Letter from the Council of Presidents

We hope you’ve been having a relaxing summer so far and have been able to squeeze some downtime into your schedule. But, as you are probably all too aware, a nurse’s work is never done, and the same goes for the RN members of National Nurses United.

This spring and summer, the nurses of southern Maine have been fighting the takeover of Eastern Maine Medical Center’s dialysis clinics by a giant for-profit corporation based in Colorado called DaVita. DaVita has a spotty track record, and if it succeeds in its bid to buy EMMC’s dialysis operations, that means patients with end-stage renal disease in a large chunk of Maine will have no other option but DaVita for their lifesaving treatments.

The 9,000 RNs NNU represents within the Veterans Affairs system are celebrating the settlement of a new master contract that will vastly improve their working conditions. It’s their first NNU contract, and the new agreement finally standardizes policies and procedures across the entire VA system so that VA nurses will all be treated equally and fairly. So congratulations to these nurses caring for our country’s veterans!

And since this is the summer of a general election year, July and August have been hot months for political activity that will really kick into high gear come fall. In California, nurses are supporting Proposition 30, which would increase taxes slightly on the state’s richest families to raise money for schools and other public services, and working to defeat Proposition 32, which would make it very hard for unions to participate in electoral politics. In Michigan, RNs are on a campaign to expose the platform of Rep. Dan Benishek, a physician who has said that he wants to privatize and end guaranteed Medicare benefits for seniors. Stay tuned in upcoming issues for more election-related news.

And, finally, every summer we publish our special book review section with an array of interesting and diverse titles to peruse. We’ve often felt that the best part about reading book reviews is you get to learn something without having to read the whole book. But if a book captures your imagination, you always have the option of seeking out and reading the whole thing. We hope you enjoy this year’s offerings.

Summer’s almost over, so rest up while you can. This fall will surely be a busy one, and we’ll need all our nurses ready for whatever comes our way.

Deborah Burger, RN | Karen Higgins, RN | Jean Ross, RN National Nurses United Council of Presidents
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Nowhere is our lack of a healthcare system more apparent than the gutting of our nation’s psychiatric services. By RoseAnn DeMoro

14 Booking It
Every year, we review a mix of books related to healthcare, nursing, and politics to help keep a busy RN up to speed on what’s being written. This year, topics range from the economy, to patient safety, to RN volunteerism.
For-profit Takeover of Dialysis in Maine

MAINE

Patients needing regular treatment in chronic dialysis are particularly vulnerable and their health truly at the mercy of these lifesaving treatments. Without dialysis, patients can die in a matter of weeks or even days. That’s one of the reasons Medicare covers end-stage renal disease for all people, regardless of age. And that’s also why it’s so disturbing that a Colorado-based, national, for-profit corporation named DaVita is poised to buy and take over Eastern Maine Medical Center’s dialysis services, making the company the only game in town for a large chunk of the state.

“They want to farm out dialysis, but it’s mind-boggling to me that we’re turning over the control of quality and safety to somebody from Denver, Colorado—a for-profit company,” said Kathy Day, a retired RN who used to work at EMMC and now volunteers as a patient safety advocate. She has been closely following the DaVita case. “We will lose local control over Maine citizens’ care.”

Eastern Maine Medical Center, a nonprofit hospital system based in Bangor, announced in April that DaVita, a Fortune 500 company and the country’s largest dialysis care corporation with more than 1,800 clinics, was paying $10 million for the rights to provide services to EMMC’s approximately 220 dialysis patients. It is reportedly not buying any of the land that EMMC’s current dialysis clinics sit on, nor the buildings, but simply the dialysis operations and, ostensibly, the Medicare and other revenues that come from billing for those treatments.

RNs and other critics fear that DaVita will cut corners to squeeze profit out of those accounts at the expense of the health and safety of those patients. They have been fighting the sale, most recently testifying at a July 10 certificate of need hearing before the state against DaVita’s takeover. “We have several serious concerns about this sale,” said Cokie Giles, RN and president of the Maine State Nurses Association. “We have heard about DaVita’s uneven record in providing quality patient care. Can we expect better? As a for profit, will DaVita put patients first and will the company keep a fair share of the revenues earned here in Maine?”

According to Day’s research and discussions with dialysis advocates across the country, former DaVita patients have charged that the company engages in numerous practices that save money but potentially jeopardize safety, including reusing supplies and equipment in dialysis machines that many agree should not be used again, and refusing to treat “troublemaker” patients who are vocal about demanding a high standard of care. Patients say there are also lesser, but still insidious ways that their dialysis company can make life hell for them if they complain, or make life easier if they are complacent, including controlling preferred appointment times and even seats for the treatment. Needless to say, staff at DaVita’s clinics are not unionized and there are no minimum RN-to-patient staffing ratios to ensure safety.

At the hearing, Day presented several stories she collected from patients across the country who have tangled with DaVita over what they charge is unfair treatment and retaliation by the company, usually after they spoke up about unsafe practices or errors by staff. The company in July just settled a whistle-blower complaint originating in Texas for $55 million, charging that DaVita overused and overbilled for an anemia medication.

Though taxpayers spend more than $20 billion a year on dialysis services, the United States has one of the industrialized world’s highest mortality rates for dialysis patients. DaVita dominates dialysis services in the United States, and the second largest is Fresenius Medical Care. Together, they control 80 percent of the dialysis market. Critics believe our poor outcomes and the fact that two for-profit dialysis companies have a virtual monopoly over this service are related.

Day, who herself suffers from parathyroid disease and a history of kidney stones, knows that she, too, one day could require dialysis. The thought of only one for-profit company controlling this lifesaving treatment for a vast swath of Maine fills her with dread. “Unforeseen illness, injury, or complications from medications could put any one of us in the same place,” said Day during her testimony before the state.

“Please try to remember this as our group of concerned citizens asks questions and makes comments about dialysis, patient safety, trust, healthcare outcomes, and the possible loss of local control in our dialysis treatment clinics. Patients are the priority, not profits or money.” —Staff report
Nonprofit Hospitals Reaping Far More in Tax Benefits Than They Sow in Providing Charity

**CALIFORNIA**

Look who’s the one receiving charity! A new report released in August by the research arm of the California Nurses Association/National Nurses United revealed that California’s nonprofit hospitals are cashing in on $1.8 billion more in tax exemptions in 2010 than they provide in care for indigent or low-income populations—a finding that calls into question whether the tax-exempt status of these hospital chains is deserved or just a scam. Another report by the state auditor issued the same month also highlighted the lack of requirements, standards, and methodology in calculating what community benefits hospitals are providing in exchange for not having to pay taxes. Other organizations have reported that some for-profit hospitals are actually providing more charity care than not-for-profit ones. Clearly, the state of California and local counties are losing millions in revenue from these entities that could help with their budget crises and preserve critical programs.

A special committee of the Senate, chaired by Sen. Ellen Corbett, convened on Aug. 15 to tackle this problem and to begin considering possible fixes. CNA urged the committee to propose legislation that would do not meet these standards from issuing tax-exempt bonds.

“We have hospitals in California who are nonprofit hospitals that are not stepping up to the plate,” said Corbett during a rally by RNs after the hearing. She said earlier at the hearing, “We need to make sure they are meeting their obligations to the larger community.” These tax benefits came in the form of

**The $1.8 Billion Windfall for California Non-Profit Hospitals**

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<th>Source: IHSP analysis</th>
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<td>Less Total Charity Care PROVIDED</td>
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EXCESS of Total Government Subsidies and Other Benefits Over Total Charity

$1,843,100,507

**PROFITS OVER CHARITY CARE**

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<td>Net Income</td>
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**THE TOP SIX**

- Cedars-Sinai Medical Center
- Stanford University Hospital
- California Pacific Medical Center
- Santa Barbara Cottage Hospital
- John Muir Medical Center
- Alta Bates–Summit Medical Center

**Source:** IHSP analysis

(continued on page 6)
hospitals provided 2.46 percent or less of their operating budget on charity care.

Since they provide so little charity care, and many of the nonprofit hospitals are virtually indistinguishable from for-profit ones in terms of the millions of dollars they pay their executives in compensation and in the billions of earnings they post each year, critics are charging that these organizations are abusing the goodwill that comes with their “nonprofit” status and label.

“If these hospitals are nonprofit, I have a third eye and a toe growing out of my forehead. That’s how outrageous these terms are,” said Carol Majesky, an interventional radiology RN at UC Davis Medical Center.

Studies by the state auditor and other organizations echo these findings. Grant Parks, principal auditor for the California State Auditor, testified during the hearing that, “for lack of a better phrase, it’s like the Wild West in terms of what is required” of nonprofit hospitals to justify their tax-exempt status. Board of Equalization member Betty Yee, who also testified, found that while researching this issue there was inconsistent reporting across hospitals and was concerned that there was “not a level playing field” with for-profit hospitals. Dr. Ellen Shaffer, codirector of the EQUAL Health Network of the Center for Policy Analysis, noted during her testimony that other states have the power to revoke tax-exempt status for not meeting certain levels of charity care. All who spoke at the hearing supported much tighter regulation of and reporting by nonprofit hospitals of the community benefit they are providing in exchange for the tremendous tax benefits they receive.

Cathy Dennis, an RN on the CNA/NNU board of directors and at nonprofit hospital chain Dignity Health, put the issue into larger perspective for the RNs at the rally.

“It’s not just about charity care, but about serving the needs of the community,” said Dennis. “It’s not about making money, it’s about taking care of our patients, and we have to always remember that.” —Staff report

To see more charts outlining the study’s key findings and to access a copy of the study, please visit http://www.nationalnursesunited.org/press/entry/new-report-california-non-profit-hospitals-save-billions-while-providing/

California RNs Urge Yes on 30, No on 32

This summer and fall, California Nurses Association RNs have identified two initiatives on the November ballot that are crucial to the future of the state, and are throwing their efforts behind passing one and defeating the other.

Nurses have endorsed Proposition 30, which would raise billions of dollars to prevent deep cuts for public schools and other services by slightly raising taxes on the state’s wealthiest and on the state sales tax, and are opposing Proposition 32, which would prevent unions and their members from having a strong voice in politics mainly by prohibiting payroll deductions for political activity.

“We know that our families cannot succeed unless our schools have teachers, unless colleges are affordable, unless healthcare is obtainable, unless libraries stay open, and unless neighborhoods stay safe,” said Deborah Burger, an RN copresident of CNA and National Nurses United, during a press conference nurses held to announce their support of Prop. 30. “This initiative puts the state’s priority back on what matters: our future, our families, our neighborhoods.”

Proposed by Gov. Jerry Brown, Proposition 30 would increase income taxes on households making more than $500,000 and individuals making more than $250,000, and raise the state sales tax by 0.25 percent. It is expected to raise $9 billion the first year, and about $6 billion every year after that. The measure expires after seven years.

“For those who have been blessed the most, it’s only right, and I think the way to go, to say give some back, temporarily, for the next seven years, until our economy finally gets back after the mortgage meltdown, where we lost so much revenue, 23 percent,” said Gov. Brown, who made an appearance at the nurses’ press conference. He noted that those who would be affected by the tax had increased their share of California’s total income from 9 to 22 percent.

“The people we’re asking to pay [for the tax] can well afford it.”

Frank Jernigan agrees. A retired San Francisco software engineer who made millions off his last position at Google, he strongly supports Prop. 30. “I’m now in the
1 percent because I benefited from a lot of the services that society had to offer,” said Jernigan, pointing out that he went to public schools, graduated from a state-funded college, and made his fortune off the Internet, which was originally government-funded infrastructure. “It’s only fair. For me, an extra 2 or 3 percent in taxes is not going to make a bit of difference in how I live day to day.”

Proposition 32 is the brainchild of conservative attorneys and business interests, and would mainly prohibit the collection of political funds from employees and union members through paycheck deductions, even if the person has already approved. The initiative is unfairly tailored to target only unions, because corporations don’t fund their political contributions through employees’ payroll deductions, but directly from their bank accounts. The Los Angeles Times recently described it as “a fraud to end all frauds.”

Various incarnations of Prop. 32 have been proposed and defeated before, most recently in 2005 as part of Gov. Arnold Schwarzenegger’s special election. Nurses plan to help take it down again. “Individual nurses can never hope to compete with billionaires, insurance companies, and hospital corporations,” said Malinda Markowitz, RN and copresident of CNA/NNU. “That’s why nurses need to be able to pool resources through their union to be able to have an effective voice on vital issues.” —Staff report

22 Changes in Other States That California Can Expect if Prop. 32 Passes

This list is based on proposed or passed laws in states that have adopted similar measures to Proposition 32. All of this won’t happen overnight, but a state dominated by corporations will inevitably move toward these types of measures. Vote no on 32.

1. Safe RN staffing ratios: Minimum standards for RN staffing are repeatedly rejected or weakened.
2. Minimum wage: City and state minimum wage laws have been eliminated or reduced.
3. Overtime pay: Workers’ ability to earn overtime pay has been restricted, removed, or eliminated.
4. Child labor laws: Laws that restrict children from working long hours at young ages have been revised, reduced, or eliminated.
5. Retirement pay: Unilaterally reduced for certain employees.
6. Wages and salaries: Unilaterally reduced.
7. Vacation pay: Have been revised or reduced.
8. Hours of work: Work hours become “take it or quit.” If an employer wants to schedule you for six hours a day, six days a week, they can demand that you do it or quit.
9. Workers’ compensation: Benefits if a worker is injured at work have been reduced.
10. OSHA: State agencies that investigate and fine companies for unsafe work conditions have been scaled back, fines for killing workers reduced, and orders to make working conditions safe reduced.
11. Sick leave: Rules and sick leave benefits have been revised and reduced.
12. Healthcare benefits: Have been lowered, copays increased, or benefits eliminated entirely.
13. Government industries: Government industries have been sold to private companies where middle-class jobs are replaced with minimum-wage jobs. The money saved goes to bloated salaries and benefits to the top owners of the private company.
14. Community colleges: Community colleges have been turned over to for-profit schools where students need to take out large loans to pay their tuitions.
15. Water and air quality: Protections have been reduced or eliminated.
16. Freeways: Freeways have been sold to private corporations for a steal and turned into toll roads.
17. Parking meters: Parking meters have been sold, also for a steal, to private companies who immediately raise rates.
18. Power plants: Public power plants have been sold for pennies on the dollar to private corporations.
19. Judicial system: Courts have become full of judges that consistently favor corporate interests over human ones.
20. Road maintenance: Jobs have been reduced or eliminated.
21. Park maintenance: Jobs have been reduced or eliminated.
22. Public parks: Have been sold to private corporations.
Massachusetts RNs Keep Key Mental Hospital Open

Massachusetts Nurses Association nurses are fighting the good fight for mental health in their state, and winning. Culminating a seven-month campaign led by RNs, the state Senate on July 12 voted unanimously to override Gov. Deval Patrick’s veto of funds necessary to keep Taunton State Hospital open. In addition, the Senate voted to override his veto of an independent study on the mental health needs of residents in the commonwealth.

The Senate action followed earlier unanimous override votes by the House of Representatives, and thereby ensured the survival of Taunton State Hospital. It will remain open with 45 beds, and the state can meanwhile—through the independent study—formulate a plan that addresses its growing mental health crisis.

“We were absolutely thrilled with the vote and what it could mean to the future of the mental health system in Massachusetts,” said Karen Coughlin, RN, vice president of the MNA and a nurse at Taunton for 28 years. “While there is much work to be done, the Legislature’s actions represent an important first step in an effort to restore the integrity of our tattered mental health safety net.”

Early this year, the Massachusetts Nurses Association and its nearly 1,600 members who are state employees were told that one of the commonwealth’s few remaining mental health hospitals would have its doors forcibly closed as part of Gov. Patrick’s 2013 budget proposal.

Taunton State Hospital is one of only six state-operated mental health facilities remaining in Massachusetts that cares for those suffering from acute and chronic mental illness. The MNA and its members knew that if the closure went forward, clients and their families would suffer. They would be forced to travel to other already overburdened hospitals, some as far as 100 miles away. In addition, eliminating an entire hospital’s worth of beds and services would have further decimated the state’s already fragile mental healthcare system.

“Mental health services in our state are inadequate and those seeking treatment are often unable to access needed care,” said Coughlin. “Our emergency departments are overcrowded with psychiatric patients who cannot access needed inpatient and community services. And our inpatient psychiatric units and beds are being eliminated.”

Faced with the news, MNA nurses immediately launched a massive campaign to save Taunton State Hospital and mental health care services in Massachusetts. It was a campaign that empowered members, patients, and families alike. The campaign’s first major public event in March was a clamorous rally, held at the statehouse’s Gardner Auditorium, where hundreds of supporters cried out that the Legislature needed to “stop and study” what effect the Taunton closure would have on patients and communities.

Meanwhile, advocates fanned out across the state as part of an enormous petition drive. They collected thousands of signatures from citizens who supported keeping Taunton open and who wanted the state to conduct a comprehensive study on the commonwealth’s mental health services before senselessly plowing ahead.

At the same time, the MNA put together a tightly knit crew of patients, family members, advocates, labor supporters, and members. These individuals walked the halls of the statehouse several times each week (for months on end!), taking advantage of every opportunity to have face-to-face discussions with members of both the House and Senate. Their goal was to get legislators to see and understand the real Taunton State—and to understand how devastating its closure would be to patients and the greater community.

All of these efforts, paired with a flood of postcard mailings, email messages, phone calls, and letters to those on Beacon Hill, set in motion a sea change, and led to the July victory. —David Schildmeier
Veterans Affairs nurses in July successfully finished negotiations on their first National Nurses United master contract, a three-year agreement that significantly improves working conditions for the RNs by providing stronger and more detailed language in its provisions, and finally bringing consistency to policies for 9,000 RNs at all 22 NNU-VA units.

“There are so many great articles and new RN rights,” said Irma Westmoreland, RN and chair of NNU-VA. “I am so proud of the work the team accomplished for our nurses.”

The RNs are expected to finish voting on the new contract by Oct. 5 and the Veterans Affairs secretary to sign off shortly after.

“The biggest achievement is a process for all the VAs nationally, for grievances, for vacation, for work schedules,” said Bonita Reid, a 27-year home care RN and director of the VA facility in Buffalo, NY who participated on the bargaining team. “We’ve raised the bar for everyone and leveled the playing field.”

Prior to this most recent agreement, the nurses’ working conditions were governed by a master contract that was last ratified in 2005 and also by many local contracts specific to each VA location. Because the old master contract unfortunately included many areas with vague, nonspecific language that left many issues to local discussion, and because many of the local contracts had not been re bargained since the 1970s or 1980s, nurses across all the VA facilities did not enjoy the same rights, rules, and procedures. Due to the quirks of federal law governing VA RNs, nurses do not bargain over wages, benefits, and “patient care” issues, but mainly focus on working conditions. VA nurses have found creative ways, however, to work around these types of bargaining restrictions.

To negotiate this contract, said Jeanell Foree, an RN who works as a safe patient handling facilitator and is director at the VA facility in Tuscaloosa, Ala., the team examined every article of the master contract and every local contract, pulling out the best parts and the best language to incorporate into the current agreement. “Everything that’s in this contract is really a gain for our nurses,” said Foree. “We made it as overarching as much as we could to be consistent throughout the VA.”

Some of the highlights of this contract include an entire article on the rights of RNs; a system for determining seniority that only includes VA service as an RN at that facility; a standardized process for scheduling annual leave and holidays that gives a lot of control to the RNs to work out amongst themselves; strengthened language against mandatory overtime; better procedures and rules for making work schedules so that RNs can better plan their lives in advance and have safeguards against unsafe assignments; and an extensive article on safety covering topics such as workplace violence, ergonomics, and safe patient handling.

Negotiations lasted just about one year, a major accomplishment when compared with other VA unions that took as many as 10 years to agree to a contract. “I know that we secured the best possible contract that we could,” said Ruby-Rose Hutchinson, RN, NP and director of the VA facility in Miami where she works in adult health. “We were able to substantiate our issue and proposals with data, with evidence.”

Foree agreed. “I think it helped that we made clear that we were there for business,” said Foree. “We’re not here to dillydally around. We want to go back and take care of our veterans.”

—Staff report

Raising the Bar for All VA RNs with New Master Contract

NNU National Officers for the 2012-2015 Term

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Karen Higgins
Jean Ross

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Cokie Giles
DeAnn McEwen
Kathleen Dennis
Malinda Markowitz
Margie Keenan
Michael Jackson
Trande Phillips
Zenei Triunfo-Cortez

The terms of office of the NNU National Officers for the 2012-2015 term will begin immediately upon conclusion of the NNU Convention in December. All officers are registered nurses.
Michigan nurses residing in Michigan’s Upper Peninsula are rising up in protest of Congressman Dan Benishek’s vote to end guaranteed Medicare benefits for seniors while protecting his own healthcare and giving more tax breaks to millionaires. MNA nurses have seen the benefits of Medicare for their patients and are fighting not only to keep Medicare but to expand it to everyone.

With that goal in mind, the nurses on July 28 shared their concerns on a mobile billboard and handed out hundreds of fans to attendees of the annual Art on the Rocks event in Marquette to call attention to the need for Medicare. The fans featured a tombstone with “R.I.P. Medicare, 1965-2012” on it and included a picture of Benishek.

“I see every day that people in our communities are hurting, said Carolyn Hietamaki, RN, a nurse at Marquette General Hospital. “They have to choose between prescriptions and food already, and they can’t afford to pay more for healthcare. That suffering would get worse if seniors lose Medicare.”

“As a nurse and a constituent, I have to speak out against those who would destroy Medicare, which would make seniors pay more for healthcare that can mean the difference between life and death,” said Barb Davis, RN, who lives in Kingsford and has worked in the emergency room at Dickinson County Healthcare System for 13 years. “If seniors lose their Medicare, we’ll see even more patients who wait until they get so sick that they have to go to the emergency room or be admitted because they couldn’t afford their medications or doctor visits. Medicare should not only continue, it should be expanded to cover everyone.”

The mobile billboard drew plenty of attention from concerned Michiganders as it left Lansing and traveled eight hours to Marquette. Many citizens came up to the driver and voiced their concern regarding the future of Medicare when the billboard arrived in Marquette, nurses spoke to the media and worried citizens, citing their protection for Medicare and to expand it for all.

“Every day at the hospital I see patients who are struggling to pay for their medications and just praying they won’t get sick again,” said Charlotte Folkersma, RN, who lives in Sault Ste. Marie and works at Chippewa County War Memorial Hospital. “People know they can count on Medicare and they want it to stay that way. Medicare is a lifesaver for tens of thousands of people all across the Upper Peninsula and Northern Michigan. This is a program that cannot disappear and must be opened to include all people in need of coverage.”

MNA nurses are continuing the fight for Medicare for all by calling upon Benishek, who is a physician, to hold a town hall meeting to discuss the future of Medicare. “It’s time Benishek quits voting to protect millionaires instead of Medicare,” said John Karebian, MNA executive director. “Nurses understand better than anyone how much Medicare is needed today and in the future. We will continue to be vigilant in making our voices heard until all Michigan and national politicians have agreed to expand Medicare for all.” —Ann Kettering Sincox
Longtime nurse activist Lil Ortendahl, RN received the Hubert Humphrey Award for her tireless volunteer work in politics at a recent gathering of the state’s Democratic-Farmer-Labor (DFL) party. The event featured a high-powered roster of speakers, including former President Bill Clinton. In introductory remarks, Buck Humphrey, grandson of the late Hubert Humphrey, noted that Ortendahl “epitomizes the greatness of the DFL.” The 77-year-old Ortendahl schooled the room of more than 2,500 guests about dedicating their efforts to electing officials we can hold accountable to values we all hold dear. She got the biggest ovation of the night with her self-assessment: “Some drink, some screw around. I do politics.” —Jan Rabbers

Minnesota RNs Fight Weakening of State Nurse Practice Act

MINNESOTA

Minnesota nurses Association members shaped the state’s Nurse Practice Act in 1905 to protect the safety of patients and advance the health of their communities. Generations of nurses later, MNA members now find themselves fighting to defend the integrity of the statute that embodies Minnesota’s standards for nursing. The siege is being led by none other than the very body entrusted to safeguard those standards.

Minnesota’s Board of Nursing (BON) is seeking to significantly change the Nurse Practice Act to alter the scope-of-practice language—and it is not a friendly change. The proposals reflect a corporate healthcare employer’s dream to muddy the lines of responsibility between RNs and LPNs—allowing healthcare facilities to get more work for less money. It also pits the two practices in a fabricated fight that will only result in a risk to public safety.

Most onerous in the proposed language is a plan to include “assessment” and “delegation” into the description of an LPN’s duties. Knowing day-to-day realities, and the profit-minded mentality of hospital administrations, MNA members predict wholesale changes in hospitals and other care facilities that would burden lesser-prepared (and less-er-paid) personnel with tasks beyond their training. Given the overwhelming amount of evidence that correlates RN care with better patient outcomes, MNA has argued vehemently that this is a patient safety issue.

BON operatives initially attempted to implement their scheme in 2008 by slipping changes in under the radar, labeling them “rules interpretations.” MNA staff, who monitor BON activity, alerted members and consulted with Attorney General Lori Swanson. Under pressure, the BON agreed to engage in a process to seek public input on the proposals.

Earlier this year, the BON announced a series of “listening sessions” to be held across the state. It also offered a comment section on its website. When nurses reported back to MNA staff that the sessions were being conducted in a one-sided manner, MNA pushed back again and issued a strongly worded complaint to the BON.

“Despite being a public comment process, only certain questions are posed to be answered by those wishing to weigh in. We believe that these questions are very leading, geared towards specific answers being sought by the Board,” stated MNA President Linda Hamilton, RN, in her written complaint. Hamilton further advised that “listening to the concerns of direct-care nurses who feel this expansion may encourage the model of ‘cost over quality and safety’ in healthcare will strengthen the objective collection and analysis of these data.”

The public comment period ended on Aug. 3, but MNA members and staff are continuing to monitor the actions of the BON and its committees. The BON has announced it hopes to form a recommendation for legislative consideration in time for the 2013 session. MNA is determined to influence any outcome to keep patients safe in Minnesota. —Jan Rabbers

MNA RN Lil Ortendahl Honored

MINNESOTA

Longtime nurse activist Lil Ortendahl, RN received the Hubert Humphrey Award for her tireless volunteer work in politics at a recent gathering of the state’s Democratic-Farmer-Labor (DFL) party. The event featured a high-powered roster of speakers, including former President Bill Clinton. In introductory remarks, Buck Humphrey, grandson of the late Hubert Humphrey, noted that Ortendahl “epitomizes the greatness of the DFL.” The 77-year-old Ortendahl schooled the room of more than 2,500 guests about dedicating their efforts to electing officials we can hold accountable to values we all hold dear. She got the biggest ovation of the night with her self-assessment: “Some drink, some screw around. I do politics.” —Jan Rabbers
California

HAYWARD

Underscoring Kaiser Permanente’s “lemon” of an idea to shutter the pediatrics unit at its hospital in Hayward, RNs and children set up a stand and sold lemonade on Aug. 22 to raise money to keep the unit open. Eliminating the unit would mean that parents would be forced to drive up to 30 miles north or south for inpatient pediatric care, a major burden for families with a sick child and especially for those without their own car. “It would create an unnecessary hardship on working families to have to drive to Oakland, Santa Clara, or Roseville for care, especially for parents who have children with chronic medical problems that require frequent pediatric services,” said Winny Knowles, an RN who works in the pediatrics unit. “Kaiser members with children deserve access to critical care in their own community in order to thrive.”

CHICO

About 700 registered nurses at Enloe Medical Center in August approved a new contract with the Chico hospital that they say will strengthen patient care standards, increase access to their retirement plans, and improve compensation that will help with retention and recruitment of RNs. “Through the unity of our members, we’ve been able to beat back takeaways that management proposed and end up with some substantial improvements for nurses and for patient care,” said Enloe RN David Welch.

One significant gain was that the hospital agreed nurses will be able to take meal and rest breaks during a shift with the relief being agreed nurses will be able to take meal and rest breaks during a shift with the relief being

U.S. Veterans

improvements. And

VETERANS AFFAIRS

IN ADDITION to settling their first NNU-VA master contract, Veterans Affairs nurses have continued to rack up big and small victories at their local facilities. At the VA facility in Buffalo, N.Y., Director Bonita Reid, RN, creatively cited the Caregivers and Veterans Omnibus Health Services Act of 2010 as part of a mandatory increase in the usage of involuntary overtime, directors have succeeded in getting increases staffing through the hires of 10 RNs—all this despite the fact that VA RNs cannot technically directly negotiate staffing issues. According to recent reports, the usage of involuntary overtime has dropped dramatically. Director Barbara Devers, RN of the Lexington, Ky. VA facility filed a similar grievance using the same strategy, and succeeded in stopping mandatory overtime there entirely.

Washington, D.C.

HUNDREDS of National Nurses United RNs rallied July 24 in Washington, D.C. at the “We Can End AIDS” march, calling for a Robin Hood Tax on Wall Street financial transactions to help raise funding for more HIV and AIDS treatment. The RNs marched with Health GAP, VOCAL-NY, ACT UP, and National People’s Action to demand that the financial sector pay its fair share toward the public health programs the country needs to keep its communities healthy. “Our patients without adequate healthcare, especially people with HIV/AIDS, our unemployed neighbors, our friends forced from their homes by foreclosures, our underfunded public health programs the country needs to be spent on healthcare, schools, job creation, and other social services. France in early August just adopted a 0.2 percent financial transaction tax, and NNU nurses are part of an effort to pass a similar tax in the United States.”-Staff report
Mental Breakdown
Our mental healthcare system has collapsed in favor of pursuing profits.

If there’s one symbol of the breakdown of our healthcare system, it might well be the growing disappearance of mental health services—with severe and sometimes tragic consequences for patients, nurses, and our communities.

With corporate hospitals shredding patient services deemed less profitable and underfunded state and county hospitals making cuts to survive, psychiatric care is often first on the chopping block.

Increasingly, if those patients get into the hospital at all now, they end up in the emergency room or other units that are unprepared to provide the specialty care they need.

Just ask a nurse—like Jane Sandoval, an ER RN at Sutter Health’s St. Luke’s Hospital in San Francisco, which long ago eliminated psychiatric services.

“The driving factors are that mental health is not a moneymaker for the giant healthcare corporations and the perception of mental illness as a stigma.” Without specialized care in the low-income neighborhoods around her hospital, says Sandoval, “the patient would languish in a hospital emergency room hallway until placement could be established or their psychiatric hold was exhausted. This meant they were released from their holds, if appropriate, and out to the public, only to meander to another ED.”

“Some psychiatric patients are gravely ill. Others simply do not have the mechanism or wherewithal to access services. Psychiatric patients need psychiatric care. An emergency department is hardly a therapeutic milieu. What they receive is a gurney, sometimes in the department corridor for up to 72 hours, and security personnel to watch over them, not a trained psychiatric clinician.”

“Nurses in the department, with patient loads up to four patients at a time in the ED, may not always be able to give optimal psychiatric care. With several psychiatric patients in the emergency department, there is a potential for escalation of their behaviors. This jeopardizes the safety of staff and nurses and visitors in the department.”

The result: rising incidents of violence against nurses, other hospital employees, and other patients, with far too many hospitals lax in providing appropriate safety protocols for staff and patients alike.

With private hospitals increasingly abandoning mental healthcare, the onus again falls on public safety net institutions, where the crisis is growing daily.

Here’s how it looks to Stu Berger, RN at a public facility in San Mateo, Calif.

“In recent years, many of the county mental health clinics have seen increasing numbers of people entering our system. There are many reasons for this, partly because of the emphasis on destigmatizing mental health issues and, more recently, loss of employment (along with health benefits) stemming from the economic downturn. There also seem to be more people who are homeless, but the resources in the community, including homeless shelters, remain inadequate. We have the knowledge and skill to effectively treat our clients, but with the administrative emphasis seeming to be on numbers versus resources, our hands remain largely tied in helping to keep clients in the community, off of the streets, out of jail, or out of the hospital.”

This cycle begins with the mentality of those corporate hospital systems that act more like Wall Street hedge funds than like institutions whose mission should be therapeutic healing.

A just-released report from our research arm, the Institute for Health and Socio-Economic Policy, on California private nonprofit hospitals report found that many, especially the biggest chains like Sutter and Kaiser Permanente, are cutting services, with mental health on the top of the list, while piling up huge excesses in tax benefits and profits over what they provide in charity care.

Three of the six most egregious hospitals in accumulation of tax benefits over provision of charity care—Sutter’s California Pacific Medical Center in San Francisco (of which St. Luke’s is a part), Sutter’s Alta Bates campus in Berkeley, and Cedars-Sinai in Los Angeles—have been especially aggressive in cutting back on mental health.

Between 2004 and 2008, CPMC eliminated 45 percent of its psychiatric beds. Alta Bates’ ancillary Herrick Hospital, which specializes in psych services, which had 34 adolescent psych beds until 2007, now rarely cares for more than eight patients, and beds for dual diagnosis patients have been cut in half.

Cedars-Sinai, whose behavior regularly contrasts with its inflated hospital-for-the-stars image, announced last December plans to cut its entire inpatient and psychiatry programs, leaving its patients out in the cold. “The patients who need psychiatric services are stacking up at the door and having a hard time getting in. It’s getting tough out there,” Randall Hagar, director of government affairs for the California Psychiatric Association, recently told the Los Angeles Times.

In California, state hospitals have seen a 16 percent drop in patients the past five years as a result of cuts.

Nationally, the number of state hospital psychiatric beds dropped by 14 percent between 2005 and 2010, the Los Angeles Times reported in July, with many severely mentally ill patients ending up in emergency rooms, jails, and prisons.

In Massachusetts, between 2008 and 2011, the state cut more than 25 percent of public-sector psychiatric beds, decreasing (Continued on page 23)
We know, we know. All of us have the best of intentions about reading more books. As you read this, you’re probably feeling guilty about the backlog of 10 books downloaded onto your Kindle or iPad that you’ve been “meaning to get to.” But it’s hard to find the time. Well, stop feeling bad. Our annual book review special is here. The beauty of book reviews is that you can almost feel like you have read the book, without really reading the book. This year, we cover everything from why, contrary to popular belief, VA healthcare outperforms every other system in the United States, to the latest essays exploring patient safety initiatives, to the policy goal of full employment for all Americans which, as nurses know, is one of the most powerful social determinants of health. And a couple of titles stand out; one is a historical fiction written by a Massachusetts RN that tells the story of Edith Cavell, a World War I-era British nurse who was executed by the Germans for helping wounded Allied soldiers, and the other is a practical guide for registered nurses seeking to volunteer their skills and experience. Hopefully, you’ll be intrigued enough by some of these reviews to pick up one of these titles and read further. Who knows? Maybe you’ll even finish it.
Back to Full Employment

By Robert Pollin; Boston Review, 2012

OPEN ALMOST ANY NEWSPAPER, click on almost any news website and the sobering data comes pouring out. An exploding chasm in income inequality, 40-year stagnation in compensation for U.S. workers, a shocking surge in the number of children living in poverty, record numbers of Americans going bankrupt because of medical bills or just skipping needed care because of the unfathomable out-of-pocket costs.

It's the rare economist who can stare at these dry statistics and find a moral dimension, much less propose commonsense humane solutions in easy-to-read text. But Robert Pollin, professor of economics and co-director of the Political Economy Research Institute at the University of Massachusetts, Amherst is no ordinary economist.

Pollin is that rare policy wonk who combines stellar analysis with activism for social change. He's animated by the same ethical imperative that has inspired so many nurses who, heartsick over patients with suffering caused by economic pain, have taken to the streets and demanded real reform.

So too is Pollin unwilling ethically to accept the status quo or political norms of high unemployment, with his analysis and prescription for action on full display in a concise new volume titled Back to Full Employment.

“Without full employment,” he writes, “the fundamental notion of equal rights for everyone...faces insurmountable obstacles.” Without jobs, the unemployed “are not able to participate on a solid footing in the life of their community.”

Further, “a high employment economy is the single best tool for fighting poverty” as well as directly confronting the shocking rise in income inequality in the U.S. the past 30 years.

With those themes as the scaffolding of his short, 161-page book, Pollin completes his work with ample supporting materials.

While labor productivity has risen 111 percent since the early 1970s, total compensation in wages and health and other benefits has stagnated. If workers are not receiving the fruits of this increased productivity, the benefits must be “flowing elsewhere”—specifically upwards, Pollin notes.

Thus, the huge leap in disparity of wealth and income and attendant jump in poverty in the United States.

The current economic collapse, caused by the banks and other financial institutions’ gambling with people's homes and retirement savings, Pollin emphasizes, has long roots that go back well beyond the 2008 crash.

Pollin defines the source as “neo-liberal” policies—an economic agenda that emphasizes, in particular, privatization of public programs and deregulation of markets, such as the finance sector deregulation that spurred the 2008 meltdown or, for that matter, that have created so much inequity, price gouging, and declining access in the healthcare industry.

Wall Street has been a principle beneficiary, says Pollin, noting throughout history, “unregulated financial markets have persistently produced instability and crises.”

Even today, after running the U.S. and global economy off a cliff, commercial banks sit on “an unprecedented $1.6 trillion in cash reserves.” And the jury remains out on whether the Dodd-Frank Wall Street reform can control “the hyper-speculative practices that produced the near-total global financial collapse of 2008-2009” and the mass unemployment that followed.

The solution to the present economic morass, Pollin says, is not blaming immigrants, whose work increases consumer demand and whose spending boosts the economy, harsh austerity measures that accelerate economic suffering for the 99 percent, or the obsession of too many politicians with deficit reduction.

Rather than paring government down to extinction, we need more government intervention, says Pollin. Government programs in the United States have produced, among other things, outstanding public universities and a Social Security system that has succeeded in reducing poverty among the aged and the disabled.

Coming out of the present recession requires a “serious alternative to what increasingly appears the prevailing approach, which is to patch up and restart the failed neo-liberal model.” That means a genuine “new, workable full employment policy framework,” and not just any, low-wage jobs.

Full employment, says Pollin, means jobs at living wages that enable workers the ability to support their families and participate fully in the civic life of the nation, safe and healthy workplaces, and strong unions.

How do we redress the present economic crisis as well as the four-decade decline prompted by “the dominance of neo-liberal policies?” By “building a sustainable full employment economy,” says Pollin, outlining several key steps. They include:

1. Dramatic investment in clean energy and education. Spending in education creates more than five times, and clean energy over four times, as many jobs as does the equivalent spending on fossil fuels. A substantial shift in spending in this direction alone could cut the jobless rate by a third, Pollin argues.
2. Industrial policies that develop and strengthen clean energy transformation and revive our manufacturing sector.
3. Tougher financial regulation of Wall Street.
4. Controlling skyrocketing healthcare costs—to which Pollin notes the huge contrast with other highly developed nations that have national healthcare systems that deliver universal coverage and generally more healthy populations.
5. Taxing Wall Street. Pollin praises the Robin Hood movement for a tax on financial speculation, noting in particular the broad organizing efforts of NNU.

Achieving these ends means not relying on markets or governments, Pollin concludes—but instead “an engaged citizenry,” (what
Best Care Anywhere: Why VA Health Care is Better Than Yours

By Phillip Longman; PoliPointPress, 2010

In this important book, which was first published in 2007 and updated for 2010, journalist Phillip Longman not only shatters the myth that government cannot be trusted to be the administrator of healthcare services, but that government cannot be trusted to be the provider of top-notch healthcare. Longman’s primary exhibit: the Department of Veterans Affairs healthcare system, better known as “the VA.” By almost every measure, including quality, safety, effectiveness, cost, and patient satisfaction, the VA healthcare system consistently outperforms American private-sector healthcare and also Medicare. It works so well that other countries looking to establish their own systems have come to the United States to study the VA.

Are you surprised? Because Longman was. He originally set out to write an article for Fortune magazine spotlighting which CEOs had the best solutions to today’s healthcare crisis. He said that his “assumptions going in were typical of those held by many Americans, particularly those with conservative, pro-market views and instinctive distrust of government.” As he diligently did his research and interviewed experts, however, about who was delivering the best healthcare in America, he “kept hearing an answer [he] could not believe.” Everyone kept pointing him to the VA, and they backed up their statements with many, many peer-reviewed studies published in prestigious journals. Longman found “the hardcore data were overwhelming,” and was shocked that so little discussion of the merits of the VA system factored into current healthcare debates. He is attempting to correct that problem with this book by explaining how and why the VA has been able to achieve these kinds of results while the rest of the healthcare industry flails.

But first, Longman provides a little background and history into the VA system. Though states and communities have been taking care of veterans as long as they have been fighting wars, it wasn’t until World War I that Congress established a national system of benefits for veterans, including healthcare. Unfortunately, as Longman describes, the VA over its history has been plagued by a series of mismanagement scandals and subject to the whims of Congress and the public’s attitude toward veterans (positive after WWI, more negative after the Vietnam War). Over time, administrators just added layer upon layer of government bureaucracy to the system, which caused the VA to stagnate and “ossify.” The only things that saved it during the 20th century from being dismantled were a smart decision after World War II to partner with the country’s medical schools for training, and politicians’ fear of being labeled “unpatriotic” if they voted against the system.

Still, Longman explains, the VA healthcare system has a few major advantages going for it. Foremost, the VA as an institution has a near-lifetime relationship with its patients. This allows it to not only collect and use decades of data and hold a vested interest in preventative health measures to ensure long-term health but, most importantly, to reap the rewards of any efforts they put into making the system more effective, more efficient, more accountable, and more affordable. As Longman points out, in the private-sector healthcare world, patients change insurers all the time, using different hospitals, doctors, and clinics. There is little to no business incentive in the for-profit, private-sector healthcare industry to invest in promoting health beyond making sure that customers pay their premiums but don’t use their insurance. To that end, it’s easier to just deny them coverage than to make everyone healthier. And while we’re on the subject of financial motives, unlike the vast majority of the healthcare industry, the VA system does not exist to make money. It exists to care for its veteran patients, and that also helps to attract the kind of idealistic and committed staff and administrators needed to run this kind of system.

In Longman’s view, arguably the best thing the VA ever did was to adopt an electronic health records system, called VistA, early on in the 1970s and 1980s. Unlike the counterintuitive, commercially developed systems many RNs and doctors struggle to use today, VistA was created from the bottom up by a loose grouping of providers scattered across the country. Known as the “Hard Hats,” they labored in secret against the massive VA bureaucracy to write primitive, open-source software that would do things like gather all of a patient’s data into one complete chart, allow for online psychodiagnosis tests, or run a patient discharge system. In 1981, more forward-thinking VA officials decided to embrace these initiatives, grouping them into what would be known as VistA, and also gave the Hard Hats the green light to continue their innovation. Since then, VistA has evolved into the most sophisticated, inexpensive, and expansive electronic medical records system in the country, unrivaled by any private software company. According to Longman, VistA allows the VA to not only maintain higher safety standards, but to also boost quality standards by providing researchers a vast quantity of data with which to determine what medical interventions work, and which ones don’t. And because it runs off of open-source software, anyone can make inexpensive improvements or alterations to the system to optimize it further. Unfortunately, recent shifts toward privatization are forcing the VA to buy more commercially developed health IT software, even as public health systems in Finland, Germany, Mexico, Nigeria, India, Uganda adopt the VistA system.

After taking the reader through how and why the VA system is superior to any healthcare the private sector is providing, Longman argues, very persuasively, that the VA needs to be opened up to all veterans, their families, and eventually any member of the American public that wishes to participate. Since World War II, the VA has suffered from excess capacity, particularly in areas far from the Southwest where its aging patient population has migrated. Instead of laying people off and shutting down facilities, we should use the benefits for veterans, including healthcare. Unfortunately, as Longman describes, the VA over its history has been plagued by a series of mismanagement scandals and subject to the whims of Congress and the public’s attitude toward veterans (positive after WWI, more negative after the Vietnam War). Over time, administrators just added layer upon layer of government bureaucracy to the system, which caused the VA to stagnate and “ossify.” The only things that saved it during the 20th century from being dismantled were a smart decision after World War II to partner with the country’s medical schools for training, and politicians’ fear of being labeled “unpatriotic” if they voted against the system.

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existing infrastructure that works so well to provide healthcare to Americans so desperately in need of proper care. Longman’s proposal is both refreshing and exciting, a no-brainer answer to the current healthcare crisis that had been sorely missing in all the debates leading up to and following the Affordable Care Act, or Obamacare. “Framed correctly, this proposal for government provision of healthcare, as opposed to government provision of mere health insurance, should not seem out of step with American tradition,” argues Longman, pointing to government operation of fire departments, police departments, public schools, and the highway system as examples. “None of this is considered socialism. How is government-provided health care fundamentally different?” It’s hard to refute his logic.

Even working at a nurses union, which represents a number of VA nurses, I was surprised by much of what I learned about the VA in Best Care Anywhere. This easy-to-read book is well worth your time if you care about deepening your understanding of what is wrong with the American healthcare system and what we can adopt from the VA system to fix it. —Lucia Hwang

**Fatal Decision: Edith Cavell WWI Nurse**

**By Terri Arthur; Beagle Books Publishing, 2011**

In this impressive historical novel, Massachusetts RN Terri Arthur dramatizes the true story of Edith Cavell, a British nurse who, during World War I, defied the German occupiers of Brussels to treat and aid wounded British, French, and Belgian soldiers—an act of nursing and of humanity for which she would later be executed by the Germans. Her death prompted a renewed wave of enlistment in Britain and, by many accounts, was also highly influential in pulling the United States into World War I. Some argue that, if not for the worldwide public outrage over her death, World War I might have turned out differently. Today, a statue of Edith Cavell stands in Trafalgar Square, but many people and nurses outside of England are not familiar with her story. Arthur's thrilling, suspenseful, and very readable book about Cavell fixes that.

Before Cavell even gets involved in helping Allied soldiers, however, she was already an important figure in the development of modern nursing. Herself trained at the Royal London Hospital in the late 1890s, Cavell soon began teaching and was recruited by a prominent surgeon to Brussels in 1901 to found the country’s first school of nursing. In Belgium at that time, nursing was still not considered to be a respectable profession. Catholic nurses without medical education or training performed nursing duties, often with very poor patient outcomes. This all changed when Cavell, the surgeon Antoine DePage and his wife, and a group of forward-thinking benefactors started the rigorous “Clinique” nursing school. Over the next decade, Cavell would help transform standards of nursing and medical care in Belgium.

In August of 1914, World War I broke out in Europe. Though Cavell could have returned to England, she was unwilling to abandon the school, her life’s work, and stayed in Brussels. Later that month, German troops, advancing toward France, marched in and occupied Brussels. Among various edicts, they prohibited anyone from aiding “enemy” soldiers.

But Cavell, as a nurse, placed her duty to patients, any patient of any nationality, above all else. She willingly gave the best care possible to German soldiers as well as Allied soldiers. So when two wounded British soldiers soon showed up at her doorstep, she agreed to treat and hide them at her school until they were well enough for a growing underground network of Belgian resistance workers to move them out of the country. In this way, Cavell joined the underground and helped more than a thousand Allied soldiers until the Germans finally arrested her about nine months later.

Cavell was quickly imprisoned, court-martialed without real representation, sentenced to death by firing squad, and executed on Oct. 12, 1915 despite appeals for clemency by American and Spanish ambassadors. After the war, her remains were returned to and buried near her hometown in England, and she received a state funeral at Westminster Abbey.

Arthur does a remarkable job of making Cavell and her world come alive. She says that, for the most part, all of the events that took place actually happened, and she spent two years researching for the book, including two trips to Belgium and four to the United Kingdom. Arthur spent four years writing the book while working evening shifts on a coronary step-down unit. All her hard work paid off. Her characters’ dialogue rings true (even in English, French, and German), she seamlessly weaves in the history and culture from that time, and her writing is fluid and enjoyable to read. My only quibbles are that the book could have been edited more tightly and used a stronger, cleaner cover design, and that her publisher could have hired a better proofreader to eliminate the typographical errors that pepper the book. But these are minor criticisms. Terri Arthur has done an amazing job and anyone, registered nurse or not, will not fail to be moved by Cavell's story. —Lucia Hwang

**First, Do Less Harm: Confronting the Inconvenient Problems of Patient Safety**

**Edited by Ross Koppel and Suzanne Gordon; Cornell University Press, 2012**

Most casual readers with an interest in healthcare policy will probably not consider the title of Koppel and Gordon’s book, First Do Less Harm: Confronting the Inconvenient Problems of Patient Safety, particularly provocative. It’s a confounding head-scratcher, to be sure.

It would be easy to overlook this volume while browsing the shelves in search of a good read on the factors associated with increased morbidity and mortality of hospitalized patients. Its cover does not do a good job of hinting at the important issues inside. But if readers press on, they will be confronted by essays contrasting the market gospel of blind faith in healthcare information technology and the realities of its use.

For direct-care RNs caught in the crossfire between the competing and conflicting interests encroaching on the profession of nursing, the subject matter will surely provoke a visceral reaction. Read it and weep, but don’t say I didn’t warn you. After all, it was Florence Nightingale who said, “It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do no harm.” Trust me, I’m a nurse.

Patient safety is an imperative, not an inconvenience. There are harmful barriers to achieving it, but working to identify and remove the barriers to safe, therapeutic, and effective patient care does not do a good job of hinting at the important issues inside. But if readers press on, they will be confronted by essays contrasting the market gospel of blind faith in healthcare information technology and the realities of its use.

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Unlike most books about medical tourism which do not critique why there should be a need for Americans to travel to foreign lands for important, needed medical care, Katz discusses at length how her health insurance coverage is so terrible that she is essentially forced to go abroad for her surgery as a last resort. As a non-wealthy person in the real world, Katz has had enough personal experiences and watched enough friends suffer to understand that the healthcare system in the United States is all about making a profit, not necessarily healing patients or keeping them healthy. As a result, she refuses to refer to her health insurer as the “insurance company,” but only as her “Withholding Company.”

“Hey, there's nothing wrong with making money...My issue is with the immorality of a for-profit system that squeezes the life out of people in need. There must be a more decent way to make a billion...How do these guys sleep at night?” writes Katz. She doesn’t explicitly say that the United States should pass a single-payer system like Medicare, but she implies that a national health insurance system would be preferable to the “hell” that people like her currently endure when seeking medical care.

After carefully studying her policy and thoroughly researching the costs, Katz concludes that she and her husband would need to pay at least $90,000 out of pocket to get her hips replaced and that the only workable solution would be to get the surgeries in India. So she does, through a company that arranges all the details of these sorts of trips. The rest of the book is all about her (successful) surgery experience in India and her slow recovery to full mobility back in the United States.

As can be expected from a memoir, Katz’s personal observations can come across at times as incredibly naïve. For example, Katz describes Indian doctors and the Indian healthcare system as infinitely more warm, attentive, and human, and implies that, unlike in the United States, their system is not motivated by money. Umm, you are an American who was able to scrape together $19,000 cash—about 38 times the average annual household income in India—and you think that the quality and manner of care you are receiving in India is not heavily influenced by money? Please. And she, more than once, referred to persons or things as “exotic.”

But, overall, Katz’s tale is an interesting one of the lengths a patient must go to in order to circumvent our sorry excuse for a healthcare system. —Lucia Hwang

How We Do Harm: A Doctor Breaks Ranks About Being Sick in America

By Otis Webb Brawley, M.D., with Paul Goldberg; St. Martins Press, 2012

You’d be forgiven for being suspicious of Dr. Otis Brawley upon opening How We Do Harm: A Doctor Breaks Ranks About Being Sick in America. He starts out with his bona fides: He’s a physician. He’s a biostatistician. He’s an epidemiologist. You might just think he’s full of himself.

But soon, you’d discover in this book, cowritten with investigative journalist Paul Goldberg, that he’s actually full of righteous fury about the inequities in our healthcare system. The book, in fact, is a call for no less than a social movement for sane and science-based healthcare for all.

Healthcare reform hasn’t worked from the top down, he argues. What we need is a groundswell inside and outside medicine.

“Genuine healthcare reform—like the right to vote—will not be granted magnanimously,” he writes. “Like civil rights, the right to good health care will have to be won in public struggle. To bring about real change, real people will have to say, 'Enough!'”

How we get to “Enough!” is laid out thoughtfully in the following 250 pages. Brawley promises a “guided tour of the back rooms of American medicine,” and he delivers with story after story of what Brawley thinks is wrong with America’s healthcare system. As a statistician, he values individual stories less than research, so he starts with the most damning numbers: While our healthcare system is the most expensive in the world (costing $8,000 per person a year and amounting to 18 percent of our gross domestic product), we come in 50th worldwide in health outcomes.

Then he lays out the particulars, wedding statistics with often enraging and heartbreaking stories of real patients he’s treated: “wallet biopsies” that determine how much care a patient gets; the more-is-better ethos that encourages researchers to put patients’ health in danger to overload them with treatment, doctors to do extreme treatments and patients to ask for more care even when to do so would harm a terminally ill loved one; corrupt doctors and hospitals that all but sell patients for parts, giving them so much care that every practitioner who gets involved gets a cut; so-called evidence-based medicine guidelines driven by profit motive rather than scientific reality; health screenings as money makers; poverty as a carcinogen; and finally, an American culture that valorizes new treatments and technology even when it can harm them, even when it can overrun their lifetime maximums and cost them their health insurance coverage, even when it could shorten their lifespans.

In short, and without saying so explicitly, Brawley has found what many of us know already: Capitalism in healthcare makes for a sick system.

“I have seen enough to conclude that no incident of failure in American medicine should be dismissed as an aberration,” he states plainly. “Failure is the system.”

Along the way, we are treated to a little background on Braw-
ley himself: Born to working class parents in Detroit’s Black Bottom neighborhood, Brawley receives a scholarship to a Jesuit high school. His uncle helps to pay for his education at the University of Chicago. He does an internship at Case Western Reserve Hospital in Cleveland and a fellowship at the National Institutes of Health’s National Cancer Institute. Then he covers his work today as medical director of the American Cancer Society and a medical oncologist at Emory University and Grady Memorial Hospital in Atlanta.

What Brawley wants most, we learn, is not that we subscribe to his way of thinking but that we think at all—that we think critically, that we are skeptical of the healthcare system. Wise up, he seems to be saying. Think for yourself. Demand more of your doctors, your healthcare system, yourself. He challenges the reader not to be distracted by shiny new medical devices like the da Vinci surgery robot. More is not always better.

We must have a grassroots rebellion—not just from patients tired of being excluded from or bilked by the health care system—but by healthcare providers who are trying desperately not to do harm. That’s a message that any RN who’s watched as patients are turned away from her ER can get behind. —Heather Boerner

The Passage of Power: The Years of Lyndon Johnson

By Robert Caro; Alfred A. Knopf, 2012

WI TH HIS PRODIGIOUS four-volume (going on five) opus on the deeply flawed but master politician Lyndon Johnson, Robert Caro has redefined the standard on political biography that may be hard to match.

In earlier works, some of which are recapped in his latest work, Caro has, through the story of Johnson’s rise to power (the theme by which Caro is obsessed), provided stunning insight on how the 1930s New Deal transformed the lives of rural Americans, the undermining of democracy through manipulation of elections, and the frozen tundra also known as the United States Congress.

Caro’s new book covers the 1960 election, Johnson’s years of angst as vice president, and his early tenure as President following the Kennedy assassination. While the whole work is endlessly rewarding, of particular note for nurses and healthcare activists is how LBJ broke through the gridlock of the Senate (no it was not invented by the current crop in the Beltway) and the House to pass the landmark Great Society reforms, starting with the historic Civil Rights Act of 1964, but also including, of course, Medicare.

For 26 years, says Caro, Congress was the death chamber of social reforms. Roosevelt failed to get a “single major reform through Congress” in his last eight years in office. Truman’s proposals “for national health insurance, for expanded unemployment insurance, for reduced taxes for the poor, for the expansion of federal aid to education” all “died on Capit0l Hill.” And except for a few blips while LBJ was himself Senate Majority Leader, the door slammed shut again during the Kennedy presidency.

It took Johnson’s unique political sophistication and strong-arming savvy and skill to crack through what Caro labels the “southern-conservative coalition” that was such a roadblock to social progress. Not to mention a massive grassroots popular movement, a critical factor, of course, which Caro underplays.

While we will have to wait for the next, and final, Caro book on Johnson to read the full story on the enactment of Medicare, and what lessons it offers for people fighting to expand Medicare to the rest of the population today, Caro does provide glimpses of Johnson’s determination to act. Thinking of Truman just hours after Kennedy’s murder, Johnson told top aides, “By God, I’m going to pass Harry Truman’s medical insurance bill.” —Charles Idelson

Uprising: How Wisconsin Renewed the Politics of Protest, from Madison to Wall Street

By John Nichols; Nation Books, 2012

THE TEA PARTY MOVEMENT that rose into national prominence in 2010 held election parties late into the night on November 2 of that year. Champagne corks flew; large platters of fancy hors d’oeuvres were consumed, and feet squeezed into Guccis and Jimmy Choo throbbed from dancing all night in celebration of their victory. Tea Party activists provided the ground troops for the right-wing 1% corporate elite who spent their millions campaigning on the erroneous premise that public service workers were the cause of shortfalls in local and state budgets, and ought to be blamed for the economic crisis. Throughout the year, you couldn’t
pick up a newspaper, turn on a television or a radio or surf the Internet without hearing how public workers were living high on the hog, eating up taxpayer dollars. This mean-spirited public discourse provided the constant barrage of attacks leveled at those public workers who support and provide the sorely needed services that millions depend upon for survival. When the dust settled after the November 2010 elections, state after state had elected the most anti-worker, anti-poor, anti-student, anti-farmer, and anti-union city, state and Congressional representatives in modern history.

The 1% were ecstatic, but for the rest of us, the future looked bleak.

And then, the uprising in Wisconsin happened!

John Nichols’ *Uprising*, published this year by Nation Books, chronicles the extraordinary actions that began in the snow-covered capital of Madison, Wis. that grew to hundreds of thousands in early 2011. These actions would eventually spark a nationwide movement of workers, students, farmers, and unemployed people determined to resist the unfettered power grab by corporations and Wall Street financial speculators. Thousands poured into the streets of Madison due to the heinous attack on public workers’ wages, benefits, pensions and bargaining rights by a new Republican governor, financed by the infamous right-wing Koch brothers, Charles and David. These corporate attacks spread to farmers and people who were recipients of Badger Care and other safety-net programs, as well as students in public schools and universities. The demonstrations grew in numbers and intensity and when the “occupation” of the state Capitol began, word spread throughout the world that the people of Wisconsin were fighting back. Support came from public- and private-sector workers and their unions as well as students, farmers, PTAs, and other community-based organizations, even from as far away as Cairo, Egypt—which had recently experienced its own uprising and thrown out a dictator.

The Wisconsin uprising would eventually spread to Ohio, Michigan, and other states undergoing the same attacks. NNU nurses and other progressive groups who were on the ground in Wisconsin would go on to build actions in Washington, D.C., California, and New York, with the same “Blame Wall Street” message throughout the summer of 2011. And by September of the same year, hundreds of thousands of people from all walks of life would be occupying strategic locations in cities, towns, and universities throughout the world, challenging Wall Street greed and demanding justice for the 99%. For a time, the Tea Party would be silenced and the blame for the economic calamity was put squarely on Wall Street greed.

Nichols’ story is most certainly a “biased” account written by an admittedly “biased” observer. He is a proud native son of the state and dedicates his book to the Mineral Point, Wis. miner from whom he is descended. He is unabashedly in love with Wisconsin and its people, who were targets of the attacks by Scott Walker and his corporate backers.

Nichols provides solid background of the history of working people in the state and describes how the actions of 2011 were rooted in the past political movements of Milwaukee Socialists and Robert M. La Follette’s Progressives. He makes the point that when history is acknowledged, it can make powerful connections to a “legacy worth defending.” In the case of Wisconsin, that legacy was the birth of public-sector unions in Madison. He lauds the progressive groups within the uprising who put the blame on the economic crisis back where it belonged. “Blame Wall Street” and “No Cuts, No Concessions” signs proliferated on the streets and inside the Rotunda. Nichols discusses how these interjections continued the progressive legacy of the state by defending the democratic rights of working people to challenge the accumulation of wealth by an elite few. “This is what democracy looks like” to Nichols, meaning that the rich elite need to have their power put in check in a fundamental and permanent way.

The controversial move to divert the Wisconsin uprising into an electoral agenda, which focused solely on recalling Republican politicians in the state, ended with mixed results. Nichols warned in his book, prior to the recall, that the “soft messaging” of Democratic party consultants focusing on the “politics of personality” would harm not only the goals of the recall movement, but that it could actually suppress the larger movement that had latched onto a very clear anti-corporate message and agenda. In *Uprising*, Nichols argues for a different approach. Through mass mobilization and action, not just relying on election-focused list building, there could be a different, long-lasting result. He points to the strategy and tactics of a different labor movement operating “beyond the boundaries” of the Democratic Party from 1932-36 that built labor and farm groups on a local, state, and national level, keeping low-income and working-class people engaged to hold politicians and officials accountable. Clearly, Nichols is on to something deeply important if the uprisings of Wisconsin and the Occupy movement and those that will surely come in the near future are to have the staying power to bring about the fundamental change needed to ensure economic justice for the 99%. —Jill Furillo, RN

**Volunteering at Home and Abroad: The Essential Guide for Nurses**

*By Jeanne Leffers and Julia Plotnick; Sigma Theta Tau International, 2011*

**If you have ever dreamed or desired to use your nursing skills as an international or national volunteer, run, do not walk, to the store to purchase the book by Jeanne Leffers and Julia Plotnick, titled *Volunteering At Home and Abroad: The Essential Guide For Nurses*. It is of value to new and seasoned volunteers. This guide was written by registered nurses for registered nurses. There are other books about volunteering and while they are helpful, this book is*
unique in that it addresses the specific needs of nurses before, during, and after their volunteer experience. It also addresses nursing volunteer roles.

Both authors have extensive experience volunteering in the United States and overseas. They draw from their own discoveries. They invited nurses from around the globe to share their experience and knowledge. Their individual stories reinforce the statement at the beginning and end of the book that in changing lives, our own life may also be changed.

Jeanne Leffers is a faculty member at the University of Massachusetts Dartmouth and has volunteered in the Dominican Republic, Guatemala, Honduras, Uganda, and Haiti. She has led nursing students abroad. Chapter 6 is a plethora of information for faculty and students. There are two pages outlining diverse types of global nursing students’ experiences.

Julia Plotnick has routinely traveled abroad throughout Eastern Europe and Africa following natural and man-made disasters to help governments and local providers. She was in Sudan at the time of the famine, the orphanage situation in Romania, and the aftermath of the Rwandan genocide. The chapter on nursing response to disasters attests to her extensive knowledge and offers practical information.

Chapter 2 provides tools for self-assessment, helping the reader identify nursing expertise, skills, goals, and needs. Volunteering locally or globally is not for everyone. The self-assessment and resulting self-knowledge is valuable whether the decision is made to volunteer now, later, or not at all. The flow of the following chapters provides information about potential opportunities. There is practical information about travel costs, living arrangements, needed vaccinations, etc. The self-assessment needs can be contrasted with what a particular program would need. It is all about finding the right fit for all concerned to make it a win-win situation.

Chapter 7 is a wealth of useful questions and practical information, including packing for the trip, safety and ethical issues, travel insurance, professional and cultural preparation, personal medical kits, etc. To quote the authors, “The more you learn ahead of time, the less affected you will be by unexpected situations, allowing you to be more effective in your service.” I wish this book were available when I started volunteering 20 years ago but I am pleased I can recommend it to others who ask about volunteering.

I appreciated the chapter on assignments and the sections dealing with respecting the local culture as well as respecting the host setting environment. However, I would have liked the importance of the volunteers working together as a cohesive team to be more developed. In my experience doing disaster relief as well as long-term development work, the volunteer team that works well together accomplishes much more on every level.

Reverse culture shock is a reality and is addressed in the last chapter. The emotional impact of coming home can be more difficult than the physical return. This insightful chapter looks at adjustments the volunteer needs to make as well as giving suggestions for moving forward and making contributions to the site they left. The various sidebars from volunteers relating their difficulties and how they solved them are helpful. The comments from the nurses relating the benefits of working with the volunteers were heartening.

The eight pages of references and the four appendices at the end of the book are an added gift from the authors who are passionate about volunteering and what they have done with their nursing careers; they have empowered others and are continuing this empowerment by offering us this Essential Guide for Nurses.

—Patrice Coolick, RN

MENTAL BREAKDOWN
(Continued from page 13)
from 848 in 2008 to 626 in 2011. This year, the state proposed cutting an additional 120 beds from Taunton State Hospital, and wanted to close the entire facility. With an active campaign by the Massachusetts Nurses Association/NNU, the closure has been blocked for now.

During this same period, Massachusetts saw similar cuts to psych and substance abuse beds in the private sector while the state has failed to increase funding for community-based services. Every day in Massachusetts, MNA notes, hospitals are holding many psychiatric patients, sometimes 10 to 20 such patients, and those patients are stuck in the EDs for a day, up to week, waiting for a bed or service to open to treat them.

In recent weeks, we’ve heard a flurry of reports of mass shootings in which the suspects were all too often described as men with serious psychiatric problems.

But there are also stories not making the national headlines, like the case of a 67-year-old man beaten to death with a flower pot outside his Berkeley, Calif. home in February. The suspect: a 23-years-young man said to suffer from paranoid schizophrenia who has been in and out of institutions and whose parents told reporters they have spent years trying to get him more help.

Ruled mentally incompetent to stand trial, the young man was ordered to be placed in a state hospital, but a bed was not available. Left untreated while waiting for transfer to somewhere, his parents told the San Francisco Chronicle, he first injured himself, and then broke the jaw of a deputy sheriff.

How much longer can we as a society put up with such intolerable abandonment of patients who need mental healthcare, and a healthcare system dedicated to pursuit of private profit rather than public protection, safety, and care? RoseAnn DeMoro is executive director of National Nurses United.
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