number of opposing dimensions at the same time. In the current tensions over the future of nursing, this **AND** means advancing the nursing profession through the successful convergence of nursing unions **AND** the forces of Magnetism.

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