BAD TREATMENT
Filipino RNs confront and overcome racism at work

WE GOT YOUR BACK
California RNs win landmark safe lift law

RNs call for finance tax to heal global economy

Nurses without Borders
Letters from the Council of Presidents

BESIDES FIGHTING like hell for safe patient staffing ratios and quality healthcare for everyone, we NNU nurses now have one more thing in common with our RN colleagues in Australia, Ireland, France, and South Korea: We are all calling for our governments to pass a global financial transaction tax that would raise billions of dollars to help save the lives and futures of our patients.

On Nov. 3, nurses from four continents met up in Cannes, France to participate in demonstrations calling for world leaders convening at the G-20 summit there to pass a financial transaction tax (FTT)—essentially a tiny sales tax on trades of stocks, bonds, derivatives, and other financial instruments—that could be used to help create decent jobs, buttress education, provide healthcare, and a whole lot of other things working people desperately need now. We were joined by international labor group Public Services International, the International Trade Union Confederation, and anti-poverty groups like Oxfam International. Together, we made the case for an FTT and did our part in a global day of action that included NNU rallies and marches in Washington, D.C., San Francisco, and Los Angeles. The next day, President Obama actually softened his stance against an FTT, so our protest appears to be working! Please read the article in this issue about our Nov. 3 events to learn more about how nurses are part of a global movement to win FTTs in all major markets.

While we are on the subject of fairness and equity, in this issue we also have a feature story exploring racism against Filipino registered nurses. While nurses of other ethnicities and nationalities also experience discrimination, we focused on Filipino RNs because they constitute such a large and essential part of the U.S. RN workforce. They are often singled out for unfair treatment, denied promotions, or in the case of some hospitals, denied jobs. We hope that the article helps nurses from all walks of life to better understand the obstacles some of their Filipino colleagues face and to speak up against injustice wherever and whenever it happens.

On a happy note, California RNs recently helped pass the nation’s strongest safe lift law, which requires all acute-care hospitals to train staff members and have equipment on hand to eliminate the manual lifting of patients. Also, University of Michigan Health System nurses just won a new contract; their intense organizing of their coworkers along with the community paid off.

Lastly, in this issue we report on our medical volunteer work at many of the Occupy sites around the country. As of press time, our first aid stations in Oakland and in New York City have been destroyed, but our spirit remains strong and the movement is simply regrouping. Please join us to help guide and heal America.

Deborah Burger, RN | Karen Higgins, RN | Jean Ross, RN
National Nurses United Council of Presidents

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They can be about practice or management trends you’ve observed, or simply something new you’ve encountered in the profession. They can be about one nurse, unit, or hospital, or about the wider landscape of healthcare policy from an RN’s perspective. They can be humorous, or a matter of life and death. If you’re a writer and would like to contribute an article, please let us know. You can reach us at nationalnurse@nationalnursesunited.org

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ON THE COVER: National Nurses United RN leaders with Oxfam International ambassador and actor Bill Nighy in Cannes, France on Nov. 3 to call for a global financial transaction tax. Photo courtesy of International Trade Union Confederation.
HER NAME WAS SUSAN, and she came to the nurses’ OccupyLA first aid station complaining of pain in her left breast that always seemed to appear during her menstrual period. RN and Registered Nurse Response Network (RNRN) activist, Maureen Cruise, listened to her symptoms and gave some suggestions for positioning and care and comfort for her pain and swelling, then handed Susan a list of free clinics and county facilities where she could seek additional help.

Susan quickly scanned the sheet and pointed out that she had approached almost all on the list; none were options for her. County facilities wouldn’t accept her, she said, and the “free” clinics weren’t really free, but still required a minimal fee that she could not afford on her low income.

Susan is just one of hundreds of people participating in the Occupy movement who have sought medical aid from first aid stations established by RNRN and National Nurses United at various Occupy encampments around the country: New York City, Washington, D.C., Chicago, San Francisco, Oakland, Detroit, Los Angeles, San Diego—the list keeps growing. The first aid stations are both a way for NNU nurses to support the Occupy movement’s protest of the huge income gap between rich and poor in the United States, as well as a practical way for nurses to do what they do best, helping and healing communities largely shut out of the healthcare system—patients like Susan.

“The people we see have been victims of the system for a long time,” said Cruise, a public health nurse and single-payer healthcare activist. “For these people, what are their options in this non-system? Many of them were comforted just to have nurses pay attention to them and have their basic worth as human beings affirmed.”

NNU established many of the first aid stations starting in mid October, often in the face of police opposition and under threat of bodily harm. At Occupy Wall Street in New York City’s Zuccotti Park, only a chain of human protesters around the station and the unexpected participation of noted civil rights leader Jesse Jackson prevented the New York Police Department from tearing down the preliminary structure that NNU nurses and staff had erected. The next morning, they succeeded in setting up an even larger station.

In Chicago, even a chain of peaceful protesters and the presence of two registered nurses were not enough to keep the police at bay. In the early morning hours of Oct. 23, police arrested a group of protesters defending the first aid station at Occupy Chicago in Grant Park, including RNs Jan Rodolfo and Martese Chism. Rodolfo and Chism were held for nearly 24 hours, and the next day appeared at a press conference to confront Mayor Rahm Emanuel about why he was denying protesters their First Amendment rights to assemble.

“We believe that they have a right to assemble and the right to the freedom of speech under the Constitution,” Chism told the Chicago Tribune. “We see our patients suffer from the economic crisis, and we believe the only way to heal America is to address Wall Street.”

Nurses staffing the medical stations report that people are presenting with the types of minor scrapes, injuries, and ailments associated with living outdoors and in close quarters. Blisters, dehydration, and upper respiratory infections are common. RNs in colder climates, such as New York and Washington, D.C., are seeing cases of hypothermia and foot problems, often a result of protesters staying in wet shoes and clothes. “Without proper shelter, they’re soaked to the bone and their body temperatures dip too low,” said Maria Fehlig, RN and NNU staff person who ran the New York City station for almost a month. “We need to warm them back up.”

The vast majority of protesters do not have medical insurance, and their visit to the Occupy first aid station was the first time they’ve talked to a healthcare provider in years. In addition to registered nurses, physicians, paramedics, social workers, and mental health workers are helping to staff the stations.

And as a sign of just how bad lack of access to medical care for the uninsured has become, San Francisco news media reported that a woman who had been stabbed elsewhere in the city sought help at the OccupySF first aid tent for her wounds.

“I feel like I’m honoring the ancestors of all the people who fought before us to have basic human needs met,” said Alicia Rucker, an RN at Washington Hospital Center about her volunteer work at OccupyDC. “High quality healthcare is a human right, not a privilege.” —Staff report
Safe Lift Now the Law in California

**CALIFORNIA**

As registered nurses and other healthcare workers know, taking care of patients can literally be backbreaking work. These professions report some of the highest rates of musculoskeletal injuries in the nation, and countless nurses have had their careers cut short after hurting their backs lifting a patient at work.

That's why RNs in California are celebrating a new state law signed in October that requires all acute-care hospitals as of Jan. 1, 2012 to have trained lift team personnel and also equipment available 24 hours a day, seven days a week to help move and maneuver patients. Sponsored by the California Nurses Association/National Nurses United and carried by Assemblymember Sandré Swanson, AB 1136 is known as the “safe lift” bill and is considered to be the strongest such worker protection law in the country. By requiring safe lifting policies, the law also protects patients from preventable falls and other injuries.

“California’s nursing workforce is aging at the same time patient acuity and obesity are rising,” said Bonnie Castillo, RN and CNA/NNU legislative director. “Manual lifting can injure fragile patients by putting too much pressure on sensitive joints and compromised skin. This is a great step forward to protect our nurses and other healthcare workers from injury, and provide patients with safe and appropriate care.”

CNA/NNU had worked for years to pass lift team legislation. Earlier versions had passed the Legislature but been vetoed by then-Gov. Arnold Schwarzenegger. This year, RNs successfully fought the opposition of the California Hospital Association, the lobbying group of the hospital industry, to pass the law.

By requiring safe lifting policies, the law also protects patients from preventable falls and other injuries. Nursing surveys have found that 83 percent of RNs work in spite of back pain, 52 percent report chronic back pain, and 12 percent who leave the profession say back injuries were the main, or a major, reason for leaving the RN workforce.

“Nurses are essential to our healthcare system and it is important that we have proper safety measures in place to protect them from career-ending injuries,” said Swanson in a statement. “AB 1136 will decrease the rate of injuries for nurses and other healthcare workers and improve patient safety. I am pleased that our governor recognized that the bill preserves quality care for patients, strengthens the nursing workforce, and protects hospital budgets.” Swanson said he was compelled to introduce the bill because his own mother, a lifelong registered nurse, retired partly due to severe back pain.

In addition to requiring safe lift policies, trained personnel, and equipment for handling patients, the law also states that the registered nurse, as the coordinator of care, decides based on her or his professional judgment of each patient's need how each lift is handled. The law also states that the registered nurse, as the coordinator of care, decides based on her or his professional judgment of each patient's need how each lift is handled.

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The law applies to all acute-care facilities, even rural and children's hospitals. CalOSHA enforces the law, and hospitals can incur fines and penalties if they do not comply. Correctional facilities and developmental centers are exempted.

South Florida RNs Win Election

**FLORIDA**

Eager to have a hand in improving the quality of patient care at their facility, registered nurses at Palmetto General Hospital in Hialeah, Fla. voted overwhelmingly by 86 percent on Nov. 15 to unionize with National Nurses Organizing Committee-Florida, the state affiliate of National Nurses United.

“We are thrilled with our victory,” said Rose Campbell, an intensive care unit RN at Palmetto. “I am looking forward to bargaining for improved staffing which will decrease turnover. We need to recruit and retain experienced RNs in order to provide the safest patient care possible.”

NNOC-Florida will represent 500 RNs at the south Florida hospital and now represents some 6,000 Florida RNs in 15 facilities around the state. Palmetto General is an affiliate of the Tenet Health chain, one of the country’s largest for-profit hospital systems. Nationally, NNU now represents 3,700 Tenet RNs in nine Tenet hospitals in Florida, Texas, and California.

“With more RNs from Florida joining our ranks, we are increasing our collective strength to fight for patient care standards and safe nursing practice throughout Tenet facilities,” said NNOC’s Tenet RN Bargaining Council Chair Sherri Stoddard, RN.

Key issues for the Palmetto RNs include a stronger voice in patient care protections at the hospital, improved staffing, and strengthened economic and workplace standards for RNs.


The need for a safe lift law has been apparent for years. Bureau of Labor Statistics data in 2008 documented that nationally, 36,000 healthcare workers were injured by lifting and transferring patients. Nurses endure more work-related musculoskeletal injuries than truck drivers or construction workers—and California leads the nation in the number of musculoskeletal injuries.

Nursing surveys have found that 83 percent of RNs work in spite of back pain, 52 percent report chronic back pain, and 12 percent who leave the profession say back injuries were the main, or a major, reason for leaving the RN workforce.

“In addition to requiring safe lift policies, trained personnel, and equipment for handling patients, the law also states that the registered nurse, as the coordinator of care, decides based on her or his professional judgment of each patient's need how each lift will proceed. The law also requires that lift team members be trained and designated ahead of time in five areas of body exposure: vertical, lateral, bariatric, repositioning, and ambulation. Most importantly, the law also prevents RNs and healthcare workers from being disciplined for refusing to lift if they have concerns about their own or patient safety, or if they are asked to lift with untrained personnel.

The law applies to all acute-care facilities, even rural and children’s hospitals. CalOSHA enforces the law, and hospitals can incur fines and penalties if they do not comply. Correctional facilities and developmental centers are exempted.

—Staff report

OCTOBER 2011

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NATIONAL NURSE
The Massachusetts Nurses Association held its annual convention and business meeting from Oct. 5-7, with the MNA/NNU Main Street Contract campaign as a major fixture in a number of events and activities, involving hundreds of nurses in education programs, demonstrations, and political events during the three-day gathering of nursing activists from across the commonwealth.

A key highlight of the convention was an address to the nurses by Massachusetts senatorial candidate Elizabeth Warren. In September, MNA and NNU had taken the unprecedented step of endorsing her candidacy even before she officially announced she would run, precisely because Warren is a champion of working people’s values and a nationally recognized advocate for regulation and reform of banking and Wall Street practices, the same practices nurses are fighting through our Main Street Contract campaign. Warren came to the convention to thank MNA nurses for their endorsement, and to ask for our help.

“I am so thrilled by this endorsement because I have been working with nurses on healthcare issues for more than 15 years, but this fight and your fight is more than just about healthcare issues, it’s about the question of America’s future,” Warren told the crowd. “Nurses get up every day, and they work for us every day and the idea that nurses would come to me and say I want to be part of your campaign, to go forward with a vision of a stronger America for ordinary families, for working class families, for middle-class families, for families working at the economic margins, it just felt right and I knew I had to be here with the nurses today.”

Warren was so taken with her visit that the next day, she contacted MNA in search of Shannon Sherman, a medical surgical RN at Cape Cod Hospital, whom she met in the ladies’ room during her visit. The two had struck up a conversation about the economic crisis and its impact on Sherman and her community. Warren was so moved by the encounter that she asked Sherman to introduce her at her campaign kick-off event on Oct. 6.

The same day as Warren’s visit, more than 300 nurses boarded buses from the MNA convention and headed to the site of Occupy Boston. When the nurses arrived on site, they were greeted by a swarm of media. The profile of the event was heightened further by the appearance of noted civil rights activist and author Cornell West, who spoke in support of MNA/NNU’s Main Street initiative and our call for a tax on Wall Street. One of the highlights of the day was a march through Boston’s financial district co-led by Occupy Boston organizers, MNA President Donna Kelly-Williams, RN, and Cornell West—all marching arm in arm and carrying NNU’s ubiquitous “Heal America, Tax Wall Street” signs.

The event was not only covered by all Boston-area media outlets, but was featured in news stories from coast to coast, lending nurses’ credibility to the Occupy movement, and broadcasting our “Tax Wall Street” message to a national audience.

The following day, at MNA’s annual business meeting, the membership passed a resolution affirming the organization’s support for the Main Street campaign, and pledging membership involvement in a number of activities over the coming year.

As MNA President Kelly-Williams said at the Occupy Boston event, “Nurses are in this fight for the long haul. We will not be silent, we will not go away, we will do whatever we need to do to restore the promise of the American dream.” —David Schildmeier
RNs Win New Contract

The 4,000 registered nurses at the University of Michigan Hospital, represented by the Michigan Nurses Association, cast a resounding vote in early November to ratify a new three-year contract. The contract offers nurses wages and benefits that are among the best in the marketplace, as well as a continued commitment to support the delivery of the highest quality care.

“We felt the university was trying to take advantage of the economic times and attempting to roll back improvements we have won over many years through our MNA contract,” said Katie Oppenheim, RN, president of the local bargaining unit. “The credit goes to our members. Our nurses came together to stand up for what they believed. It was the strength and unity of our union that has allowed us to push forward to such a successful settlement. This is a win for all parties, and the biggest winners will be our patients.”

The nurses had been working without a contract since July 1, and had staged a number of massive pickets to put pressure on the university and rally nurses and the community. The contract provides for new provisions that will give nurses a significant voice in areas such as staffing, nursing practice, and the use of technology. As one example, under the terms of the new agreement, charge nurses will have a say in determining whether more staffing is needed to meet the specific needs of patients.

The contract also provides for step increases and across-the-board wage increases, which will result in many nurses seeing increases of $5 to $10 an hour by the last year of the contract. The agreement also made some improvements to the health insurance package negotiated throughout the university for all other employee groups while preserving important rights and benefits the hospital wanted to take away from nurses.

“We owe a great deal of thanks to the Ann Arbor community members that rallied with us during the long negotiations,” said John Karebian, MNA executive director. “Their support was key to a fair settlement. When we started this process we knew the community appreciated the care nurses provide, but as time went on, it was very heartening to have the level of support that we did. The work of our members and community clearly made a difference at the bargaining table.”

Nurses in Michigan were also busy this fall taking the Main Street Contract for the American People to the public with a rally and march to Congressman Camp's office in Midland. Weeks before the nurses visited Camp's office, nurses sent him a letter requesting the answer to a simple question: “Are you for Wall Street or for Main Street?” Receiving no reply, nurses who were attending the Michigan Nurses Association convention suited up in red ponchos and headed out on Sept. 30 into a cold, windy, and rainy Michigan morning. More than 100 nurses rallied in a nearby park, then marched several blocks to Camp’s office and demand an answer to their question. Camp was not present, but his aides assured nurses that “he would get back with them shortly.” Weeks have gone by and still no answer, but Michigan nurses will continue to press him for one.

All nurses should care about how Camp responds. As chairman of the House Committee on Ways and Means and a member of the congressional debt-reduction “super committee,” Camp holds a position of unlimited resources in determining what gets cut and what gets taxed. Camp, however, is a primary target for lobbyists with fat checkbooks. Prior to Camp’s position as chairman, lobbyists had been courting both Camp and his aides, jockeying for power, writing checks, and holding fundraisers.

—Ann Kettering Sincox
Maine

Maine State Nurses Association nurses and healthcare professionals won in October a new three-year contract at Maine Coast Memorial Hospital that they believe will improve nursing standards and patient care. The new contract will include rate increases of up to 8.5 percent over the term of the contract, a 3 percent employer contribution to retirement, and more flexibility for use of PEP time. Staffing language includes setting safe nurse-to-patient staffing levels in the obstetrics department as well as protecting the safe floating practices of OB nurses. A primary or secondary OB nurse may not take a patient assignment when floated to ensure safe availability to the OB when the census quickly increases. In medical-surgical, charge nurse and patient acuity language was added.

Pennsylvania

On Sept. 26, Pennsylvania state Reps. Phyllis Mundy and Deberah Kula joined with the Pennsylvania Association of Staff Nurses and Allied Professionals to introduce a nurse-to-patient ratios bill in the Pennsylvania state House. This bill, modeled on California’s extremely successful 1999 law, would amend the Health Care Facilities Act to establish life-saving minimum nurse-to-patient ratios throughout acute-care hospitals.

“It’s important to note that retaining adequate nursing staff is crucial to good patient care, and that nurse-to-patient ratios are an important patient safety issue,” said Mundy. “I am very concerned that, in trying to pinch pennies wherever they can, some healthcare facilities are cutting nursing staff to unsafe levels.”

PASNAP played an integral role in getting many of the 40 cosponsors of the bill to sign on before it was introduced.

“Many of the issues we are faced with on the job are a direct result of poor staffing levels,” said Patricia Eakin, ER nurse at Temple University Hospital and PASNAP president. “When there is not enough staff, workplace violence against nurses is harder to prevent, talented RNs leave the profession because they simply burn out, and the quality of patient care is at risk because we just don’t have the time to do everything we would if we had safe ratios.”

This past February, state Sen. Daylin Leach introduced SB 438, the companion bill to HB 1874. “Various reports in recent years have shown that insufficient staffing has a direct correlation to patient lives lost, and one of the best ways to ensure Pennsylvania provides safe patient care and a healthy working environment for nurses is by implementing realistic and attainable staffing ratios,” said Leach.

Texas

NNOC-Texas nurses at Cypress Fairbanks Medical Center in Houston, Texas held a press conference to protest the hospital’s punitive sick leave policies; Veterans Affairs RNs support Occupy Pittsburgh

Texas

Texas nurses at Cypress Fairbanks Medical Center took their concerns for safe patient care public with a press conference and rally on Oct. 27. “Occupy Cyfair” was the theme as nurses spoke out about the hospital’s punitive attendance policy. This policy forces nurses to make a decision to come to work sick—and possibly infect patients or patients’ families — or stay home and be potentially disciplined.

Nurses stood in solidarity against hospital discipline for a legitimate sick call for themselves or sick family members—especially during the flu season. Labor and community supporters were there to support the nurses. RNs called on the hospital to respect nurses and patients by suspending the punitive policy during the flu season. “Being sick at work does not help our patients, our nurses, and our community,” said Stephanie Danaher, an ICU nurse.

Veterans Affairs

The NNU-VA national negotiation team visited Occupy Pittsburgh on Oct. 18 to spend time meeting and listening to protesters and their stories. Their favorite signs were “I couldn’t afford a lobbyist so I made this sign,” and “Pittsburgh Loves the Steelers, not Stealers.” Team members met a taxi driver who told them that he came to the protest because, that day, he had transported a very ill young child from one hospital to another. The mother and grandmother had chosen a taxi because they could not afford an ambulance. He said the child was clearly very ill. He was very emotional as he told his story. He said he had never protested before but came out because of that incident. Nurses know this is not an unusual story, but something they see every day. Families must make choices that could endanger their health and the health of others because they do not have the basic human right of health insurance coverage.

And from Oct. 3-5, NNU-VA met in Chicago to discuss changes in the VA and receive training about unfair labor practices (ULP) by Peter Sutton, the regional director of the Chicago office of the Federal Labor Relations Authority (FLRA). — Staff report
"Never believe that a few caring people can’t change the world. For, indeed, that’s all who ever have.” —Margaret Mead

“The nurses (NNU) aren’t just making noise. It looks like they’re changing the debate, altering the policies of the most powerful players in Washington—and perhaps the world.” —John Nichols, The Nation, Nov. 3, 2011

As NNU members marched and rallied Nov. 3 at the G-20 summit of world leaders in France, outside the White House and Treasury Department in Washington, and in financial districts in Los Angeles and San Francisco, our campaign to “Heal America, tax Wall Street” has clearly resonated across the nation and globe.

Scores of other labor, environmental, consumer, and community groups, and participants from the Occupy Wall Street movement have joined us arm in arm in the United States, as have nurses and global trade union and non-governmental organizations internationally. And on the day we were pressing the Obama administration to join the global movement, the administration sent signals it was dropping its opposition to financial transaction tax in Europe, at least.

NNU’s campaign to challenge Wall Street and the financial giants that have such a powerful grip on our nation’s and the global economy, has also increasingly drawn the notice of the world’s press, and those who wonder why RNs would embrace such an undertaking. Here are five reasons why.

Nurses see the effects of the economic crisis every day. Early this year, nurses began reporting a huge uptick in specific health conditions they were seeing at the bedside and in medical offices that were directly related to the prolonged economic crisis.

These include stress-induced heart ailments in younger patients, adult diseases surfacing in children due to high-fat diets linked to low incomes, anxiety disorders and higher asthma rates, and even deaths tied to poverty or insurance obstacles.

For years, nurses have seen patients delaying or skipping preventive medical care or medication because of costs. But it’s getting worse, with nurses now reporting patients who have lost their jobs or homes even foregoing life-saving treatment.

A Commonwealth Fund study issued in early November reinforces the point. It compared the United States to 10 other high-income nations. It found that we stand out for having cost and access problems with 27 percent of patients unable to pay medical bills or encountering serious problems compared to from 1 to 14 percent in all the other countries. Further, 42 percent of U.S. patients reported not visiting a doctor, filling a prescription or avoided getting recommended care, more than twice the rate of most of the other nations.

Nurses are experiencing the consequences of the economic meltdown in their own families. RNs across the country have sent us numerous reports of a dramatic change in their own lives, many becoming the sole lifeline for their immediate and extended families. Their spouses have lost jobs, adult children unable to find work or health coverage are moving back home, parents faced with daunting medical bills need economic help, and other relatives need support.

A survey we conducted this summer of nurses in just one big health system, Sutter Health corporation, confirmed the anecdotal reports. Today 50 percent of Sutter RNs support their children or grandchildren, 51 percent of Sutter RNs support brothers, sisters, or other extended family members, and 19 percent of Sutter RNs support parents.

Our communities and families need immediate help, not more cuts. Rather than provide solutions that would address the crisis ripping through our communities, far too many politicians in Washington and in state capitals were promoting programs that would deepen the suffering. The focus was on slashing deficits, cutting pensions and health benefits for public workers, including nurses, national proposals to cut Medicare, Social Security, and Medicaid, and deep reductions in other programs that help people in need.

Our program, a Main Street Contract for the American People. With the inaction from our elected leaders, NNU adopted a recommenda-

RoseAnn DeMoro is executive director of National Nurses United.
Strong Medicine

NNU is joining with nurses around the world to jumpstart a global movement for a Wall Street tax.
The global economy is deathly ill, and registered nurses all over the world are stepping up with the first dose of the cure: a small sales tax on trades of stocks, bonds, and other financial instruments that, here in the United States, would raise $350 billion a year to help rebuild the country’s economic and social infrastructure. Other world leaders, such as President Sarkozy of France and Chancellor Merkel of Germany, are seriously considering such a sales tax for European markets and the global movement for a “Robin Hood tax” seems to be gaining momentum.

To support and increase awareness for a financial transaction tax (FTT) on Wall Street, National Nurses United joined nurses from four continents on Nov. 3 in a global day of action. In Cannes, France, NNU nurses joined with their Australian, Irish, and Korean counterparts as well as international labor organizations to tell world leaders attending the G-20 summit that time is running out and a global finance tax is needed immediately to restore economies, governments, and the livelihoods of millions of struggling people. In addition to a press conference held with Public Services International, the International Trade Union Confederation, and Oxfam,
International ambassador and actor Bill Nighy, NNU marched with thousands of other union members and activists to protest the G-20’s failure to address global human needs at a time when multinational corporations are wealthier than ever. By some estimates, the biggest non-financial U.S. corporations are sitting on at least $2.5 trillion and more in cash.

“I’m incredibly proud of the nurses internationally for their global advocacy for their patients and society,” said RoseAnn DeMoro, executive director of National Nurses United. “The nurses don’t ever give up on people and we won’t give up on this cause.”

Other groups said they appreciated the nurses’ leadership in calling for an FTT. “Thank you to the trade unions and to the nurses for this very powerful message,” said Elise Buckle, World Wildlife Fund international policy advisor. “The financial transaction tax is a question of survival for the world’s poorest people.”

Stateside, NNU held a massive march and rally in Washington, D.C. where nurses picketed the White House and the U.S. Treasury Department, urging President Obama to “tax Timmy’s friends,” referring to treasury department secretary Timothy Geithner and the banking and financial officials he counts among his inner circle. Geithner has lobbied here in the United States and abroad against an FTT. Ralph Nader, veteran consumer crusader, addressed the
Washington, D.C. crowd and predicted that nurses "are going to change the country." In San Francisco, nurses marched from the Federal Reserve Bank to Wells Fargo Bank headquarters and rallied outside. In Los Angeles, nurses marched from the OccupyLA site to the financial district.

“Were back here, again, and we’re saying the same thing: We need to tax Wall Street, heal Main Street,” said Karen Higgins, RN from Massachusetts and a copresident of NNU. “A real finance tax would generate $350 billion a year in the U.S. alone and bring relief to families out of homes, friends out of work, patients out of care, communities running out of time.”

The global movement for a financial transaction tax on Wall Street and other global markets appears to be working. Bill Gates at the G-20 summit presented a report expressing support for an FTT and was quoted as saying, “The money could be well spent and make a difference.” And the day after the G-20 protests, President Obama shifted his stance against the tax, saying the United States “would not block others from going ahead,” essentially signaling to Europe that it should try to pass such a tax.

Here in the United States, Rep. Peter Defazio and Sen. Tom Harkin have proposed a watered-down, weaker form of an FTT that would impose only a 0.03 percent tax on transactions. Expected to raise only $350 billion over almost a decade, with half that amount earmarked for debt reduction, their bill does too little, too late for the economy, say critics. It would not generate enough funds to tackle systemic problems like unemployment and the loss of jobs for entire industries, lack of access to healthcare, and our quickly-crumbling public school systems, but also would not make much a dent in the pockets of the big Wall Street firms whose bad bets on mortgages and other toxic assets caused much of the economic meltdown in the first place.

“This is far short of what is needed to reframe our devastated economy,” said DeMoro. “We do not have nine years to wait. A better approach would be an FTT that raises $350 billion every year.”

A U.S. financial transaction tax would have very little effect on ordinary investors buying shares of stocks that they plan to hold onto for the long term or for their 401(k) funds. It would primarily affect huge financial institutions that gamble in the market daily, making thousands of trades an hour. Not a new or untested idea, the United States actually had a modest FTT from 1914 until 1966.

“Taxes are not a punishment,” said Peter Waldorff, secretary general of Public Services International, which represents public sector unions globally. “We collect them to support public services. If you care about the imbalances between the rich and poor, you should support the financial transaction tax.”

“A real finance tax would generate $350 billion a year in the U.S. alone and bring relief to families out of homes, friends out of work, patients out of care, communities running out of time.”
Substandard

From left: Filipino RN leaders Siony Servillon, Zenei Triunfo-Cortez, and Ron Villanueva have all faced unfair treatment at some point in their careers because of their ethnic background.
Despite being valued and essential members of the American RN workforce, Filipino nurses must still often challenge and overcome bias and discrimination.

By Momo Chang

“Our accents are hard to understand.”

“They all seem to know each other. Are they all related or something?”

“They all seem to know each other. Are they all related or something?”

These are the types of coded comments that Filipino registered nurses hear all too often in the workplace. While not blatantly racist, these subtle digs belie the prejudice against Filipino nurses that unfortunately still exists among the RN workforce.

For Ron Villanueva, a 45-year-old critical care RN with more than 20 years of experience working in the United States, discrimination came in the form of so-called “advice.”

Several years ago, when Villanueva tried to apply for a promotion to a managerial post, upper management told him, “I strongly advise you not to apply for the position.” When he heard that, he flashed back to a previous incident. A year and a half prior, while waiting to be interviewed for a supervisor position, he overheard a different person in upper management say, “Do not hire foreign graduate nurses.”

It wasn’t hard to connect the dots and conclude that his employer, St. Luke’s Hospital in San Francisco, appeared to be discriminating against Filipino nurses. Villanueva’s union, the California Nurses Association/National Nurses United, eventually filed in August 2010 a class action grievance on behalf of Filipino nurses at the facility, which is owned by the large corporate hospital chain Sutter Health.

“I just wanted people to be treated fairly,” Villanueva said about why he chose to speak up about the injustice. “Ignorance and intolerance shouldn’t have a place here, let alone in San Francisco.”

And while unfair treatment is often subtle, it can still be shocking and flagrant. As just one example, Filipino nurses at Delano Regional Medical Center in California’s Central Valley allege that Filipinos were the only group singled out by the hospital for enforcement of a stringent English-only policy. The Filipino workers, mostly nurses, were threatened with job loss if they were overheard speaking Tagalog.

These incidents, and more, show that prejudice against nurses from other countries and of different ethnicities and nationalities is, sadly, still a part of the work environment for many RNs. While discrimination is not just targeted at Filipino nurses, they constitute the largest group of foreign-educated RNs in the United States. Today, one in four immigrant women from the Philippines are nurses, and Filipino nurses make up 69 percent of all foreign-educated nurses seeking licenses in the United States.
To understand and hopefully overcome these prejudices, nurses, physicians, and other healthcare workers must make an effort to understand the culture and backgrounds of their Filipino colleagues and the complex history, rooted in the U.S.-Philippines colonial relationship, that eventually led to waves of immigration by Filipino nurses.

“Filipino nurses, as immigrants, have sometimes unfortunately been stereotyped as exploiting the United States and as being a detriment to the domestic nursing force,” said Catherine Ceniza Choy, author of Empire of Care: Nursing and Migration in Filipina American History and professor in the department of ethnic studies at the University of California at Berkeley. “If you know that history and you know that U.S. hospitals actively trained and recruited Filipino nurses after World War II in large numbers, you would learn that Filipino nurses are making an important contribution to U.S. healthcare delivery.”

Filipinos have a long history of working as registered nurses in America. Many were recruited to work in areas or shifts where it was difficult to place nurses, such as in public, inner-city hospitals or rural areas and for night shifts.

To understand that history, one must go back to 1907, when the U.S. colonial government first opened nursing schools in the Philippines. Teaching and training Filipino nurses was seen as a “benevolent” form of colonialism and a way to combat ailments such as tuberculosis and cholera. (The U.S. colonial relationship with the Philippines lasted from 1898 until 1946.) While that early training – the first Filipino nurses graduated in 1911 – was intended for Filipinos to work in the Philippines, it laid the foundation for the eventual mass migration of Filipino nurses to work abroad, according to Choy.

Two major factors led to the mass migration of Filipino nurses abroad: facility in the English language, and a U.S.-based nursing education system. Nurses were taught in English within a nursing education system that was very similar to programs in the United States, and the best and brightest were encouraged to study abroad in America.

This education in English and Americanized way of nursing, coupled with nurses’ own desires to visit the United States, paved the way for future nurse migrants. Because it was seen as a booming, high-status field, particularly for women, girls from the most “respectable families” were recruited into nursing programs in the Philippines, where they lived in dorms in a strict environment.

In 1948, the U.S. government created an exchange program called the Exchange Visitors Program, which was rooted in Cold War goals. This led to the first large wave of Filipino exchange nurses here. Between 1956 and 1969, 11,000 Filipino nurses participated in the program as exchange visitor nurses on two-year contracts.

The vast majority of these nurses returned to the Philippines, though there were a number of nurses who remained in the United States through marriage, by going to Canada, or working with hospital employers to change their status, Choy said.

Starting in the 1960s, recruitment agencies began recruiting these former exchange nurses to return, either as immigrants or temporary workers. Then in 1964, the value of the peso, the currency in the Philippines, plummeted. The incentive to work in the United States grew even greater. Now nurses from the Philippines could work here and make ten times as much as they did at home — even if they were paid less than their American counterparts. By 1964, half of all Filipino nurses went abroad, according to Choy’s research.

When the Immigration Act of 1965 passed, it allowed for the mass, and permanent, migration of Filipino nurses to the United States. It gave preference to highly skilled, professional workers such as nurses. During the 1970s, the Philippines government focused on labor export as an economic strategy and relied heavily on remittances, or money sent back from workers abroad. Today, many Filipino nurses still send money to relatives in the Philippines and are expected to use their salaries to help support a much wider extended family than most Americans.

Filipino nurses, in short, became one of the country’s best and most valuable commodities for export. The growth of Philippine nursing schools reflects the demand: between 1950 and 1970, nursing schools in the Philippines grew from 17 to 140; by 1990, there were 170 schools, and today, about 300, according to Choy.

The United States, coincidentally, had a severe nursing shortage; by 1967, there was a shortage of 125,000 nurses. Filipino nurses who came to the United States after 1965 qualified not just as “exchange nurses,” but as temporary workers and immigrants.

So while the original intent under the U.S.-ruled Philippines government was to create a nurse workforce to serve the Philippines, it set the stage for international migration: In the two decades between 1966 and 1985, at least 25,000 Filipino nurses migrated to the United States, according to estimates by Paul Ong and Tania Azores, researchers who have written about Asian American immigration.

Teresita Supelana, 60, was one such nurse who came over to the United States during a nursing shortage in 1977 at age 24, after working in a government hospital in the Philippines for three years. “During that time in the Philippines, you don’t earn that much. When you get a job, it’s not even enough for yourself,” said Supelana, a critical care RN in the coronary care unit at John H. Stroger, Jr. hospital in Chicago. Her father was a farmer and her mother a...
Some had to return to the Philippines when they didn’t pass. “I could have been recruited by other places,” says Servillon.

At first, the foreign-trained nurses were not accepted by the local hospital workers. The nurses’ aids and nurses in training may have felt threatened by these younger nurses from abroad telling them what to do, Servillon said. But the Filipino nurses were able to break the cultural barrier and befriend their Southern coworkers. “We invited them to our parties,” Servillon said. “We brought them Filipino food.”

After working in the Tennessee hospital for two years, Servillon moved west to Daly City, Calif., just outside of San Francisco and is now an evening charge nurse in the ICU at St. Luke’s Hospital where she has worked for more than 36 years, in the Mission district of San Francisco. She is the same hospital where Vilanueva, the RN discourage from seeking a promotion, works.

Servillon counts her blessings that her experience being recruited was positive overall. “I could have been recruited by other places that did not treat their workers right.”

Other nurses who came to the United States were not so lucky. Some had to return to the Philippines when they didn’t pass required nursing exams. And tales abound of unscrupulous recruiters and employers who deceive nurses about the type of work they would do and the working conditions they would have.

Nurses were sometimes given the most undesirable shifts, like the night shift, were paid stipends instead of full wages, or were not paid overtime wages. Others were assigned work in nursing homes as aids instead of as nurses in clinics or hospitals.

“They are vulnerable to exploitation, especially new migrant nurses,” says Choy. “Their work is tied to their migration status. They become vulnerable to overwork, to undercutting of wages, because they want to do well and keep their jobs.”

This type of exploitation is a “longstanding pattern” that continues today, according to Choy.

In 2006, a high-profile case of nurses recruited from the Philippines to work in Long Island came to light, with extensive coverage in the New York Times and Newsday. When the nurses arrived, they found that they were not given what was promised, including fair wages and benefits and decent working conditions in a nursing home. A lawyer advised the nurses that their employer had breached their contracts and 24 workers resigned en masse.

In response, SentosaCare, their employer, filed a civil suit against 10 of the workers for breach of contract and patient abandonment. The nurses then countersued and filed a complaint against the recruiting arm of the company in the Philippines, with the Philippines government temporarily halting the company’s recruiting privileges. In May 2010, the nurses were successful in court and a judge decided they did not have to pay the recruitment agency up to $25,000 in damages. But the case stands out as an example of how unethical recruitment of Filipino nurses is an ongoing problem.

“It’s a big victory for migrant nurses, especially Filipino nurses,” said Zenei Triunfo-Cortez, RN and co-president of the California Nurses Association. “Hopefully, we are encouraging nurses, if they believe they are being discriminated against or favored over others, to speak up.”

In addition to unethical recruiters, constantly changing immigration laws and government policies also put Filipino nurses recruited from abroad in precarious situations.

Noreen David Brion, 49, a critical care RN at Mountain View Hospital in Las Vegas, Nev., and a negotiating team member of her union, spent several months running away from immigration when she first arrived in the United States. She immigrated on a working visa in 1988 at age 28 after working in the Philippines for a few years where she helped organize a nurse union.

Soon after her arrival, the United States passed the Nursing Relief Act of 1989, which expanded the number of foreign nurses in U.S. hospitals. However, the Chicago hospital where she worked was not able to prove that they tried to hire domestic nurses first before hiring foreign nurses under the attestation law, so Brion and a handful of other nurses lost their visas. In fact, she didn’t realize she was working without a visa until later so, for a short time, she was undocumented.

“We panicked and all ran to different states,” Brion says about herself and the other Filipino nurses working with her who were also working without a visa. “We basically went into hiding. It was difficult for me to get legal in the U.S.” She found a hospital in Los Angeles that could sponsor her work visa, but first had to go back to the Philippines for a month before re-entering the United States. Brion eventually got a green card and is now a citizen.

And while U.S. employers have historically pursued Filipino candidates to fill nursing positions, it seems that some facilities are biased against hiring Filipinos.
At St. Luke’s Hospital in San Francisco, where Villanueva was discouraged from applying for a supervisor position, data collected by the California Nurses Association points to what Villanueva and others allege as systemwide discrimination against Filipino nurses. Just before St. Luke’s was incorporated into California Pacific Medical Center by the large corporate hospital chain Sutter Health in January 2007, Filipino nurses at St. Luke’s made up 66 percent of the nursing population. That year, one in three nurses hired were Filipino. From 2008 until the end of 2010, only 15 percent, or six of 41, of new hires were Filipino.

Claimants and the union charge that the sudden drop in Filipino nurse hires is evidence that the hospital was using discriminatory practices.

The California Nurses Association filed a class action grievance on behalf of Filipino nurses against California Medical Pacific Center, which owns and operates St. Luke’s Hospital. Villanueva was not alone in overhearing the statement of not hiring foreign nurses. A manager who worked there for two years said that one member of upper management suggested to him not to hire foreign graduate nurses because patients have a hard time understanding them.

The hospital had had a longstanding practice of hiring Filipino nurses, even going directly to the Philippines to recruit nurses. But recently, it’s clear that they have been trying to “cut the cord” with Filipino nurses, said Triunfo-Cortez who, as one of the country’s top Filipino nurse leaders, has watched the case closely. She believes it is because Filipino nurses have been outspoken in their criticism in recent years of the hospital chain’s plans to close the hospital. (CNA currently has ongoing litigation against CMPC).

Community organizations like the Filipino Community Center are advocating for St. Luke’s Filipino nurses. CPMC denies all allegations and the grievance has yet to be resolved.

Once on the job, however, Filipino nurses often face various kinds of discrimination by their employers and coworkers.

Language continues to be a hot-button issue for Filipino nurses. Though Filipino nurses speak English, the Delano case is just one of many cases where employers have established rules preventing employees from speaking their native language.

At Delano Regional Medical Center, Filipino workers were singled out for their English-only policy. Beginning in 2006, Filipino employees, the majority of them nurses, were called to meetings and told they were not to speak Tagalog or any other Filipino dialect at work, not even during breaks or in break rooms. They were threatened with surveillance and job loss if they were found to speak anything other than English at work. Non-Filipino workers were encouraged to report and monitor Filipino-American workers.

The U.S. Equal Employment Opportunity Commission and the Los Angeles-based Asian Pacific American Legal Center have filed lawsuits on behalf of 52 Filipino workers, some who have worked at the hospital for decades, for violation of U.S. and California civil rights laws.

The facts unearthed by the EEOC’s investigation are damaging: It found that the hospital’s stringent English-only policy created “severe and pervasive workplace harassment” for its Filipino workers.

“Non-Filipino employees, including supervisors, doctors, and nurses, regularly spoke in languages other than English (including Spanish and Arabic) without being reprimanded or censured,” according to the suit.

### Nursing Programs in the Philippines

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Data based on research by Catherine Ceniza Choy, author of *Empire of Care: Nursing and Migration in Filipino American History* and professor in the department of ethnic studies at the University of California at Berkeley; ABS-CBNnews.com
“This was really humiliating for our clients,” said Carmina Ocampo, a staff attorney at APALC. “Some have been working there for 10, 20 years, and it was just stressful and humiliating for them. People would stop them and say, ‘English only.’ A lot of times they would be told to speak English because people would mistake their accents for ‘Tagalog.’ They were afraid that they were going to get in trouble if they accidentally spoke ‘Tagalog.’” A trial date has been set for Sept. 10, 2012.

Enlightened coworkers and employers understand that multilingual staff is a strength, not a problem. Trande Phillips, an adult and pediatric RN in Northern California, believes staff should be able to freely converse in their native language, but has seen misunderstandings arise when Filipinos take breaks or speak Tagalog together. “Some of the other nurses will feel like they’re being excluded,” Phillips said. “I don’t think it’s an intentional thing, but a cultural misunderstanding.”

Phillips notes that where she works, it’s an international workforce of nurses that includes Filipino and other Asians, Polish, Russian, and African nurses. Instead of being divided, nurses need to be brought together. “It’s important for nurse leaders to help people understand that cultural diversity is not a bad thing, and how we can work together.”

Michelle Diamante, 42, an ICU nurse at John H. Stroger, Jr. Hospital in Chicago, is a third-generation Filipino nurse who also sees diversity in race, ethnicity, and languages spoken as an asset in her workplace. Her grandmother, Rosario S. Diamante, was president of the Philippine Nurses Association in 1968 and her mother is also a retired nurse. “It’s a melting pot on my floor,” Diamante, 42, says. Her colleagues include Nigerians, Filipinos, Thai, African Americans, Poles, and Mexicans. “If a patient can’t speak English, I just grab one of my nurse colleagues. It’s wonderful to work in a multicultural, diverse floor. Even the doctors, they’re also from different cultures and countries.”

Another area where Filipino RNs often encounter bias and prejudice is when seeking advancement or promotions in their positions.

Take the case of Triunfo-Cortez, a CNA co-president and a post-anesthesia care unit (PACU) nurse at Kaiser Permanente in South San Francisco. In 1990, while working as an ICU nurse at the hospital, she tried to transfer to a PACU position. She knew she was a fully qualified, in-house applicant who had worked for Kaiser for eight years. Yet she was denied the transfer and an external candidate was hired. She heard rumors that the manager in PACU said that there were “too many Filipinos” in that department.

Instead of accepting the situation, Triunfo-Cortez brought her case to her union, the California Nurses Association, filed a grievance, and her complaint was reviewed by the hospital. She won the position. Though the hospital would likely never say that Triunfo-Cortez was discriminated against, she believes she was.

“The stereotype is that we’re the quiet types,” Triunfo-Cortez says of Filipino nurses. “They think we won’t pursue or escalate the issue, or bring up the issue at all. I think the manager was surprised that I took it all the way up through the escalation process.”

Although Filipino nurses have established themselves as an essential part of the American RN workforce, they are still unfairly seen by some as inferior.

“There is a pattern of viewing foreign-trained nurses, who are predominantly Filipino, as second-class professional citizens or second-class workers,” Choy said. This is despite the fact that many nurses, such as Servillon, graduated from the top nursing programs in the Philippines. And that stigma shouldn’t apply to Filipino nurses who either attended American nursing program or were born, raised, and educated in the United States, but it still exists.

Today, Filipino nurses come to the United States through a combination of ways: as immigrants through family visas, or employment-based visas to fill shortages, such as the H-1 or EB-3. And some are second- or third-generation American nurses, such as Diamante.

Choy believes that two things need to change in order to protect workers and patients: ethical recruitment of foreign nurses, and ethical employment.

Ethical recruitment would include advertisement that is accurate, so that nurses have a clear idea of what their placements are and what they are going to be paid, and are informed of their rights and responsibilities. Ethical employment means fair working conditions, wages, professional respect, and employment as nurses – and “more sensitivity to their cultural background,” Choy says. She also believes that nurses should be allowed to speak their home language during break time.

Many interviewed also say that having union representation is critical in helping nurses speak up about injustices. “Having the union back up the suit made me more comfortable bringing it up,” said Ron Villanueva about the St. Luke’s grievance.

For many workers, standing up and speaking out has been a way to combat stereotypes and forge alliances with non-Filipino nurses. Many interviewed said that speaking up is one of the only ways to combat discriminatory practices. Triunfo-Cortez says she is glad she fought her case until she received her transfer. She is now one of the highest-ranking Filipino nurse leaders in the country.

Choy believes that Filipino nurse migration will continue due to the aging U.S. population, so it is even more important to understand the group’s history and culture, and to combat discriminatory practices. “It’s a form of intimate labor that relies on people that can’t be outsourced.”

Since so many Filipino nurse graduates will eventually end up working in the United States and other countries, it is important for them to avoid exploitation by getting educated about the standards they should expect and demand for their working standards and compensation, as well as how to stand up for themselves by understanding their labor rights and relevant laws. Triunfo-Cortez has given talks to graduating classes of nurses at four universities in the Philippines to cover these issues and explain how her own union and professional association helps nurses be patient, collective, and social advocates. “The students are in awe when I tell them how our RNs are engaged, how public officials seek and value our endorsements,” said Triunfo-Cortez.

Meanwhile, Filipino nurses like Villanueva keep up the fight. He still works at St. Luke’s, but his bad experience with management’s prejudicial attitudes prompted him to step down from his supervisor position to return to work as an ICU nurse. He is happy being a bedside nurse again, he says. The case in which he has been outspoken about is still pending.

“After all this, I’m still here because I love working for St. Luke’s," he said. “Our patients here are so appreciative of what we do. This all stems from the fact that we want to advocate for the underprivileged, underserved population in this area and for future nurses, whether they be local graduates or foreign nurses.”

Momo Chang is a freelance journalist based in Oakland, Calif., where she writes about Asian American communities, immigrants, and youth.
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