Some nurses are taking their work out of the hospital and into the community.

Unconventional Medicine
They say diversity is one of the things that makes our country great. It’s also one of the strengths behind our organization, National Nurses United, which represents nurses from the crowded emergency rooms of Los Angeles to the mountains of Appalachia and everywhere in between.

In this month’s feature story, we showcase nurses who have chosen a career path that takes them off the beaten track. Whether these RNs are working to lower their community’s lead poisoning rates or helping law enforcement solve sex crimes, their workdays look nothing like the standard hospital rotation. But as their stories make clear, the skills they need are the same: critical thinking, versatility, and most of all, a human touch.

NNU is expanding our diverse family with organizing in traditionally non-union states of the South, Southwest and Southeast. This month, we bring you news of nurse actions in Florida and Texas, where RNs are on the move in a big way. If nurses considering joining us have any doubt about the benefits union representation can bring, they need only read Jacquelyn Baugher’s letter in this issue, ‘What the Union Has Done for Me.’ We guarantee you’ll be moved.

No matter where we hail from, nurses share common goals: quality care, control over our practice, and the ability to advocate for our patients. These issues are at the heart of all our NNU organizing, from fighting for a decent contract in Minnesota to protesting unsafe staffing at Massachusetts hospitals. And they are all part of Senator Barbara Boxer’s National Nursing Shortage Reform and Patient Advocacy Act, a landmark bill that could transform nursing in this country. Donna Smith gives you the details in the News section.

Also in News, meet our sister and brother RNs from South Korea, who are grappling with their own patient care problems. You’ll be awed at the conditions they face (50 patients to one nurse, anyone?) and the steps they’re taking to change them.

NNU will need our hard-fought unity in the coming year as the winds of change sweep the healthcare industry. In her column this month, NNU Executive Director Rose Ann DeMoro weighs the pros and cons of the new federal health insurance law, and explains why we’re still waiting for real universal healthcare. Look for more coverage of healthcare reform from us next month.

In the meantime, enjoy these opportunities to learn from your fellow RNs around the country. We’re all in this together.

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

Please contact us with your story ideas
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: Registered nurse Teresa Miller (right) and community health worker Liz Esparza work to bring lead poisoning rates down in their rural California county. Photo by Nancy Dionne.
HEN United States Senator Barbara Boxer (D-CA) introduced the National Nursing Shortage Reform and Patient Advocacy Act, S. 1031, in May 2009, she noted that having safe staffing levels for nurses can make the difference between life and death for patients. As the nation moves toward implementing a health reform law that fails to guarantee a single standard of high quality healthcare for all, extending safe staffing ratios across the nation becomes even more vital.

“Too many nurses are overworked because of staffing levels that are inadequate,” Boxer said as she addressed RNs in Washington, D.C. following the introduction of her bill. “I am proud to be the author of a bill that will improve the healthcare of all Americans.”

Patterned after California law, Sen. Boxer’s bill would not only establish limits on the number of patients per registered nurse in hospitals but would also provide legal support for registered nurses as patient advocates. Whistle-blower protections would be enacted to protect nurses who expose unsafe conditions, and there would be a prohibition on mandatory overtime (except in cases of declared emergency). Mandatory overtime can contribute to medical errors, studies have shown.

S. 1031 also envisions a reduction in the national nursing shortage by keeping nurses at the bedside, promoting the recruitment of new nurses, and creating a federal RN workforce initiative to promote nursing education. The workforce initiative would offer living stipends, preceptorships and mentorships, and training for new nurses so they can provide the best care for their patients.

The effort to pass S. 1031 will be ongoing and not without challenge.

“No question there is a lot of work before us,” said Joe Jurczak, National Nurses United’s political director. “I’m often reminded that it took 12 years for the nurses in California to persevere and to enact landmark patient ratio legislation. So now we must continue with the struggle, continue the work of educating the public and politicians, and continue our engagement in the electoral process to achieve our goals.”

Setting RN-to-patient staffing ratios of 1:4 nationally could save as many as 72,000 lives each year, according to a 2005 study in Medical Care, a journal of the American Public Health Association.

Studies show that improving and protecting staffing levels for RNs reduces both unexpected deaths and medical complications. Hospitals see greater transmission of MRSA staph infections during periods of understaffing, according to a 2008 report in medical journal The Lancet.

Sen. Boxer watched the struggle in California for the safe staffing bill, and saw nurses fight in the years after the bill’s passage to protect the ratios from political attack by those who did not share their commitment to patient care. “I am proud of your strength,” she said in announcing her legislation, recalling how the members of the California Nurses Association stood up to Governor Arnold Schwarzenegger on this and other issues.

Nurses across the country recognize the importance of safe staffing ratios.

NNU nurses in Michigan say hospitals are cutting costs by slashing staff, making nurses work back-to-back shifts and cover more patients than they can handle.

“Administrators are claiming it’s due to the economics and finances behind it. However, nurses still need their numbers to be able to do what we’re supposed to be doing, which is safe patient care,” said Shawn Shuler, RN of Michigan.

“Right now in law there are rules that govern how many hours a pilot can fly, how many hours a truck driver can drive, but not the number of hours a nurse can be forced to work,” said Ken Fletcher, associate executive director for government relations of the Michigan Nurses Association.

Florida RN Tina Bauer put it this way: “If you’re giving pain meds to six patients, somebody’s going to have to wait, and that last person is not thrilled.”

While Sen. Boxer does not have other co-sponsors for her bill as yet, NNU nurses will be seeking those co-sponsorships from their own U.S. Senators and also asking members of the House to support the bill. Advocating for patients is not an issue confined to California or any other individual state, and passage of national safe staffing legislation will signal improved conditions for nurses and their patients no matter what the larger healthcare reform effort brings. —Donna Smith
Revolt Brewing Against Health Insurance Industry

When Mary and Gordon Feller’s 26-year-old daughter moved back in with them because she had developed cancer and was struggling to pay her medical bills, they thought their family’s health insurance problems couldn’t get any worse. They were wrong. Between 2009 and 2010, the Fellers’ insurer, Anthem Blue Cross, raised the rates on their own policy by 80 percent, to over $1600 per month.

The rate increase left the Fellers paying more for health insurance than they do for the mortgage on their home in San Rafael, Calif.—and mad enough to sue Anthem Blue Cross, saying the company violated state law by imposing steep rate hikes on consumers in an attempt to force them into different, less-comprehensive plans.

“We are seeing a system that bankrupts Americans,” said Mary Feller in a March 2 press conference announcing the lawsuit. “Every American is one major illness away from bankruptcy.”

Like many self-employed Americans—Mary works as a freelance journalist and her husband as an environmental consultant—the Fellers find themselves at the mercy of a largely unregulated individual insurance market, where coverage is difficult to find and maintain and prices can skyrocket overnight. Insurance industry excesses are causing widespread outrage in America, and activists frustrated by the federal government’s inaction are mounting their own campaigns to rein in price gouging and denials of care.

Anthem Blue Cross’s rate hikes for hundreds of thousands of individual policyholders in California set off a national controversy, forcing the company to agree they would delay the increases while the state’s insurance commissioner investigates whether they are justified.

In Maine, Anthem and another insurance company are proposing increases of over 20 percent for individual policyholders. Blue Cross Blue Shield asked regulators in Michigan for permission to boost individual plan premiums by 56 percent in 2009, but settled for 22 percent under pressure from the state’s attorney general. About half of states—including Maine and Michigan—have laws allowing regulators to approve or deny rate increases; the rest, like California, do not.

Insurance companies claim the tough economy has forced them to raise rates. “Raising our premiums was not something we wanted to do,” Angela Braly, president of Anthem’s parent company, WellPoint, testified at a Congressional hearing on the rate increases. “But we believe this was the most prudent choice, given the rising cost of care and the problems caused by many younger and healthier policyholders dropping or reducing their coverage during tough economic times.”

Yet studies show insurance companies continue to reap healthy profits while denying and restricting care for consumers. A report on managed care released this month by Goldman Sachs described the situation in the insurance industry as “a rising tide lifting all boats” as “health reform uncertainty recedes.” The paper cited comments from a well-known broker that prices are up and competition is down, and recommended investing in the industry, especially in large carriers like United and Cigna that enjoy virtual monopolies in their coverage areas.

A recent study by National Nurses United’s research arm, the Institute for Health and Socio-Economic Policy, found that California’s largest insurers rejected on average a quarter of all claims last year.

“As nurses, we see healthcare being denied on a daily basis,” National Nurses United Secretary-Treasurer Martha Kuhl, RN said of the findings. “There is nothing worse as a nurse than seeing a parent facing a child with a deadly disease who is being denied care and having to scramble to get care for their child.”

The Obama administration recently proposed but failed to add a provision in health reform legislation that would create a new federal Health Insurance Rate Authority with the power to set limits on health plan prices. Administration officials say they will still push for federal regulation of premiums, but nurses and other activists are not waiting for the administration and Congressional Democrats to act.

At the press conference announcing the Fellers’ lawsuit, Consumer Watchdog—a consumer rights group—and the California Nurses Association/National Nurses Organizing Committee said they will mount an effort to pass legislation allowing the state to regulate health insurance prices, just as it does for the auto insurance industry.

“There is a consumer revolt in this state,” said NNU Executive Director Rose Ann DeMoro. “There is human suffering going on in the hospitals while the insurance industry is living high off the hog, and nurses can’t take it anymore.” —Felicia Mello
Mass rallies and actions across the country in February and March showed the power of the new national nurses movement.

Over 900 Minnesota nurses turned out for a rally March 27 in support of their contract negotiations with Twin Cities hospitals (below). The nurses recalled historic strikes in 1984 and 2001 and said they are ready to walk out again if necessary to maintain a fair contract and protect patient safety.

In Michigan (above), over 1000 RNs and nursing students converged on the state capitol March 24 to advocate for legislation that would ban mandatory overtime and set minimum nurse-to-patient staffing ratios at hospitals in the state.

“We are in the fight of our life for our profession,” said Michigan Nurses Association President Jeff Breslin, RN.

Nurses also took to the streets in Pennsylvania (see p. 16), Florida (p. 12) and Texas (p. 11) to defend their patients and their practice.
Employers’ Proposals Threaten Patient Care, Say Minnesota Nurses

**MINNESOTA**

The first session of negotiations for a series of contracts throughout Minnesota’s Twin Cities exposed a wide gap in commitments to patient care between the hospitals and Minnesota Nurses Association bargaining-unit nurses.

The Twin Cities Hospitals/MNA Pension Plan negotiations opened on March 5 with proposals by the employer to reduce the pension benefit to scales nurses haven’t seen since 1968. “The employer’s proposals don’t really give me any incentive to continue working,” said Pension negotiator Pat Webster, RN from North Memorial Hospital.

When nurses are driven away from the bedside by profit-driven tactics, patient care suffers, and MNA nurses are determined not to let that happen.

As the pension table opened, nurses swooped up stickers proclaiming “Protect Our Pension,” and hospital management in every facility couldn’t walk a hallway without seeing dozens of nurses proudly wearing their conviction on their scrubs. The action was fast and formidable. The wordy, lengthy table report sent out by employers within an hour of closing the session was effectively neutralized by nurses sending their own message, the only one necessary: “Nurses are putting patients first, and we are solid.”

In addition to reducing the benefit formulary to 1.1 percent from 1.65 percent, employers also have proposed eliminating the early retirement option and eliminating another important benefit regarding accumulated hours.

Contract talks for the 14 Twin Cities facilities occur from mid-March through May 31.

MNA nurses in Duluth will begin negotiations in April, with a contract expiration date of June 30 for all three major facilities.

—Jan Rabbers

Successful Push Back on Governor’s Plan to Decimate Healthcare for the Poor

Minnesota’s governor and state legislature signed an agreement March 5 to restore cuts to medical benefits for low-income residents, the result of a determined campaign by nurses, other unions, faith communities and activists.

Governor Tim Pawlenty, a Republican and reported Presidential hopeful, met with widespread opposition when he attempted to eliminate funding for General Assistance Medical Care, a program for Minnesota’s most vulnerable populations. MNA nurses joined thousands of Minnesotans to call, write and rally on behalf of people Pawlenty was willing to turn his back on. Much of the population affected by cuts to GAMC are military veterans or homeless, and require compassionate monitoring.

While attending a conservative PAC convention in Washington DC, Pawlenty sent a long-distance veto to a bill restoring the funding that had passed by overwhelming margins in both chambers of the state legislature in February. Undaunted, House Representative Erin Murphy, a registered nurse who once served as MNA’s Executive Director, reentered negotiations with legislators and hammered out an agreement that the Governor agreed to sign.

Fairview Nurses to Management: “Can’t Buy No Patient Satisfaction”

MNA nurses at Fairview Health Systems did a double take when they saw the newest ploy from management. The memo was filled with bubbly marketing terms like “opportunity,” “build momentum,” and “cumulative statewide goal.” Nurses initially saw it as the latest variation on the theme du jour: engaging employees in efforts to boost patient satisfaction.

What made this push different, however, was the phrase “one-time monetary award.” Management was seeking MNA’s support to offer bargaining-unit nurses a financial reward if more patients scored Fairview 2.5 percent higher in satisfaction than the previous year. How very convenient – and yet tragically ill-timed. Contract negotiations were set to begin within three weeks of receipt of themissive and in the wake of difficult cutbacks.

MNA shot back a letter immediately, saying “MNA finds the timing of this proposal and the method chosen for improving patient satisfaction rather suspect. Fairview has recently gone through a painful process to reduce costs with layoffs, restructuring and excessive mandatory low need census hours. MNA would be interested in knowing why Fairview has not invested its resources into improving staffing levels and other resources supporting patient care.”

The MNA response also went on to remind Fairview management that MNA nurses advocate for patients on a day-to-day basis and warned “bribing nurses to inflate satisfaction scores . . . is unacceptable.”

MNA made a formal demand to bargain over terms and conditions of employment, and is awaiting response regarding the matter.
Michigan Nurses Combat Nurse-to-Nurse Bullying, Promote Respect

MICHIGAN

It’s been called “nursing’s dirty little secret,” the “elephant in the room,” and “nurses eating their young.” In the last few years, more formal names have emerged – lateral violence, incivility, nurse-to-nurse aggression. For decades, nurses have been subject to emotional attacks from peers in the workplace with little to no understanding of why they happen or how to prevent them.

For the last year, the Michigan Nurses Association has been removing the elephant from the room through research and teaching on lateral violence, a term that encompasses both casual, thoughtless acts that leave psychological scars and abuse that is intentionally designed to harm, intimidate, or humiliate another group or individuals. MNA’s continuing education session on the topic was presented over 60 times during 2009 and continues to be popular in 2010. In two modules of one hour each, nurses and nursing students receive the facts, figures and armor to repel lateral violence through lecture, question and answer sessions, and group participation.

In the first module, audiences learn the basic facts about lateral violence—what it is, where it comes from, what it does on a personal and corporate level, and how it affects patient care. They discuss potential solutions to the problem. The Joint Commission code of conduct is reviewed in light of how it relates to lateral violence policies within workplaces.

The second module uses methodology based on the work of Dr. Martha Griffin, RN, CS, PhD to teach cognitive behavior rehearsal techniques. Participants are introduced to the top 10 most frequent forms of lateral violence—including gossip, sabotage, and withholding information—and then given acceptable responses to these attacks. They then divide into small groups and role-play different situations using the responses in their own words.

In addition to teaching the two modules at schools, conferences and health institutions, MNA has partnered with the Michigan State University School of Labor and Industrial Relations to survey several Michigan hospitals regarding the level of lateral violence within their workplaces. The preliminary research results have already been presented at international conferences in San Juan, Puerto Rico and Rome, and will be presented at the United Association for Labor Education in San Diego in March.

Dr. Griffin’s research points out the huge toll lateral violence takes on nursing: Approximately 60 percent of new nurses leave their first position within six months due to some form of lateral violence being perpetrated against them. Lateral violence is costly in terms of retaining nurses and millions of dollars are spent every year in “mental health” days. Meanwhile, nurses suffer lasting emotional distress.

“A lateral violence attack is like getting struck by a poisonous snake,” the program materials state. “You didn’t see it coming, it strikes quickly, and before you know it, the poison is spreading. You want to stop the venom from getting any farther into your system and apply the antivenom.”

—Ann Kettering Sincox
A medical/surgical nurse from Sparrow Hospital in Lansing, Michigan, is brimming with emotion from her relief work in Haiti on the Navy ship USNS Comfort. She tells of bonds made with patients and new teammates. “And it truly was a team,” she says. “One thing you learn on the ship is that everything you do makes a difference to your teammates. How much water you use during your shower. How much water you drink. How noisy you are in your quarters when people working other shifts are trying to sleep.”

For Forsberg, who spent a week and a half aboard the Comfort as a volunteer with National Nurses United’s Registered Nurse Response Network, shipboard life was full of amazing experiences. “We had drills to go through—fire drills, abandon-ship drills and then falling out for muster to make sure everyone was on the ship. Every morning reveille would sound at 6:00 a.m. whether you worked the night shift or not! There was always sound—machinery humming, water running, PA announcements.”

The fantail of the USNS Comfort became a place to reach home for Navy personnel and civilians alike, as it was the only place where spotty cell phone reception could be had. It was also the perfect location from which to see some spectacular sunsets, Forsberg recalls, and to see her first sea snake, an experience she could have done without.

But the patients and her co-workers were what Forsberg remembers the most. “We would get done with our shift,” she says, “go catch up on some sleep or do laundry, then head back down to the wards to see how our patients were. We were there for them and even for the length of a shift it was hard to leave them.”

They blanketed the Haitians frequently as the ship was air conditioned—“it even was a little cold for me”—and for people used to living in 106-degree heat, the change was dramatic. Much of Forsberg’s work was in caring for people who had had external stabilizers applied to broken limbs during the first wave of patients and were now coming back for internal stabilization work. While she was there she saw multiple tibia-fibula fractures, head wounds, amputations, pressure ulcers and debridements. One of the worst things for Forsberg was watching patients be discharged from the USNS Comfort knowing they had no home to return to and few to no possessions.

She made numerous friends among her NNU teammates and enjoyed harassing her fellow Michigan medical personnel from the University of Michigan’s Wolverine Team 1. Forsberg can’t say enough about the Navy personnel who worked as corpsmen, surgeons, nurses, and in other positions. “It was always amazing to me to see some burly corpsmen tenderly holding a small Haitian child.” Some of the corpsmen were young men and she commented on how much trauma and death they’d seen already as crew members of the USNS Comfort.

Forsberg is grateful to Sparrow Hospital, the Michigan Nurses Association, and NNU for their support in sending her to Haiti. “I would never have had this incredible experience without their help,” she says. “The new friendships I’ve made and the healthcare I was able to provide will live with me forever.”

Still, Forsberg worries about the patients she left behind. The island is on the verge of monsoon season and with that comes the very real possibility of malaria and dengue. Already, typhoid and shigellosis are on the rise in the tent camps. Sanitation is a huge issue in Haiti—only 19 percent of Haitians had access to any form of sanitation even before the earthquake. Forsberg saw incredible scenes of squalor on her way to and from the airport and the harbor. She has grave fears about the new amputees and the infections and lack of medical care they may face in the coming weeks.

“We have to realize that just because the media has moved on and the emergency patients are taken care of doesn’t mean we’re finished in Haiti,” she says. “The people there are facing a public health crisis that we can’t even imagine here in the United States. And yet Haitians are immigrating to America. All nurses must be aware that diseases that we don’t think about, like tuberculosis, are still very prominent in some third-world countries. They are destroying these people and they are a danger to the entire world if we don’t act to bring public health to the affected countries.”

Would she go again? “In a heartbeat,” says Forsberg. “I’m on the list and I’m hoping I get called again. It’s not an experience for everyone but for me, it was life changing. I’m grateful to everyone that helped me to go to Haiti and I’m ready to go wherever I’m needed.”

—Ann Kettering Sincox
Registered nurses at Boston Medical Center’s East Newton Campus and Tufts Medical Center conducted joint informational picketing outside the hospitals in February to protest dangerous changes in RN staffing levels.

“Nurses go to work every day with the fear that an unnecessary patient death or injury will take place under the current staffing conditions,” said Barbara Tiller, RN, a nurse at Tufts Medical Center and co-chair of the nurses’ local bargaining unit.

“The public has a right to know about decisions that are being made at these hospitals that jeopardize their safety,” added Ann Driscoll, RN, a longtime nurse at BMC and chair of the local bargaining unit.

Boston Medical Center, which is a level one trauma center, and Tufts Medical Center, which has a level one pediatric trauma and level two adult trauma center, care for some of the sickest patients in the Commonwealth, requiring more nursing care to keep patients safe. At current staffing levels, nurses contend it has been a struggle to provide the level of care patients deserve.

Now, both hospitals are proposing and implementing staffing changes that increase the number of patients assigned to many nurses, and neither facility is adequately adjusting their level of nursing care based on patient acuity. At both facilities, nurses believe management is pushing staff to move patients through the hospital faster and faster without providing the resources to support this speedup in care delivery.

In creating the new staffing model, the hospital violated the nurses’ union contract, which includes a process for the union and management to work together to address staffing concerns. Tufts management instead utilized the consultant to put on a show of listening to employees, common in these redesign schemes, where committees are formed and elaborate processes are implemented to give staff the illusion that they have helped develop the new model of care.

“This process is a sham,” said Julie Pinkham, RN, executive director of the Massachusetts Nurses Association. “Management knows from the beginning what cuts are going to be made and what model they will end up with. The committees are used to co-opt the employees and to make them believe they are responsible for creating the changes, the very changes that will undermine their ability to deliver safe patient care.” —David Schildmeier
When managers at Christus Spohn Shoreline Hospital in Corpus Christi, Texas disciplined two nurse leaders for speaking up about unsafe staffing and other patient care issues, they might have hoped to silence RN voices. The effect was just the opposite.

The plights of RNs Missy Gorbet, who was suspended, and Buddy Caro, who was fired, quickly drew support from other Texas nurses who recognized that their right to advocate for their patients was under attack, not just in Corpus Christi but statewide.

On February 23, dozens of nurses from across Texas staged a rally in Corpus Christi, calling on hospital administrations to respect nurses who speak out for safe patient care. They marched to the offices of Christus Spohn's CEO and delivered over 400 postcards of support for nurse rights signed by nurses and community supporters, including teachers, firefighters and police. The postcards demanded that Christus Spohn, a Catholic hospital system, follow state and federal laws as well as Catholic social justice teachings in respecting nurses' right to advocate collectively for their patients.

The nurses were joined by state Rep. Abel Herrero and Texas AFL-CIO President Becky Moeller.

“Every day you go on the floor and we as nurses are short [handed],” Gorbet told a local television reporter. “You can have one nurse to anywhere from seven, eight, nine patients. That is unsafe.”

The rally was an indication of a growing RN movement in Texas. Over 10,000 nurse activists in the Lone Star state now participate in National Nurses Organizing Committee-Texas. The rally comes on the heels of another victory for Texas RNs, when a nurse in West Texas was acquitted of trumped-up charges filed after she reported a local doctor for endangering patients.

NNOC-Texas has sponsored state whistle-blower protection legislation to shield nurses who expose unsafe conditions at their workplaces. Nurses will hold public hearings on the legislation around the state this year.

After filing unfair labor practice charges with the National Labor Relations Board, Gorbet, Caro, and NNOC-Texas won a settlement that clearly acknowledges Texas RNs' legal rights and duties as patient advocates. The hospital paid Gorbet and Caro over $25,000 in lost wages and erased any mention of the disciplinary action from their records.

Hospital management also posted notices inside the facility acknowledging the right of RNs to act collectively to address workplace issues free of intimidation or coercion.

—Staff Report
Florida RNs Mobilize to Improve Patient Care

On February 16 and 17, more than 200 RNs from every major Florida city boarded planes, buses, and automobiles to Tallahassee to march, rally, and advocate for the Florida Hospital Patient Protection Act of 2010, which would set safe nurse staffing levels in hospitals and protect nurse whistle-blowers. The event illustrated the dramatic growth of the National Nurses Organizing Committee-Florida over the past two years.

Inspired by the success of the California ratio law and the efforts of NNOC-Texas, the Florida RNs join nurses from Arizona to Pennsylvania who have been actively working to win passage of safe staffing laws in their states over the last few years.

RNs intrinsically understand how ratios save lives and money. But legislators need to hear the everyday experiences of direct-care nurse constituents to be convinced.

After a continuing education course on February 16 about the specifics of the ratio law and effective patient advocacy, RNs were ready to talk to their legislators.

The next morning, in the face of unusually cold temperatures hovering barely above 30 degrees in the sun, the nurses marched through downtown Tallahassee clad in red scrubs, chanting and waving at curious shop owners and their customers who stood in doorways to get a peek at such an unusual sight.

NNOC-Florida’s message of patient advocacy resonates strongly with nurses in the state. Florida RNs interviewed by National Nurse spoke passionately about conditions in their local hospitals and the grave need for the law.

“My first job I had too many patients, and I couldn’t stay because of the staffing,” said Marie Platel-Wesh, an RN since 1986 from the Miami area. “Families are being treated badly because nurses have too many patients. I would like to return to bedside nursing. I think ratios would be beneficial to hospitals and to patients, and nurses would be happy to go to work.”

“From the first day I started nursing I knew something had to be done,” said Tanya Runfola, RN, who works at a Tampa Bay hospital. “There are different interests in healthcare, patient interests and profit-centered interests. It’s important for nurses to advocate collectively because they have a duty and obligation to their patients.”

The Florida Hospital Patient Protection Act of 2010 will:

- Have unit-specific RN-to-patient ratios for all shifts including coverage for breaks and absences from the unit
- Establish whistle-blower protections for RNs who expose unsafe conditions
- Prohibit unsafe floating and layoffs of ancillary staff
- Assure RNs the legal guarantee to serve as patient advocates
Eastern Maine Medical Center Nurses Win Staffing Changes

Maine

By using their Professional Practice Committee to document changes in staffing and their effect on patient care, nurses at Eastern Maine Medical Center have transformed the working environment in one hospital unit.

The campaign started last fall when the nurses, members of the Maine State Nurses Association/National Nurses Organizing Committee, noticed an increase in the number of assignment despite objection forms being filed by RNs working in the hospital’s dialysis unit.

The forms indicate that a nurse believes conditions on a unit compromise patient safety and are filed with the Professional Practice Committee, a board of staff nurses empowered by the collective bargaining contract to oversee patient care.

“These nurses were expected to work all day long, take call that night, and come in the next day to work,” said PPC co-chair Lisa Oliver, RN. “It was horrible.”

Working through the PPC, Oliver and other nurse leaders decided to conduct a study of conditions on the unit. They followed nurses throughout their shift, documenting each task they performed and how long it took. Then they set up a task force to develop solutions.

By the first of this year, the nurses had won changes in the call schedule and convinced the hospital to fill two more full-time positions on the unit.

“Everything that we set for goals at the beginning of our subgroup we achieved,” said Oliver. Oliver said when she ran into one of the dialysis nurses recently, the impact of those changes was clear.

“Every time I’ve seen her before, she had the weight of the world on her shoulders, but this time she was lit up like a Christmas tree,” Oliver said. “She said ‘I slept all night and I know when my day is done, it’s done. I can see my family.’”

The victory provides one example of how RNs are using their Professional Practice Committees to win gains in safe staffing in states that don’t yet have legally mandated staffing ratios.

And it’s not the only recent win at EMMC. After hospital management this month announced plans to lay off 23 nurses, MSNA/NNOC negotiated an agreement with the hospital that avoids any RN layoffs by creating new positions for nurses displaced from their current jobs.

“This is good news for our community,” said bargaining unit president Judith Brown, RN. —Staff Report

University of California Nurses Take Strike Vote

California

Nurses at University of California medical centers voted overwhelmingly this month to authorize a strike. The 11,000 nurses are in a pitched battle against the university administration, which has refused to abide by the recommendations of a neutral fact-finder to settle the nurses’ contract by providing improvements in patient care, wages and benefits.

The strike vote is the latest step in a statewide pressure campaign led by the California Nurses Association/National Nurses Organizing Committee, in which thousands of nurses signed pledges of support for their bargaining committee and dozens of state legislators sent a letter urging the university administration to implement the fact-finder’s suggestions.

The vote comes amid rampant patient-care problems at the prestigious university medical centers, many linked to poor staffing. At UC Irvine this month, following revelations of faulty narcotics pumps, medication errors and delays in treatment, federal regulators found that the hospital did not meet national safety and quality standards and could lose eligibility for Medicare funding if conditions do not improve. UC Davis Medical Center routinely staffs one-third of its shifts with fewer nurses than indicated by its own patient-acuity system, according to internal hospital documentation.

Because they care for some of the state’s sickest patients, UC hospitals are legally required to provide larger numbers of nurses than the minimum mandated by state nurse-to-patient ratio laws.

The fact-finder, who was chosen jointly by CNA/NNOC and UC administration, recommended that the university provide break relief to nurses, discuss staffing changes with CNA/NNOC before they are carried out, and offer a four percent raise to keep wages at UC in line with competitors.

While flouting the recommendations, the university has announced record bonuses this year for top executives. For example, UC Los Angeles Medical Center CEO David Feinberg received a 30 percent bonus this year, for a total compensation package of close to $1 million.

“The university in its infinite arrogance has seen fit to give executives huge bonuses while not being willing to invest in patient care,” said Geri Jenkins, an intensive care nurse at UC San Diego and co-president of CNA/NNOC.

“I shouldn’t have to make a choice between whether I get lunch or my patients are cared for safely, especially on a 12-hour shift.”

In their letter, legislators wrote they were “concerned that this year’s medical center profits may have in part been due to chronic understaffing and staffing cuts.”

“We urge you to re-evaluate the fact-finder’s recommendations…and keep the UC medical centers back on the path to world-class status,” the letter read.

A strike date has not yet been set.

—Staff Report
When Korean Health and Medical Workers’ Union general secretary Yoo Ji-hyun shaved her head on the floor of South Korea’s Parliament late last year, she wasn’t making a fashion statement. Instead, Yoo was protesting new labor laws that will affect the KHMU—a bold, scrappy union that represents 41,000 nurses and other healthcare workers in South Korea and uses determined organizing and attention-grabbing tactics to challenge attacks on the country’s government-subsidized healthcare system.

In February, KHUM activists shared the flavor of that struggle in a meeting with leaders of National Nurses United and the California Nurses Association/National Nurses Organizing Committee in Oakland, California. They had traveled to the United States to learn from the experience of CNA/NNOC and NNU, they said, because the unions share progressive values and a commitment to universal healthcare.

“We are both discussing healthcare reform and single-payer from the vantage point of how it affects nurses at the bedside,” said Yoo through a translator. “How President Obama’s healthcare reform shapes up has a very strong potential impact on South Korea because of the close relationship between our two countries.”

For most nurses in the United States, the idea of caring for 50 patients at once is mind-boggling. But that’s what happens in extreme cases in the South Korean health system, said Yoo. Average patient loads are 12 to 15 on medical-surgical units, she said, and four to five in intensive care. Low pay and tough working conditions have created a severe nursing shortage, especially in rural areas.

South Korean patients can count on the government to cover roughly two-thirds of their medical costs, and the nation’s hospitals are required to treat any patient. But pro-business President Lee Myung-bak wants to allow new, less-regulated hospitals to be constructed in the country’s free-trade zones that would be permitted to cherry-pick wealthier patients—a proposal the KHMU strongly opposes. Even as the government moves to cut back on the public healthcare system, it plans to hold a medical tourism conference in April to introduce insurance companies from the U.S. and other rich countries to the boutique hospitals—including a planned ‘healthcare town’ on picturesque Jeju Island that would include a water park and riding trails.

The KHMU and other unions in the Korean Confederation of Trade Unions—South Korea’s AFL-CIO—are leading the fight against such economic inequality in South Korea, a first-world country with an economy that relies heavily on exports. The union, which represents all healthcare professionals except for doctors and has the motto ‘Life Before Money,’ has taken strong stands in favor of the rights of temporary workers, who make up a third of South Korea’s labor force. It also maintains a support fund for workers that are unfairly dismissed.

“Our perspective is that the union represents the interests of broader society and not just the workers we represent,” said organizer Kim Hyung-Sik. “Any issue that comes in conflict with the rest of society or patients, or harms them in any way, we oppose.”

CNA/NNOC itself has inspired KHMU’s local bargaining strategy. The South Korean union translated into Korean the entire contract that CNA/NNOC signed with health management organization Kaiser Permanente.

“We had our policy department study the Kaiser contract and have used its concepts and ideas in almost every local, to say look, this is what California nurses are getting,” said Yoo.

KHMU currently advocates for the government to pay 92 percent of all healthcare costs for patients, rather than the current standard of 62 to 65 percent.

CNA/NNOC co-president and NNU vice-president Malinda Markowitz, RN said she was struck by the Korean nurses’ discipline and dedication to improving their working conditions and patient care.

“No matter where in the world we are, nurses have the same concerns and struggles, and we have a common bond that we really need to facilitate,” said Markowitz. —Felicia Mello
District of Columbia

The District of Columbia Nurses Association is standing in solidarity with 15 nurses who were fired by Washington Medical Center after a snowstorm in early February prevented them from making it to work. The RNs were fired just as the independent nurses union that represents them was preparing to begin contract negotiations with the hospital, which is the District’s largest private medical facility. They included a nurse who was employed by the hospital for 35 years and another who had received glowing performance reviews. A number of support staff were also dismissed. “DCNA will do everything in its power to assist the nurses and their representatives until every last nurse who wants to come back to work is returned to work,” DCNA Executive Director Herman Brown, Jr. wrote in a March 5 letter to the hospital’s president, Harry Rider. “Since there seems to be a snowstorm brewing in your head, maybe you could shovel out the snow and take some advice from a staunch supporter of unionism in the District of Columbia. Reinstate the nurses before this issue becomes a huge blemish on your hospital.”

The DCNA, a National Nurses United affiliate, represents over 2000 nurses in six District hospitals and is working to organize other RNs in the Washington, DC area.

Zenei Cortez, co-president of the California Nurses Association/National Nurses Organizing Committee, explains to Illinois nurses the difference nurse-to-patient staffing ratios have made in her state at an NNOC-sponsored forum February 19. California passed legislation mandating safe staffing ratios in 1999; a similar bill is under consideration in the Illinois legislature.

Illinois

Nurses from northern Illinois gathered in Chicago February 19 to discuss safe nurse-to-patient staffing ratios and strategies for achieving them in Illinois. The Nursing Care and Quality Improvement Act (S.B. 867, H.B. 5033) is a bill in the Illinois legislature that would mandate safe staffing by limiting the number of patients assigned to an RN. On January 25 the bill was introduced by Representative Mary Flowers, who joined the nurses at the forum, pledging her support and admiration for the nursing profession. Also at the forum was a panel of registered nurses. Zenei Triunfo-Cortez, a co-president of the California Nurses Association/National Nurses Organizing Committee and a vice president of National Nurses United, shared the history of winning ratios in California, and how ratios have improved the working conditions of nurses and quality of care for patients in California hospitals. Brenda Langford, president of NNOC Region 13 and vice president of National Nurses United, analyzed the

**Healthcare Stat of the Month**

| Number of maternal deaths per 100,000 live births |
|---------------------------------|----------|
| GERMANY                        | 4        |
| GREECE                         | 3        |
| KUWAIT                         | 4        |
| ISRAEL                         | 4        |
| JAPAN                          | 6        |
| UNITED STATES                  | 11       |

Source: World Health Organization
critical difference between current staffing laws in the state and the proposed ratio bill. Dorothy Ahmad, Linda Riccio, Regena Ellis and Dennis Kosuth all passionately discussed their personal experiences with unsafe staffing, the dire necessity for ratios in the state, and how the nurses present could take action to make ratios a reality in Illinois. The nurses left the forum excited about the ratio campaign ahead.

Maine
After Eastern Maine Medical Center announced plans to lay off 23 nurses along with dozens of other employees this month, MSNA/NNOC negotiated an agreement with the hospital that will avoid any RN layoffs.

In bargaining with MSNA/NNOC, the medical center came up with a number of new positions to replace those that will be eliminated. Although not all nurses will remain in their original jobs, those that don’t will be offered opportunities to bid on the new positions.

The hospital’s Professional Practice Committee, a staff nurse group that oversees nursing practice issues at the hospital, will meet with management over the next month to investigate the potential impact of the staffing changes on patient care.

“We commend our membership for their patience and hard work,” said bargaining unit president Judith Brown, RN.

Veterans Affairs Council
The national veterans affairs Council is proposing changes in Veterans Administration policy that would grant nurses who are accidentally stuck with a soiled needle the right to know whether the patient tests positive for blood-borne diseases such as HIV. Currently, the VA asserts that patient privacy preempts nurses’ health concerns, and nurses must decide whether to take powerful prophylactic drugs without knowing if they have been exposed.

Veterans Affairs Council leaders will also join a VA-wide training in Las Vegas in April regarding a new model of care being introduced in the VA system. The union will work to ensure that nurses’ interests are addressed under the new model, which is expected to give registered nurses and nurse practitioners a greater role in primary care.

—Staff Report

Temple University Hospital Nurses and Allies Strike Over Gag Clause

Nurses and healthcare professionals at Temple University Hospital in Philadelphia went on strike March 31 after they were unable to reach a settlement in contract negotiations with the hospital. The 1500 employees, who are represented by the Pennsylvania Association of Staff Nurses and Allied Professionals/National Nurses Organizing Committee, are fighting against a proposed new policy allowing management to discipline or fire RNs and other workers who publicly criticize the hospital or its executives.

“We’re obligated by our licenses and professional ethics to advocate for our patients,” said Maureen May, RN, president of the Temple nurses union. “We won’t give up our right to raise our voices on their behalf.”

The hospital also wants to triple healthcare premiums for some workers and eliminate a popular tuition reimbursement program.

PASNAP/NNOC held a rally outside the hospital March 19 with AFL-CIO President Richard Trumka, who was born in Pennsylvania. “We will not allow Temple Hospital, an institution supported by taxpayer funds, to thumb their noses at the labor movement and the political leaders that consistently support Temple when they request additional funding,” Trumka said.

PASNAP/NNOC members at the hospital have been working without a contract since September.
Diary of a Wimpy Healthcare Bill
The new federal law fails to challenge the stranglehold of insurance companies on our health system.

PASSAGE of President Obama’s healthcare bill proves that Congress can enact comprehensive social legislation in the face of virulent rightwing opposition. Now that we have an insurance bill, can we move on to healthcare reform?

As an organization of registered nurses, we have an obligation to provide an honest assessment, as nurses must do every hour of every day. The legislation fails to deliver on the promise of a single standard of excellence in care for all and instead makes piecemeal adjustments to the current privatized, for-profit healthcare behemoth.

When the boasts—comparing the bill to Social Security and Medicare, probably to mollify liberal supporters following repeated concessions to the healthcare industry and conservative Democrats—fade, a sobering reality will probably set in.

What the bill does provide
Expansion of government-funded Medicaid to cover 16 million additional low-income people, though the program remains significantly under-funded, which limits access to its enrollees as its reimbursement rates are lower than either Medicare or private insurance with the result that some providers find it impossible to participate. Though the federal government will provide additional subsidies to states, those expire in 2016, leaving the program a top target for budget-cutting governors and legislatures.

Increased funding for community health centers, thanks to an amendment by Senator Bernie Sanders that will double the number of health center sites nationally and the number of patients they serve over the next five years.

Reduction—but not elimination—of the infamous “donut hole” gap in Medicare prescription drug coverage which requires enrollees to pay the full cost of medicine out of pocket.

Insurance regulations covering members’ dependent children until age 26, and restricting limits on annual and lifetime insurance coverage.

Permission for individual states—though weakened from the version sponsored by Rep. Dennis Kucinich—to waive some federal regulations to adopt innovative state programs like an expanded Medicare.

All of these reforms could, and should, have been enacted on their own without the poison pills that accompanied them.

Where the bill falls short
The mandate forcing people without coverage to buy insurance. Coupled with the subsidies for moderate-income people not eligible for Medicare or Medicaid, the result is a gift worth hundreds of billions of dollars to the very insurance industry that created the present crisis through price gouging, care denials, and other abuses.

Inadequate healthcare cost controls for individuals and families. Insurance premiums will continue to climb. Proponents touted a “robust” public option to keep the insurers “honest,” but that proposal was scuttled. The administration also dropped its plan to crack down on rate hikes with a federal insurance authority, a promise made after Anthem Blue Cross of California announced 39 percent premium hikes.

No standard benefits package, only a circumspect reference that benefits should be “comparable to” current employer-provided plans. Even in the regulated state exchanges, insurers remain in control of what they offer and what will be a covered service. Insurers are likely to design plans to attract healthier customers, and many enrollees will likely find the federal guarantees do not protect them for medical treatments they actually need.

It’s not universal. By 2019, 23 million will remain uninsured, one-third of them undocumented immigrants, the rest mostly those who are still unable to afford the ever-increasing cost of private insurance.

No meaningful restrictions on insurers denying claims they don’t want to pay for. Proponents cite a review process on denials, but the “internal review process” remains in the hands of the insurers, and the “external” review will be up to the states, many of which have systems in place that are dominated by the insurance industry with little enforcement mechanism.

Significant loopholes in the much-touted insurance reforms. Insurers will be able to:

- More than double charges to employees who fail “wellness” programs because they have diabetes, high blood pressure, high cholesterol readings, or other medical conditions.
- Sell policies “across state lines,” avoiding patient protections passed in other states.
- Charge three times more based on age plus more for certain conditions, and use marketing techniques to cherry-pick healthier, less costly enrollees.
- Continue to drop coverage (rescissions) for “fraud or intentional misrepresentation”—the main pretext insurance companies now use to purge sick people from their rolls.
- Charge significantly more for policies for children with pre-existing conditions. Confusion over the requirement that insurers agree to sell policies to families with sick children cropped up only after the bill was signed, one of many “fine print” loopholes likely to emerge.

Taxing health benefits for the first time.

Though modified, the tax on benefits remains, a 40 percent tax on coverage with value exceeding $10,200 for individuals or $27,500 for families. With no real checks on premium hikes, many plans will reach that amount by the start date, 2018. The result will be more cost-shifting from employers to workers and more people switching to skeletal plans that leave them vulnerable to financial ruin.
Erosion of women’s reproductive rights through provisions that will likely mean few insurers will cover abortion and perhaps other reproductive care.

A windfall for pharmaceutical giants. As a result of a deal with the pharmaceutical industry, the White House blocked provisions to give the government more power to negotiate drug prices and gave the name-brand drugmakers 12 years of marketing monopoly against generic competition on biologic drugs, including cancer treatments.

Most critically, the bill strengthens the economic and political power of a private insurance system based on profit rather than patient need.

As former Labor Secretary Robert Reich wrote after the vote, “Don’t believe anyone who says Obama’s healthcare legislation marks a swing of the pendulum back toward the Great Society and the New Deal. Obama’s health bill is a very conservative piece of legislation, building on a Republican [a private market approach] rather than a New Deal foundation. The New Deal foundation would have offered Medicare to all Americans or, at the very least, featured a public insurance option.”

Unlike Social Security and Medicare, which expanded a public safety net, this bill requires people—in the midst of mass unemployment and the worse economic downturn since the Great Depression—to pay thousands of dollars out of pocket to big private companies for a product that may or may not provide health coverage in return.

Too many people will remain uninsured, individual and family healthcare costs will continue to rise largely unabated, and private insurers will still be able to deny claims with little recourse for patients.

If, as the President and his supporters insist, the bill is just a start, let’s hold them to that promise. Let’s see the same resolve and mobilization from legislators and constituency groups who pushed through this bill to go farther, and achieve a permanent solution to our healthcare crisis with universal, guaranteed healthcare by expanding and improving Medicare to cover everyone.

Leaders of National Nurses United have raised many of these concerns about the legislation for months. But, sadly, as the healthcare bill moved closer to final passage, the space for genuine debate and critique of the bill’s very real limitations was largely squeezed out.

Much of the fault lies with the far right, from the streets to the airwaves to some legislators that steadily escalated from deliberate misrepresentations to fear mongering to racial epithets to hints of threatened violence against bill supporters that continued after the law was enacted.

For its part, the administration and its major supporters shut out advocates of more far-reaching reform, while vilifying critics on the left.

Both trends are troubling for democracy, as is the pervasive corporate lobbying that so clearly influenced the language of the bill. Insurers, drug companies, and other corporate lobbyists shattered all records for federal influence peddling and were rewarded with a bill that largely protected their interests, along with a Supreme Court ruling that will allow corporations, including the health care industry, to spend unlimited sums in federal elections.

Rightwing opponents fought as hard to block this legislation as they would have against a Medicare-for-all plan. As more Americans recognize the bill does not resemble the distortions peddled by the right, and become disappointed by their rising medical bills and ongoing fights with insurers for needed care, there will be a new opportunity to press the case for real reform.

Next time, let’s get it done right.

Rose Ann DeMoro is executive director of National Nurses United.

California Bill Would Protect Nurses Injured on the Job

The California Nurses Association/National Nurses Organizing Committee is mobilizing RNs to support legislation that would make it easier for nurses injured on the job to receive workers’ compensation benefits.

Registered nurses and other hospital workers are suffering increasing numbers of head and back injuries and exposures to infectious diseases due to the physical nature of patient care. California’s aging nursing workforce, and rising patient acuity and obesity.

Sponsored by Assemblymember Nancy Skinner, A.B. 1994 would establish that when a hospital employee contracts a blood-borne infectious disease, neck or back impairment, MRSA infection, or H1N1 influenza, it is presumed to have been contracted through employment with the hospital. This would dramatically cut down on the bureaucracy RNs must navigate in order to receive benefits.

“Police and firefighters now have the benefit of presumptions under workers’ compensation law for a number of job-related injuries,” said Assemblymember Skinner. “Isn’t it curious that female-dominated professions such as nursing do not have the same protections? I’ve introduced A.B. 1994 to create equity.”

As National Nurse went to press, the bill was scheduled to be heard in early April by the Assembly Insurance Committee.

CNA/NNOC is also working to amend S.B. 1111, which would change the disciplinary process followed by the state’s healing arts boards, including the Board of Registered Nursing. S.B. 1111 was proposed in the wake of media reports about delays in disciplining nurses with a history of drug use and other infractions.

CNA/NNOC believes reform is needed, but the bill also contains provisions that could harm nurses and patients, said CNA/NNOC Government Relations Director Bonnie Castillo, RN. Among other things, the legislation would require nurses’ addresses to be posted on the internet and eliminate the Board’s substance abuse diversion program, which helps nurses with addictions receive treatment. Additionally, the bill would give the director of the Department of Consumer Affairs, an unelected political appointee who is not a health professional, the power to suspend an RN’s license, weakening nurses’ due process rights.

CNA/NNOC is opposing two bills in the legislature that would permit dangerous infringements on nursing practice. S.B. 1051 would allow classified employees in the state’s school system to administer Diastat, a form of Valium that must be applied rectally in the midst of a seizure, to epileptic children. A.B. 1802 would allow unlicensed personnel to inject diabetic students with insulin. —Staff Report
Some nurses are taking their work out of the hospital and into the community.

Unconventional Medicine

BY HEATHER BOERNER
Three days a week, Lori Bowers, RN, puts on her scrubs, enters the sterile halls of Alpena Regional Medical Center in Alpena, Michigan and assists in the births and deliveries of northeastern Michigan’s babies.

But between April and October, you’re just as likely to find Bowers, 47 and a nurse since 1993, standing on the dusty tarmac of Alpena Combat Readiness Training Center, watching as medical personnel scale two-story-high piles of rubble in search of victims of natural disasters and military strikes.

Bowers is a captain in the Air National Guard. Every week, spring through fall, she helps train 45 to 75 medical reservists in how to save military personnel and civilians during disasters or wars as part of a Guard program called EMEDS, or Expeditionary Medical Support.

Most of Bowers’ time is spent outside, supervising and teaching the reservists to set up the $3.2 million mobile hospital (what she calls a “very expensive tent”), complete with an emergency room, surgery suite with centralized sterilizer, dental clinic, ICU, x-ray, laboratory and full pharmacy. “It’s like MASH, but more high-tech,” she said.

The real test comes on the third day, when the reservists must confront a simulated emergency. That’s where the pile of rubble comes in. Fake “patients” made up and taught to explain specific injuries are hidden in the rubble. Suddenly, doctors who work in private practice must learn to diagnose and treat without the luxury of a CT scanner or MRI and learn laboratory values for blood and medications that are different in a mobile hospital than in a traditional one. They must learn when to treat there and when to airlift patients to remote trauma centers.

Instead of running the halls of a hospital between patients, Bowers is criss-crossing the tarmac, stopping students from lifting a litter with two men instead of four, teaching a medical technician the right and wrong way to treat an injury, and watching as a thoracic surgeon teaches everyone, including her, to insert a chest tube—just in case they are in an emergency situation and no one else can do it.

“I’m used to working with a laboring patient and supporting her to bring a new baby into the world,” Bowers said. “What we do at EMEDS is not the same at all. I enjoy both of them, but they’re two totally different things. When you work in a hospital, especially a union hospital, if you’re a med-surg nurse, you are a med-surg nurse. If you work in the ER you work in the ER. Everything is so clear and concise. In the military, you slip into different positions. Even though you may be a med-surg nurse, for the day, you may become an ICU nurse. You become comfortable, knowing that if you’re deployed somewhere you can walk into a facility and know you’ve been trained on how to make it work.”
Diana Emerson was getting ready to head home after a long day of interviewing child-
hood sexual abuse victims when the call came in from police: They were bringing in a local 
woman who had spent the day tied up while two burglars ransacked her home, ate her food 
and demanded that she write each of them checks for $500. She was sexually assaulted during the ordeal and her 
husband was tied and beaten in the other room.

When the woman arrived at the San Mateo Medical Center emergency room in San Mateo, California, she was covered in bruises and 
and wearing only a robe. The home invasion had started at 9:30 a.m., 
when she was just getting ready for the day.

Emerson, a nurse practitioner and the clinical coordinator of 
a forensic medical unit for the Keller Center for Family Violence Intervention, did a quick but thorough physical exam to make sure 
she didn’t have immediate medical needs and then put her in a wheelchair to bring her to her office.

Over the next hour Emerson and a police detective talked to the 
shaken woman, gathering any information they could get to help identify and apprehend the suspects.

The woman asked to be alone with Emerson for the next portion 
of her visit—a grueling, three-hour-long forensic exam of her body, 
in which Emerson took pictures in triplicate of every bruise, every 
mark left by the material used to bind her arms, and every bit of 
duct tape residue on her wrists. She ran a black light over the 
woman’s body looking for organic material and performed a pelvic 
exam to collect DNA samples from the man who assaulted her and 
treat any injuries she sustained. She also collected a few strands of 
the woman’s long, dark hair in case any of her hairs clung to the men 
as they fled in her truck.

“Her body is a crime scene,” said Emerson, 55, who worked as a 
certified nurse aide, LPN and RN before becoming a nurse practi-
tioner and getting a master’s degree in forensic nursing. “Our exams 
are always two-fold: One is for the medical management and treat-
ment of injuries. The other is for forensic evidence. It requires all 
your assessment nursing skills.”

In the end, Emerson gave the woman a pair of sweats and helped 
her call her husband, who was taken to the local Kaiser Permanente 
hospital for treatment of his injuries. She talked to her about possi-
ble sexually transmitted diseases and pregnancy, and she offered her 
referrals to counseling services to help her deal with the fallout of

The Detective

Diana Emerson, RN, NP

Photos by Lauren Reid
the trauma. And then she had the duty of informing the woman that, as much as she just wanted to go home, her home was now a crime scene and she and her husband would have to stay in a hotel.

Seeing people on their worst day is just about Emerson’s specialty. She’s been the clinical director of the Keller Center since it was founded in 2001. While the center is located within San Mateo Medical Center, it’s a distinct entity, funded mostly privately and working with police, local doctors and social service agencies to provide the right information for law enforcement to convict abusive partners, rapists, and other perpetrators of violent crime.

In addition to doing exams and working with police, Emerson also meets with Child Protective Services staff members, victims’ advocates, social workers, district attorneys and other officials as necessary to prosecute crimes. And when the cases go to court, she’s often the first one called to describe the evidence and explain what it means.

“It’s an incredible job because sometimes a woman will come in who’s been married to the same man who’s been abusing her for years, who’s tried to kill her, and I’m the first person she’s sitting down and talking to,” she said. “Sometimes you can see the weight lifted off their shoulders, that their lives might be different from here on out.”

Emerson sometimes follows cases for years, providing expert testimony in court. She also gives lectures to medical students and community groups about the signs of child abuse and how to recognize it. Because she’s worked so closely with local doctors, they know to refer any patient who’s been abused to her center for treatment.

The majority of the cases she sees are child sex abuse, and those are the ones that keep her up at night. Because such molestation is often ongoing, the exam she does for those cases is very different from the exam she did on the home invasion survivor: Instead of looking for acute trauma, she’s looking for evidence of chronic abuse.

She describes one case where a mother brought her 16-year-old daughter into the center after finding her common-law husband sexually assaulting the girl. When Emerson interviewed the teen, she revealed that the abuse started when she was 11. It began with tickling, she said, until at 13 it became full-on vaginal penetration. It stopped at 14 and resumed at 16.

Emerson remembers being confused by the two-year gap. She asked the girl what happened.

“She tells me, ‘Oh, that’s when I got cancer,’” Emerson recalled. “She had to have a kidney removed and she was too sick for him to molest her. After she got better it started again.”

While Emerson has a team of at least a dozen other nurses and nurse practitioners working with her, she says cases like that still take an emotional toll.

“The cases that are really hard are the families where childhood sexual abuse has occurred,” she said. “It’s finally disclosed, the father has been arrested, the mother is devastated. All their income comes from the father and now the family is destitute and near homeless. How can you tell a child that when you tell the truth it’s going to be OK, when in reality life may become chaotic and unpredictable?”

On the other hand, Emerson said, the home invasion survivor she treated “was really strong and articulate. I know she’s traumatized now, but I know she’ll end up being OK.”

For Angie Eccles, RN, one of the biggest challenges of her work as a visiting nurse isn’t finding the time to get to a patient or the work itself. It’s Fido and Fluffy.

Like the time when Eccles was perched in the kitchen of an older man with a leg wound, changing his dressing, and looked towards the doorway to see a huge, black pit bull staring her down. “Will he be OK with me putting this dressing on your leg, or will he think I’m attacking you?” Eccles remembers asking the dog’s owner.

He assured her that the dog would be fine, and he was. Eccles? Not so much.

“I did the dressing to the best of my ability but that dog just sat there the entire time. He didn’t bark or snarl. He just watched me with those beady black eyes,” she said. “It raised the hair on the back of my neck.”

As a visiting nurse, Eccles has spent 34 years driving from home to home, doing house calls on patients too remote or frail to make the trip to the clinic or the doctor’s office. By now, Eccles knows her corner of South Portland, Maine—where she’s spent half her career—like the back of her hand.

The therapy itself is straightforward, Eccles says. It’s the environment in which she works that’s complicated. After all, she treats the same medical conditions as any nurse in a hospital: changing dressings, checking IVs, treating and preventing pressure sores, and educating patients about how to care for their health when the nurse is no longer there. But because homebound patients aren’t under the watchful eye of a nurse 24/7, and because the home environment can sometimes encourage old, bad habits, the care requires more education and the support of family members.

“Seeing people in their homes and on their own turf you get a better perspective of who they really are and what their learning abilities are around their disease,” said Eccles. “Patients are also more comfortable in a home situation—there are no bells or buzzers and few interruptions.”

But seeing people in their homes is a double-edged sword. Take the pet issue, for one thing. Once a cat has jumped in Eccles’s lap during a visit, she carries that pet hair and dander to the next home, possibly causing a reaction in her next patient. Sometimes she has to begin setting up a sterile work environment all over again.

Several of Eccles’s patients over the years have developed pressure sores from laying in the same position for too long, a problem that in a hospital would be carefully monitored and treated—or pre-
vented altogether by regular movement and monitoring by a floor nurse. But once a patient gets home, such supervision is more difficult, and compliance with treatment can be difficult to ensure.

“Once they come home from the hospital, they figure who are we to come into their homes and tell them what to do,” she said. “What we do is a lot of teaching to make it as palatable for them as possible.”

While Eccles says the company she works for pressures her to see as many patients as possible, she—like many other visiting nurses—works independently and if a patient needs an hour of her time, she can give it. Visiting nurses first became popular in the late 1800s in both the United States and the United Kingdom—including Scotland, where Eccles was born—and achieved dramatic gains in public health in city slums of both countries. They have remained an integral part of health care in the U.K., Cuba and other countries with national health systems focused on preventive care.

In the United States, visiting nurses tend to be less common but can play an important role, especially in rural areas. While Eccles works in town, many visiting nurses in Maine travel long miles in snow, ice and other conditions to visit homebound patients who may be an hour or two away from their nearest medical center.

“We want to teach them to care for themselves better,” Eccles said, “so they don’t have to go to the hospital or emergency department.”

The Fixer
Teresa Miller, RN
Photo by Nancy Dionne

The rusted-out trailer in the driveway was the only hint that the modest, single-story home in Modesto might have health problems inside. Other than that, it had the same look as all the other houses on the block, said Teresa Miller, a Stanislaus County, California, public health nurse. The trailer was filled with the carcasses of old appliances. A stove and a stove hood sat on the side of the house. Once inside, it only got worse. The house looked like a home renovation gone wrong. Drywall was missing and electrical wires were exposed between wall studs. Further into the house, closer to the bedroom of the 19-year-old young man Miller had come about, there were fist- and elbow-sized holes punched into the doors.

But it was the 19-year-old’s bedroom that was ground zero for what Miller had come for. Miller had received a report from the local laboratory indicating that the young man’s lead levels were 50 percent higher than healthy. That’s a big problem. Lead poisoning can affect every system in the body, causing everything from fatigue and vomiting in children to memory loss, mood disorders, pain and miscarriage in adults. It’s also known to cause developmental delays in children. This particular youth was bipolar and had attention-deficit disorder. The lead poisoning wasn’t helping.

That’s where Miller, who stayed home to raise her own children for 20 years before becoming an RN, comes in. She’s charged with following up every case of lead poisoning in Stanislaus County until the patient’s health is back to normal.

What she found in the room was a surprise even to her. The floor was littered with more appliance pieces and exposed wiring. It turned out that her client’s hobby was working on electronics, often by soldering them with lead. When the environmental health officer who went with Miller to the house tested the bedroom for lead, it scored off the charts. And since its occupant was walking around the rest of the house after soldering, the lead was in the carpet, too. He was eating with lead-covered hands and wearing lead-covered clothes all day.

So Miller came up with a plan to reduce the young man’s lead levels: He must have a place set up outside to solder and he must do it there only; he must wear coveralls while soldering that he takes off before coming back in the house; and he should wash his hands before he eats or returns to the house. And, because his mother is recovering from heart surgery and her other son is autistic, Miller referred her to another agency that provides mental health day programs that can help the woman deal with her two children’s special needs.

“Now the challenge is going to be to follow up on monthly lead testing until his results are normal,” Miller said.
Not all of Miller’s cases are so dramatic, but they all start the same way. Every lab result in Stanislaus County that reports more than 10 micrograms of lead per deciliter of blood gets sent to her office, where she contacts families, helping them to pinpoint the cause of the poisoning. Often, the home itself is the problem. Lead paint in older homes or lead in pipes can make one sick. Sometimes, the contaminant comes from kitchen pots or even candies.

“I’m a nurse, so I’m a fixer,” Miller said. “If I can help people fix something, I’m a happy girl.”

Miller likes the freedom the job gives her: She spends her days visiting families, working with other county officials, attending health fairs and designing public-awareness campaigns on the dangers of lead poisoning. Once a family is identified, she works with the family and the doctor until the lead levels return to an acceptable range.

“What I like best and the challenge of this job are the same thing,” Miller said. “I like working with the families. I like the one-on-one individual interaction. Parents generally are very motivated to help their children—usually more motivated for their kids than they are for themselves. But it’s sometimes hard to convince a family that it’s really an issue. There are no symptoms for lead poisoning. You can’t see it until later, when the child is developing or having learning or behavior or attitude problems at school.”

Then there are the cases that make it all worth it, like that of a two-year-old girl who was diagnosed with lead poisoning from the pipes in her house. Miller said the mother took the problem seriously immediately and moved the family. She also followed Miller’s other suggestions to beef up her daughter’s calcium consumption (because the bones recognize lead as calcium and calcium absorption declines) and add cilantro to the girl’s diet. According to some studies, cilantro is a natural chelator of heavy metals and can accelerate the excretion of the toxic metal. The girl’s lead levels came down immediately.

“It’s gratifying when people make changes and learn something,” said Miller. “I want to be part of that solution.”

Heather Boerner is a freelance health writer in San Francisco.
CEO Saviors?

Consumer crusader Ralph Nader’s new work of fiction explores whether the rich can rescue the world.

Only the Super-Rich Can Save Us! By Ralph Nader; Seven Stories Press, New York

Reviewed by Carl Bloice

Longtime consumer activist and attorney Ralph Nader had a dream. A long one. In it the country is saved, its political logjam broken and its decline reversed. Economic and social justice reigns. But wait; does it really turn out that way? Nader has rendered this hopeful vision in the form of a narrative (not a novel, he says, but “a practical utopia”) and you will have to read the book to find out how it ends. The key thing here is the premise.

As the title suggests, a small group of people come together and decide to set out a new progressive legislative agenda. What they have in common and what, in this telling, makes the endeavor possible is that they are all very, very rich. They’re also capitalists that don’t make things for sale—“older” financiers, technical innovators, artists and entertainers. This is important because arrayed against them and determined to thwart their plans are “entrenched” big business people who own and profit from things like factories and giant retail chains.

The heroes have names we recognize, like Warren Buffett, Warren Beatty, Bill Gates Sr., (an attorney; junior makes things), Bill Joy (retired), George Soros, Ted Turner, Phil Donahue, Yoko Ono and Bill Cosby. Through the words and actions of such people, Nader sets out the major themes of his cause and lifetime work.

Healthcare reform and nurses turn out to be major players in all this. When the “Agenda for the Common Good” is rolled out, item one is a $10 minimum wage. Then comes: “comprehensive health insurance coverage for all citizens, taking off from Medicare but with many refinements in the areas of quality control, cost control and organized patient participation in the oversight of this nationwide payment program for the private delivery of healthcare.” It’s a single-payer system, with “no more corporate HMOs...no more tens of thousands of deaths and hundreds of thousands of undiagnosed injuries and illnesses every year.”

The Common Agenda plotters—and they do plot—are referred to by their real-life names, but other characters have pseudonyms...including “Ann Moro of the California Nurses Association.” She emerges as a spark plug both among the crusaders and within the previously “all but moribund and anything but organized” labor movement, helping to transform the unions into a powerful force and Labor Day from an excuse to eat barbeque into a relevant and meaningful observance.

The protagonists in this story are known as the Meliorists, a title drawn from the mid-19th-century Latin term melior (better), and embrace the view that society tends naturally to progress onward and upward and that conscious agents can spur the process along. They are an agreeable lot and highly appreciative of each other’s standing in society and contribution to their common effort. Their opponents, on the other hand, are a squabbling bunch with their prerogatives at risk and their greed challenged. In the face of the campaign for the Common Agenda, they can’t quite manage to keep a united front. Therein lies Nader’s tale.

The setting for the book seems to be the recent past. The effect of the 2008 Presidential election is unregistered and the Great Recession hasn’t happened. There are no tea parties and a new leadership hasn’t emerged in the labor unions. Ten percent of the labor force is not unemployed and millions of people are not losing their homes.

All of these recent developments make the Meliorists’ effort and the message of the book all the more intriguing. The content of the Common Agenda would make a lot of sense right now. Who’s going to make it happen? Could it be the super-rich? ❑

Carl Bloice is a freelance writer in San Francisco.
A Nevada nurse explains how organizing with the California Nurses Association/National Nurses Organizing Committee has changed her life

What the Union Has Done for Me

BY JACQUELYN BAUGHER

Dear Kevin,

My name is Jacque Baugher. I’m a nurse on 4N at Saint Mary’s. I met you recently, first in the basement at our last vote and then again at the meeting for 4N and med-surg nurses last Wednesday at the Washington Street office. I figure you’re mostly contacted regarding complaints or reports about negative actions from angry people and thought it would be nice to share with you something positive that the union and yourself have done for me and my family.

I was born the third of four daughters to two very poor and uneducated, hardworking people. My mother was 15 when she became pregnant with my oldest sister. Shortly after this she dropped out of the 10th grade. My father left school a few weeks into his ninth-grade year. At the age of 14 I left my parents’ house and tried out a few situations before settling in with a foster family who encouraged me to pursue an education and therefore invest in myself. When I graduated from Oregon Health & Science University with a degree in Nursing, I was the first person in my immediate family to have ever attempted to obtain a Bachelor’s Degree.

I got a good job in a town far from home and began a life that I quickly learned was much harder than anything I had ever faced. Conditions at Saint Mary’s were very difficult. As a new graduate, I was given a short two-month period of preceptorship before I was thrown to the wolves with eight patients of my own who relied on me to monitor their health status, educate them about their conditions, and guide them through their healing process, a responsibility I was sorely unprepared for. I remember thinking at the time that this could not possibly be what I had worked so hard for. Some nights I simply ran from room to room passing meds and answering call lights. In school I was taught that as a nurse I would be an educator and that above all else my job was to promote health, but with eight patients those ideals seemed more like delusions of grandeur.

Now, I’m not one to shy away from hard work. If anyone could handle this it was me, but after a year of putting out fires and constantly feeling as though my patients’ health and safety were at risk, I began to seriously consider my options as to where it was that I could truly contribute to the greater good. Shortly after this, talk of the union became louder and more constant on 4N. I began to see Assignment Despite Objection forms, and we—myself and my co-workers—began filling them out. Next we got a pay increase, which prompted me to begin saving in a 403-B account, something I had never had the option to do before. Our nurse-to-patient ratios decreased, and I now am responsible for, at maximum, six patients at a time per shift, and this is the biggest blessing of all.

I became empowered at our meeting last Wednesday when you told us that we could not be and should not allow ourselves to be harassed by management for staying late to fill out our paperwork and chart and that if we banded together we were much stronger than if we tried to stand alone. So my point, long and rambling as it has been, is that I’m going to stay at Saint Mary’s on 4N because that’s where I want to be: with surgical patients, elbows deep in staples and sutures, because that’s where I believe I contribute to the greater good. And because you have helped to create working conditions under which I can grow and flourish, this will be the first year that I have ever been able to afford to buy Christmas gifts for my family. There are five proud, strong women in my family, and as I write this only two of us are currently employed, and of those two, one has a husband with terminal brain cancer and thus has quite the financial burden. I will be the only person in my family giving gifts this year, but gifts will be given. And that is what the union has helped do for me.

Thank you.

Jacquelyn Baugher

EDITOR’S NOTE: Jacquelyn Baugher is a nurse at Saint Mary’s Regional Medical Center in Reno, Nevada, where nurses recently joined the California Nurses Association/National Nurses Organizing Committee and negotiated their first contract. She sent this letter to CNA/NNOC/NNU labor representative Kevin Baker late last year. National Nurse has reprinted it with her permission.
Move over, Florence Nightingale.

From fighting for safe staffing to healing disaster victims, today’s nurses are making a difference like never before.

Join National Nurses United as we descend on Washington, D.C. to tell the stories of the RN Heroes among us, demand a voice in healthcare and patient safety legislation, and build a powerful national nurses movement.

RN Heroes
May 10–12,
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- Inspiring speakers
- Incredible advocacy

- Legislative visits
- Rally at the Capitol

Watch for more details! www.NationalNursesUnited.org