Feeding the Nation’s Need for Hope

RNs take Main Street contract to the people
Letter from the Council of Presidents

Summer is usually a time for rest and relaxation, but surveying our activities over the past months, it’s clear that National Nurses United RNs have been busy: busy fighting for patient safety, busy defending their contracts, and busy helping revive their communities through our Main Street Contract campaign.

We’re glad to report that nurses are taking the themes of our Main Street campaign and running with it, holding protests all over the nation and linking struggles they are having at their facilities with the corporate agenda we are trying to reverse. In our news section, you can read about a powerful sit-in protest Massachusetts nurses helped stage against Hyatt hotels, about a soup kitchen Michigan nurses held on their Capitol’s front law to shame their governor, about the intense battle nurses are fighting with Sutter Health over their latest contract, and about numerous candlelight vigils and other actions RNs have organized.

Our Main Street, not Wall Street, message is really resonating with nurses and the public. We still continue to receive many heartbreaking stories from working families going through very tough times. Often, they are from registered nurses. In this issue, we profile two RNs at very different points in their career, but who share one thing in common: they both provide significant financial support for family members who otherwise would not be able to make ends meet. Reading these stories, we were also struck by another aspect they all shared: If our leaders actually ran the country in a way that provided many of the demands of our Main Street Contract, their family members would not be in such dire financial straits. Unaffordable healthcare costs, the dearth of full-time, living-wage jobs, and the absence of real pensions are among the reasons many nurses are supporting their relatives.

Every year, we also review a pile of books that nurses should find interesting, and you’ll find that story in this issue as well. The topics these books cover run the gamut, from nurse bullying to the world of health insurance public relations. Some are written from a nurse’s perspective, and some from the perspective of patients. Don’t miss the review of Alone Together, which discusses the incessant drive toward using technology as a replacement for human caring and poses some terrific questions about the nature of their work that all RNs should consider.

Even as we do all this, we are preparing for the fall and to kick the Main Street campaign up another notch. Please join us. Go to www.MainStreetContract.org for details and come on out to your nearest protest or rally. We can’t do it without you.

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

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

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ON THE COVER: Michigan Nurses Association RNs hold a soup kitchen on Lansing Capitol grounds to protest their governor’s policies and promote the Main Street contract.
Culminating a two-year effort to win union representation to improve patient care, registered nurses at Holy Family Hospital in Methuen, Mass. voted July 11 by 69 percent to join the Massachusetts Nurses Association/National Nurses United, the state and nation’s preeminent organization of RNs. MNA will represent 357 RNs at the hospital, which is part of the Steward Health Care system.

Holy Family RNs greeted the election with cheers and hugs after the vote was tallied. “We are thrilled to have achieved this victory, which is not only a victory for nurses, but also for our patients and the community we serve,” said Ed Burke, RN, who has worked in the hospital’s pediatric unit for more than three years.

The campaign gained momentum when the MNA and Steward Health Care, the new for-profit owner of the system, entered an organizing agreement in October 2010. Under the agreement, management remained neutral in the months leading up to the union election and assured a process to maintain accurate communication with employees. The MNA already represents nurses at five other Steward facilities, including more than 2,000 registered nurses and healthcare professionals working at Carney Hospital in Dorchester, Good Samaritan Medical Center in Brockton, Norwood Hospital, St. Elizabeth’s Medical Center in Brighton, and Merrimack Valley Hospital in Haverhill.

“We will now have a voice in the future of this facility to ensure safer staffing levels and improved working conditions, which will mean better care for our patients, while also improving this facility’s ability to recruit and retain first-rate nursing staff,” said Cheryl Laorenza, RN, a nurse on the hospital’s psychiatric unit for more than four years.

MNA president Donna Kelly-Williams, RN praised the Holy Family RNs for unionizing. “When nurses are organized, patients are the biggest beneficiaries,” said Kelly-Williams.

The drive to organize the nurses began in 2009, when RNs began meeting with MNA representatives to discuss concerns about a variety of issues, including the need for improved nurse staffing ratios, improved floating policies, and improvements in job security.

In the wake of the economic downturn and changes in the industry being driven by healthcare reform, significant numbers of non-union nurses, not only in Massachusetts but also throughout the Northeast, are showing interest in union representation.

“Non-union nurses out there are seeing the rapid consolidation of the healthcare industry with hospitals merging on nearly a weekly basis. Many hospitals looking for a quick fix to boost their bottom line have gone back to the failed strategies of the 1990s—cutting staffing levels, attempting to reduce or eliminate pay and benefits—leaving employees who are without a union with no power to do anything about it,” said Julie Pinkham, RN, MNA executive director.

“They see their counterparts who have union voice with the MNA successfully combating these changes, and in many cases, winning important patient safety protections. It is no surprise that in this environment we are seeing more nurses who want to experience the power of workplace democracy.”

Now that the election is settled, the nurses will begin the work of forming their local committee. The nurses will elect members to their bargaining committee, and have already begun soliciting proposals from colleagues about what they would like to negotiate into their first contract.
Michigan Actions often speak louder than words. In Michigan, nurses not only pass out cards listing the principles of the Main Street Contract for the American People at every opportunity, they have started teaching their communities and representatives by example about key points of the contract through two successful events.

On July 4, Michigan Nurses Association members from Alpena Regional Medical Center did what the local school district, which has been heavily hit by Gov. Rick Snyder’s budget cuts, could no longer do: equip children with needed school supplies. They used the annual Fourth of July parade to talk about the Main Street contract’s demand for a quality public education and pass out 150 book bags filled with pens, pencils, and notebooks. The schools are facing teaching staff reductions, reduced services and programs for needy students, and reduced state funding by more than $400 per student. The book bags were distributed to at least one child from every elementary class in every school whose family is suffering financial hardship.

“We feel that the students who attend Alpena’s schools should not be unfairly targeted by legislators for budget problems they did not create,” said the Alpena RNs.

A little more than a week later, Michigan nurses tackled the Main Street contract’s call for protection from hunger by staging Governor Snyder’s No-soup-for-you soup kitchen July 13 on the Capitol grounds in Lansing. On a beautiful, sunny day, more than 100 poor and homeless people from the streets of Lansing joined nurses, teachers, and members of other unions for chicken noodle soup, sandwiches, and cookies. Nurses dressed in bright red scrub tops, who had driven in from all over Michigan, pulled on plastic gloves and served the people with a glad heart.

The event produced many memorable moments and speakers: the nurse who took a bowl of soup and a sandwich to a homeless woman in a motorized chair who couldn’t make it onto the grass to get into our tent; Susan Cecero, executive director of Advent House Ministries in Lansing, sharing how her group’s ability to serve the poor and needy are being stretched too far; nurses and MNA staff using smart phones to help a patient find where a prescription could be filled; Deb McMillan, a Lansing teacher who brings food for her students because they don’t have anything to eat at home and quite often also sends food home with them over the weekend; and the nurse who had to stop serving in the soup line to tend to a man having an asthma attack. Within seconds, she had the man sitting, using his inhaler, and was using her cell phone to call his case worker.

“It’s obvious,” said MNA President Jeff Breslin, RN pointing to the Capitol, “that not enough people in there are thinking about what’s going on out here in the streets of Lansing. That’s why the nurses are starting to do events like this.”

“Being able to apply the principles of the MSC in practical ways is taking Michigan nurses places they may not have gone before, and they say the ride is incredible.”

—Ann Sincos

Michigan Nurses Turn Up the Heat for a Main Street Contract
MASSACHUSETTS

Part of a nationwide protest against Hyatt, more than 250 union members, community supporters, and dozens of Massachusetts nurses marched in front of one of the giant hotel corporation’s Boston hotels in a powerful demonstration that highlighted the two-year struggle of 100 housekeepers, whose firings sparked an ongoing national protest and a boycott.

The protest culminated with an act of civil disobedience, when 35 protesters, including five members of the Massachusetts Nurses Association/NNU (NNU Co-President Karen Higgins, RN and MNA Executive Director Julie Pinkham, RN among them), were arrested after staging a sit-in at the front entrance to the hotel.

MNA President Donna Kelly-Williams, RN explained why nurses joined the demonstration. “We are here because what happened to Massachusetts Nurse Leaders Arrested Defending Workers’ Rights

MINNESOTA

A sea of red swept across the streets outside Fairview-owned Range Regional Health Services (RRHS) in northeastern Minnesota as nurses were joined by hundreds of supporters to conduct a three-day strike for patient safety from July 11 to 14.

For many of the 150 RRHS nurses on strike, the most compelling scene from those 72 hours was the visible outpouring of solidarity from community members, politicians and unions from all across the state.

“I feel honored that we have all this support,” said Mary Zahorsky, RN. “We’ve got people coming from the fire department, the Teamsters, members of electrical unions. I’m really recognizing that unions are united throughout the country. I love that our RNs have all stuck together to try and move ahead with this.”

“We’re here fighting for our patients and our families and our community,” said Amy Strukel, RN. “It’s empowering to see how many people are standing behind us. The honks, the hoots, the hollers. People have been dropping things off for us, putting us on the back, telling us stories. The community support has been outstanding. It’s really empowering to know the strength we have in this community.”

Hibbing RN Bruce Berg, who lives a few blocks from the RRHS campus, said that even when he left the picket line, he could hear constant honking and chanting from inside his home—day and night.

“We’re standing together, unified, with one voice,” he said, gesturing at the raucous picket line nearby. “It really makes me feel good.”

Melissa Estey, RN, said nurses working inside the hospital leading up to the strike also had reason to feel good as they walked outside the building and onto the picket line during the morning of July 11.

“I worked that morning, so I was part of the group that walked off when the strike began,” she said. “And our physicians wanted to wear our MNA t-shirts in support of us. The hospital administration says different things to the public, that we’re being greedy or unnecessary. But our physicians who work next to us and talk to us every day are supporting us, and that should speak more to the public than anything the administration says. If the physicians didn’t agree with us they wouldn’t be supporting us. They see what we do on the floor every day. Our physicians care about us and they know what we are going through.”

As she spoke, Estey had to raise her voice to be heard over the constant honking, cheering, and chanting taking place on the sidewalk nearby.

“The support here has been amazing,” she said, then paused to turn and thank the latest stream of well-wishers driving by with horns honking and hands waving.

As the nurses prepared to return to work, RN April Klander, bargaining unit chair, rallied them by reemphasizing their focus—safe staffing—and to stay unified. “This is about our concern for staffing,” said Klander. “Talk to each other. Stand with each other, because the hardest thing to do is stand alone. We’re not standing alone anymore. We need to stand together. And if there are any other issues that do come up, don’t take it alone. Support each other when we go back in, give the hometown care we’re used to giving, so our patients know we’re back.”

—Jan Rabbers

NEWS BRIEFS

Range Regional RNs Strike Over Staffing

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Massachusetts Nurse Leaders Arrested Defending Workers’ Rights

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MNA President Donna Kelly-Williams, RN explained why nurses joined the demonstration. “We are here because what happened to
Sutter, a Wall Street Corporate Hospital, Declares War on RNs

CALIFORNIA

Despite posting unprecedented profits, Sutter Health, a large hospital chain based in Northern California, has declared war on its registered nurses during this year’s round of bargaining talks by proposing more than 150 takeaways for collective bargaining agreements that have been in place for decades. More than 5,000 California RNs at nine different Sutter facilities are negotiating new contracts this summer, and ancillary staff at one of the Sutter hospitals are also in talks.

“They want to drastically change the livelihood of our nurses,” said Millie Borland, a medical-surgical-telemetry RN who works nights at the Summit campus of Alta Bates Summit Medical Center in Oakland. “Their proposals are severe, and border on ridiculous, and we are rejecting them.”

As many Sutter nurses point out, their contract talks this year are a critical bellwether for nurses across the state and even country because other hospital chains are watching to see what kinds of concessions Sutter is successful or not successful in extracting. “It’s set a precedent for other hospitals to follow.”

Though the takeaways vary from facility to facility, the most shocking demands by Sutter have been to force healthcare costs onto nurses while designing plans that offer fewer choice of providers, virtually eliminate paid sick leave for many RNs, compel nurses to focus on “customer” satisfaction surveys and polls while increasing their workload, strip nurses working fewer than 30 hours per week of paid benefits, cut starting nurses’ salaries by almost half, and gut retiree healthcare.

“I have been negotiating contracts for almost 25 years, and I have never seen such egregious takeaways,” said Genel Morgan, an intensive care unit RN at Mills-Peninsula Health Services and chair of her hospital’s bargaining team.

Meanwhile, Sutter, which is based in Sacramento, Calif., has posted record profits in the past few years. In 2010, the not-for-profit corporation netted $878 million after expenses, a 30 percent increase over the previous year, and is sitting on assets worth $2.4 billion. Sutter CEO Patrick Fry, with a 2009 annual compensation package valued at almost $4 million (a 41.3 percent increase from the year before), was the region’s highest-paid executive, according to a January 2011 Sacramento Bee article. Instead of focusing on healthcare, Sutter also recently donated $1 million to the Sacramento Kings, the city’s NBA basketball team.

Sutter RNs are not only facing these takeaways for themselves and their families, but are seeing services cut for their patients. The chain recently closed its birthing center at Sutter Auburn Faith Hospital (announced in the same week it announced its $1 million donation to the basketball team), forcing some pregnant mothers to travel over 60 miles to deliver their babies. It has also restricted access to high-quality breast pumps to low-income mothers in the East Bay whose newborns are hospitalized in the intensive care nursery, and it has cut its early breast cancer screening program for women with disabilities.

The hospital chain is exploiting the current depressed economic climate and healthcare reform under Obama to make claims of potential, future lower earnings. The nurses also believe that Sutter, whose CEO sits on a major board of the hospital industry’s lobbying group, is attempting to attack their union, the California Nurses Association, by demanding such outrageous concessions at hospitals that have been organized the longest—some since the 1940s.

Nurses are gearing up for an intense fight and have already stepped up the pressure through pickets and protests. “CNA always provides the organizing tools and platform for us to fight Sutter, and I’m extremely grateful for that,” said Borland. —Staff report

NNU Copresident Karen Higgins, RN was arrested at the sit-in to support fired Hyatt housekeepers.

these dedicated workers could happen to any employee,” she said. “And for any of us to allow this behavior to go unopposed allows all employers to join the race to the bottom in the treatment of working people. We are here to stand up for these workers, and workers everywhere.”

The “Hyatt 100,” as the housekeepers are known, were forced to unknowingly train their replacements and then dismissed without warning. The hotel chain refuses to reinstate the fired housekeepers despite climbing profits. Hyatt is the only major national hotel chain in Boston that outsources its housekeeping.

Higgins pointed out that this is just one in a series of activities the Massachusetts Nurses Association and National Nurses United is engaging in as part of a campaign for a Main Street Contract for the American people, an effort to reverse national priorities and policies that have placed the interests of Wall Street over the values of nurses and other workers.

“We nurses are demonstrating today because we are committed, not only to healing our patients, but to healing our nation by combatting corporate greed and abuse wherever it takes place,” said Higgins. —David Schildmeier
step in the right direction,” said Terrylyn Bradbury, an emergency room RN at Millinocket Regional Hospital. “Hospitals need to take every measure to protect nurses and employees from violence at work. In our professional practice committee, we are now working on implementing a workplace violence prevention training program.”

**National**

CNA’s Safe Staffing Law in California, which mandates RN-to-patient ratios, is

**Florida**

Two groups of Florida RNs working at Hospital Corporation of America-affiliated facilities held events in early August to highlight their continued efforts to improve patient care standards. Nurses at Central Florida Regional Medical Center in Sanford, where they are fighting for a first contract, picketed over understaffing at their facility.

RNs at Blake Medical Center in Bradenton held a press conference to push for more training for nurses because the hospital is seeking designation by the state as a regional trauma center. The RNs want more classroom time, simulation, and hands-on training so that they can be prepared to deal with the most critically ill and injured cases that will undoubtedly arrive at the hospital.

**Maine**

In response to increasing violence in hospitals, Maine nurses sponsored and won legislation this summer to address and prevent this growing problem. An “Act to Enhance Security of Hospital Patients, Visitors, and Employees” was recently signed into law, requiring hospitals to adopt safety and security plans that must include a process for hospitals to receive and record incidents and threats of violent behavior. The bill also includes protections for employees reporting on incidents and threats of violence. “This is a working and has improved nursing care, according to a major study issued in July by respected RN workforce researchers at the University of Pennsylvania and Arizona State University. Titled “Contradicting Fears, California’s Nurse-to-Patient Mandate Did Not Reduce the Skill Level of the Nursing Workforce in Hospitals” and published in *Health Affairs*, the study found that “the staffing mandate resulted in roughly an additional half-hour of nursing per adjusted patient day beyond what would have been expected in the absence of the policy.” This study adds to a growing body of evidence supporting mandated RN-to-patient staffing ratios, standards that NNU is proposing federally and in many states.

**Texas**

Texas Nurse Leaders from San Antonio, Houston, Austin, Corpus Christi, El Paso, and Brownsville met on July 14 in Houston to discuss and plan how to take the Main Street Contract campaign deeper into their facilities and communities. The nurses talked about how the Main Street campaign supports their work to win RN ratios and rights for nurses and patients; negotiate strong RN union contracts that guarantee respect, safe patient care, and economic justice; and expand nurses’ power to improve the health of our communities and country. —Staff report
Live to Tell
Nurses across the country are struggling in this economy, and calling for a Main Street contract

"I opened and closed your e-mail several times before finally deciding to respond. Here I am, a recent grad, with no source of income and a strong desire to pay off my school loans. I am currently receiving food stamps to help me get by. With no source of income, I constantly pray for Divine Intervention, and it manifests itself in my life as friends who just happen to call. I am barely holding on by my fingernails. It hurts."
—California nurse practitioner

"My mother lives in New York State. She is 79 years old with only her Social Security pension and Medicare. A year and a half ago my 38-year-old sister passed away. My mother has assumed the responsibility for her seven children, ages 3 to 21. She gets assistance with housing, utilities, food stamps, and the children under 18 have Medicaid. If Social Security and Medicare are reduced, I have a 79-year-old mother who will drown. I see patients in similar circumstances. It seems I know more people who have economic worries than those who do not."
—Michigan RN

Watching the politicians wrestle over how much more they could cut from our vital services rather than intervening to stop the freefall in our economy, I sent out an e-mail in late May to nurses across the nation.

My thesis was that the pain in our communities has hit home, and that nurses were feeling the effects in the lives and health status of their patients and their own families.

My simple question was, “Tell me where it hurts.”

Nurses began to respond, first in dribs and drabs, then in a torrent. Hundreds have flooded us with e-mails. Some have written comments on our website and in blogs we have posted on the Internet.

We’ve also been hearing from people with other backgrounds and professions who, of course, have similar debacles in their lives.

“My income today, when combined with my wife’s full-time income and adjusted for inflation, is actually less than the income my father earned by himself over 40 years ago. The middle class standard of living of living has been allowed to be sold out in the name of the almighty quarterly dividend.”
—North Carolina social worker

“I retired from the St. Louis Fire Department in ’03. My wife still worked. She retired in ’06. We sold our home of 22 years and bought a home 125 miles away. We tried to get medical insurance but I had a preexisting condition, so you know the story. When the economy tanked due to Wall Street and corrupt government, my retirement fund was gone. We (had to) move back to St. Louis where I found a job and my wife now watches four kids five days a week and we still have no medical insurance, which means the first time we get sick we are bankrupt and may lose everything we worked for, for our whole lives. And no one is still being held accountable for this mess. Why not?”
—Missouri firefighter

Their heartbreaking accounts tell a story of a society that has gone off track, of ordinary people, in small towns and big cities, on rural farms and middle-income suburbs, who feel abandoned and betrayed.

Whose husbands or wives have lost their jobs. Whose adult children can’t find work or afford health insurance and have returned home. Whose parents can’t get by on meager pensions that so many budget cutters think is fair game for further cuts, who feel paralyzed by soaring medical bills. Whose friends or relatives have become dependent on food pantries or face homelessness.

All while corporate America records record profits, and is rewarded by politicians who advocate even more handouts to Wall Street rather than demanding they pay their fair share.

“I am a nurse. I am homeless. Just two years ago, I had a house, with a mortgage, a dog, two cars, and pride. Now I am on the bottom of a bunk bed, my child on top... and I try to give a decent answer when she asks why I cry “all the time.” Because she’s too young to understand that everyone is just one big unexpected crisis away from devastation.”
—Florida RN

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—Florida RN

There is a mountain of statistics that can tell the story of the new face of America, but perhaps I only need one. Since the onset of the official “recovery” in June 2009, according to a recent report by Northeastern University economists, 88 percent of the real growth in national income has gone to corporate profits, and just 1 percent to aggregate wages and salaries.

NNU has launched a national campaign, for a Main Street contract for the American people premised on good jobs, healthcare for all, quality education, housing, a safe environment and freedom for hunger. We also have a plan on how to pay for it—by taxing the Wall Street traders who mortgaged our families and future with reckless speculation on derivatives, credit default swaps, and other schemes.

These compelling reports are essential for our campaign. They bring to life the (Continued on page 27)
As a busy nurse, you may not sit down with a book as much as you’d like—much less one about your chosen field. Don’t worry. Here’s our annual survey of healthcare titles to help you stay on top of your profession.

Getting a Good Read on Things
Read a good book lately? Chances are, probably not. Between juggling work, family, household chores, all your volunteer obligations, and trying to have a few moments to yourself once in a while, who has time to read an honest-to-goodness book anymore—much less one about the healthcare industry or medical field? That’s fine, because every summer we round up the titles most interesting and relevant to nurses and review them here. This year, authors are discussing how technology is supplanting human relationships and caring, revealing how the health insurance public relations machine works, and talking about how to stop bullying in the workplace—among a host of other topics. Some of the books are even written by nurses.

So even if you can’t read the whole book, you can pretend you have by simply reading these reviews. We’ll never tell. And who knows? Maybe reading these will inspire you to pick up a book.
Alone Together: Why We Expect More From Technology and Less From Each Other

Alone Together is a thought-provoking book that fires a serious shot-across-the-bow, black-box warning and eye-opening wakeup call for technophiles, armchair intellectuals, and humanists alike. Author Sherry Turkle is a professor at the Massachusetts Institute of Technology, where she is the founder and director of the MIT Initiative on Technology and Self. She holds dual doctorate degrees in sociology and clinical psychology from Harvard, and has been studying the unique interface and effects of social media and artificial intelligence programs on people for more than 30 years.

Turkle’s book is written in an engaging anthropological style. It contains a well-documented history of our computer culture and observations from her research into human interaction with computers, hand-held technology, and so-called “sociable humanoid robots” in a variety of settings, including schools and nursing homes.

The book is organized into two main sections. In part one, subtitled, “Towards Embodied Intelligence,” Turkle tells of being troubled about the true costs of life with simulation in a virtual environment and the manipulation of society’s bending toward the inanimate with a new solicitude. In part two, subtitled, “Networked: In Intimacy, New Solitudes,” Turkle voices concern about the loss of authentic relationships between people—the result of technological screens that transform how and with whom we interact.

She describes a brave new world on a digital terrain, and the inherent risks of allowing technologies to shape us and redefine our understanding of privacy, intimacy, and community. At the threshold of what Turkle calls “the robotic moment,” she asserts our devices should prompt us to recall that we have human purposes, needs, and desires. Based on interviews with hundreds of children and adults, she invites the reader to consider the value of face-to-face communication, the importance of human touch and hands-on work within the context of our everyday lives. Turkle explores the concept of emotional dislocation and social isolation enabled by unquestioning faith and reliance on technologies, and the impact on our sense of self-worth and human dignity. She writes, “We don’t need to reject or disparage technology. We need to put it in its place.”

The most provocative, compelling, and horrifying part of this book was reading about the sickening rationalizations technology industry proponents use as justification in experiments where “care” has been delegated to robots. During the course of her research, Turkle visited several nursing homes where residents had been given robotic dolls, including one called “Paro,” a seal-shaped stuffed animal programmed to purr and move when it is held and talked to. She describes how, in many cases, seniors apparently “bonded” with the toys and were observed privately sharing their life stories with them.

In arguing for “caring machines,” roboticians often make their case by putting things in terms of quandaries. So, they ask, “Do you want your parents and grandparents cared for by robots, or would you rather they not be cared for at all?” And alternatively, “Do you want seniors lonely and bored, or do you want them engaged with a robotic companion?” Turkle identifies a technique for breaking out of this kind of thinking. For example, when fifth graders considered robotic companions for their grandparents, they immediately wondered, “Don’t we have people for these jobs?” The robots-or-no-one quandary takes social and political choice out of the picture when it belongs at the center of the picture, according to Turkle.

“While the children only began that conversation, we, as adults, know where it might go. We know that the time we spend caring for children, doing the most basic things for them, lays down a crucial substrate. On this ground children become confident that they are valued, no matter what. The ill and the elderly also deserve to be confirmed in this same sense of basic trust.” If we divest ourselves of such things, we risk being desensitized and hardened. Turkle observes, “When we lose the ‘burden’ of care, we begin to give up on our social compact that human beings will care for other human beings.” And, once you have elder bots and nurse bots, why not nanny bots?

During one of her seminars at MIT that focused on the role of robots and computers in medicine, her class considered a robot that could help turn weak or paralyzed patients in their beds for bathing. A robot now on the market is designed as a kind of “double spatula”: one plate slides under the patient; another is placed on top. Some students insisted that it is inevitable for robots and telemedicine to take over nursing and monitoring roles (they cited cost, efficiency, and the insufficient numbers of people who want to take the job). Others countered that the elderly and disabled deserve the human touch and that anything else is demeaning.

Turkle aptly quotes philosopher Kwame Anthony Appiah: “In the real world, the act of framing—the act of describing a situation, and thus of determining that there’s a decision that must be made—is itself a moral task. It’s often the moral task. Learning how to recognize what is and isn’t an option is part of our ethical development.” When caught up in a discussion about robot caregivers her class turned away from the dilemma at hand and began asking different questions. “What about hiring people to do the work?” And, “What must be done to get them where they are needed?”

As many have observed, one place to start would be to elevate elder care above the minimum-wage job that it usually is, often without benefits. How can we revisit social priorities so that funds are made available? We have the unemployed, the retired, and those currently fighting in wars—some of these people might take these positions. Many have a heart for service, valuable skills, and
I n his book, Deadly Spin, former private health insurance executive Wendell Potter credits the nurses of the California Nurses Association and their protest on behalf of Nataline Sarkisyan in December 2007 as one of the primary reasons for the “crisis of conscience” that led him to speak out.

The year 2007 was a time of undeniable soul-searching for Potter. The book gives an intimate glimpse not only into Potter’s world of corporate power and privilege but also into his personal journey. He is an accomplished writer and journalist, so the book is well researched and written with clarity and purpose.

During that time, Potter worked for CIGNA, the insurance giant based in Philadelphia and the Sarkisyan family’s insurer. Nataline’s story was a classic case that nurses hear all too often. The 17-year-old’s doctors believed she had enough of a chance for survival to want to give her a liver transplant, but CIGNA denied the procedure. With media help from the California Nurses Association and the support of Southern California’s extended Armenian community, the family protested and raised a huge public outcry.

On page 154 of his book, Potter writes, “My phone started ringing off the hook as soon as the nurses’ release went out. I knew I had a crisis on my hands when calls poured in not only from local TV and radio stations but also from the Los Angeles Times, CNN, and NBC—and even from the general public: The release, which was posted on the homepage of CNAs Web site, also appealed to the public to call CIGNA demanding that it ‘provide the care Nataline needs.’”

CIGNA eventually relented, but it was too late. Nataline was too ill to receive the new liver and on Dec. 20, 2007, she died.

Potter’s book recounts the story of that protest and its impact, not only on CIGNA, but on the entire national healthcare reform debate. The nurses, and their steadfast protest and clear-minded press work on behalf of the family and the issue, had changed the course of history. Potter would never be the same.

In another section of Deadly Spin, Potter outlines in great detail his participation as a CIGNA executive in the efforts to discredit Michael Moore and the 2007 documentary film, SiCKO. The film chronicles the stories of several insured patients (including yours truly) and their families through the broken and brutal healthcare system nurses confront every day. In SiCKO, Moore challenged the notion that simply having insurance means having the single-standard of high-quality care that nurses strongly support as patient advocates.

Potter was charged with making sure Moore’s film was maligned, and he traveled to places the nurses had arranged for early screenings of the film and even to Sacramento, where the nurses helped arrange for an early screening of the movie and for Moore to testify at a hearing held by California Sen. Sheila Kuehl, then chief sponsor of the state’s single-payer legislation.

Potter was a “spy” for the for-profit health insurance industry and an audience member in Sacramento for that nurse-sponsored, West Coast premiere of the film. “Moore had been persuaded by the California Nurses Association and Physicians for a National Health Program—both advocates of a single-payer health care system in the United States—to show the movie in Sacramento first because California lawmakers had twice approved bills creating a single-payer system in the state...I probably would have joined all the others in the audience in giving the movie a standing ovation, just as the people at Cannes did when it was first screened.”

Most of Potter’s book provides a bird’s-eye view of the inner workings of the private health insurance industry’s spin doctors—the folks like Potter who make sure even the most horrific denials and decisions are painted in the most positive light possible.

Many sections of the book give readers insights about the political maneuverings of the for-profit health insurance industry and the work of shadowy front groups to advance the propaganda Potter helped fashion and to craft the healthcare reform legislation that would best benefit the health insurance industry—not patients and not nurses. One of the more fascinating sections of his book outlines the strategy as follows, “All of the tactics used by the oil, beverage, and banking industries to influence lawmakers at every level of government were pulled straight from the cigarette makers’ playbook: Distract people from the real problem; generate fear; split communities with rhetoric, pitting one group against another; encourage people to doubt scientific conclusions; question whether there really is a problem; and say one thing in public while working secretly to do the opposite.”

No matter what Potter was paid to spin, he just could not overcome the truth of the cry nurses helped raise. As he closes out his book, Potter thanks that young, beautiful woman whose life was cut short. One life can and does make a difference in this world, and registered nurses often stand with patients and their loved ones at the most difficult moments and during times when other support systems have forsaken them. That power and the absolute dedication to patient advocacy showed Wendell Potter a whole new world over which even the “deadly spin” of the insurance industry held little sway.

The book provides a great history of the reform effort and helps us see even more clearly how critical nurses are to hastening the day when a single standard of high-quality care for all without financial barriers will be the law of the land and not the result of deathbed protests. —Donna Smith
perhaps, the willingness to perform these satisfying jobs if there were salaries at living wages to pay them.

The baby boomer generation begins to turn 65 this year, which will create many challenges for our healthcare system. This generation of older adults will be the most socioeconomically and racially diverse the nation has ever seen. They are more educated, with more widely dispersed families, and increased longevity. The majority will suffer from one or more chronic conditions and will need to rely on healthcare services with a greater frequency than other segments of the population. It is estimated that the number of older adults in the United States will almost double between 2005 and 2030, yet there is a dramatic shortage of all types of healthcare workers, especially those in long-term care settings.

In 2008, the Committee on the Future Health Care Workforce for Older Americans published a report titled, “Retooling for an Aging America: Building the Health Care Workforce.” The report asserted that federal agencies should provide support for the development of technological advancements, to include the use of assistive health information technologies and remote monitoring technologies “that may reduce the need for formal care” and “enable health professionals to be more efficient.” The committee’s report, and its title, all but eerily foreshadows the subject matter of Turkle’s comprehensive body of research.

It is against this “embrace technology” backdrop and the industrial-manufacturing encroachment into the for-profit acute-care and long-term care environments that Turkle’s book should become required reading for all who value the art and science of nursing. Turkle observes that technology presents itself as a one-way street; discontents about its direction are dismissed because it’s assumed their reactions are borne of nostalgia, or a Luddite impulse, or simply in vain. But when we ask what it is we’ll “miss,” we may discover what we care about, what we believe to be worth protecting. Technologies

**When A Loved One Falls Ill: How to be an Effective Patient Advocate**

By Gerri & Brian Monaghan; Workman Publishing

As a prominent, successful San Diego trial lawyer, Brian Monaghan was a pro at being a fierce advocate and winning big cases for his clients. But the tables turned in May 1998 when Monaghan learned that he had Stage IV melanoma and two metastasized tumors in his brain. Now he was the one that needed an advocate. Luckily for him, his smart and strong wife Gerri filled that role perfectly.

After a 13-year battle involving much research; consulting of specialists for second and third opinions; Gamma Knife, brain, and other surgeries; experimental vaccines; and intensive therapy, Monaghan is still alive, doing well, and his cancer appears to be indefinitely in remission. He attributes his success in fighting such a devastating diagnosis to having such a powerful personal advocate, Gerri.

To help other patients facing serious medical challenges and share all the lessons they learned while battling Monaghan’s cancer, he and his wife wrote *When A Loved One Falls Ill: How to be an Effective Patient Advocate*. Every patient needs an advocate, they argue, “to have someone other than the patient question what’s being done and why. You need to have someone stand up for you when something doesn’t sound right, someone who’s not intimidated by the fact that the person standing in front of her is wearing a white coat.”

Written in a colloquial style, *When A Loved One Falls Ill* is a great book that simultaneously tells their story from both Brian and Gerri’s perspectives, and offers 50 “advocate tips” to follow. Some of the tips address practical matters, such as starting an advocate’s notebook to keep all of the patient’s information in one place or making sure to get copies of every record. Some of the tips address matters of the spirit, such as advising readers to trust their intuition, to stay optimistic through inspirational stories, and to keep laughing in order to stay sane. Some of the tips, such as using your networks and every contact available to you to get what you need, are just common sense yet something that people don’t apply when it comes to their medical treatment. Very importantly, they remind readers through tip #40 to treat doctors, nurses, and medical staff well!

Even as an RN, I learned a lot from this book. It really brought home for me how the medical system offers so little support for patients, how much the medical system needs to change, and how much the country needs single-payer health-care so that people can marshall all their resources toward fighting the illness and not worry about money or the insurance company. As an RN with many friends and colleagues still working in the healthcare system I mainly use, the book opened my eyes as to just how inadequate my resources would be if I had to navigate this world without my connections—as most patients do.

What I liked best about this book was that it laid out all the things patients and advocates need to be aware of, as well as answering those questions and supplying the resources to address those concerns. My only quibble about the book is that it was written from the perspective of an unusually prominent and wealthy person who was able to do things like call up CEO friends to get appointments with specialists and go on European vacations in between treatments—hardly the situation of most patients. Still, the lessons and advice ring true. Since we will all be patients one day, this book is well worth the read.

—Kay McVay, RN
The Comfort Garden: Tales From the Trauma Unit

A psychiatric nurse consultant, Laurie Barkin, RN has written a fascinatingly vivid account of her five years working at San Francisco General Hospital, the main public hospital for the city’s low-income, uninsured residents as well as its primary trauma facility. A transplant from Boston, Barkin’s job is to provide psych consults: talk to, give referrals, and suggest services for patients suffering from trauma—whether it’s a 19-year-old prostitute who gets her head bashed in with a hammer by a crazy customer, drug addicts who’ve witnessed ex-boyfriends kill their children, or teens from the local housing projects who’ve been shot multiple times. In her new job, Barkin is surprised to learn that there is no therapeutic support system in place for the staff, who listen to and must confront unspeakable horrors and sadness day in, day out. Instead, she discovers a beautiful garden on the grounds of the hospital where cedars, pines, and a myriad of flowers grow. When she feels overwhelmed by the job, she retreats to “the comfort garden” to calm down, gain perspective, and renew herself.

As time goes by, it’s apparent to Barkin that the patients desperately need some kind of support group so that they can continue to heal psychologically after they have been discharged by the hospital. When she arrives, no such services exist. One of Barkin’s great triumphs during her time at The General is that she succeeds in creating such a group. Later, she also attempts to carve out time and space for the psychiatry staff to process the emotions they feel treating these difficult trauma cases, though the lasting effects of that effort are more unclear.

Through the stories, which are told chronologically, Barkin also raises larger questions about where the modern practice of psychiatry is heading and how managed care undermines the quality of care. In her later years at San Francisco General, she finds that she is under constant pressure to increase her billable hours. She also witnesses, to her dismay, the entire institution of psychiatry becoming much more focused on pharmacological solutions instead of traditional talk therapy. As a fellow psych nurse friend put it, “Forget feelings. It’s all about pills and quick fixes.”

Often, Barkin takes refuge in her garden at work, and sometimes in her garden at home. But after five years of vicarious exposure to the stress and trauma of her patients, Barkin needs a break. She is beginning to have nightmares and irrational daydreams and fears for her family. “A part of me feels dead...I feel ravaged by overexposure to human cruelty and suffering,” she writes. But she knows that, like a plant that momentarily lies dormant to take a rest and gather energy for the spring, her “roots as a nurse [are] deep and unscathed. Come the next rain, I know I will rebloom.”

Barkin also reveals a lot about herself in the book, frequently depicting her busy family life with her lawyer husband and three young children, and how her work and personal lives influence each other. She weaves the stories about her two worlds together seamlessly.

The Comfort Garden is a beautifully written book, at times joyous and poignant, at times incredibly depressing and somber. But, above all, it is honest.

—Lucia Hwang

By Laurie Barkin; Fresh Pond Press

—DeAnn McEwen, RN

Congruent with our crucial role as patient advocates and proponents of healthy public policy, CNA/NNU has adopted a position statement that explores the potential of technology replacing human interaction in the delivery of healthcare and supplanting critical thinking and independent clinical judgment with critical pathways and other forms of artificial intelligence. As the development of technologies continues its rapid evolution, particularly in healthcare, it is important that it is harnessed to best serve the individual healthcare needs of patients. Registered nurses have a unique role in assuring the provision of safe, therapeutic, effective and efficient care in the exclusive interests of the patients we serve.

Turkle concludes, “We have to be concerned that the simplification and reduction of our relationships will no longer be something people complain about. It may become what we expect or even desire.” We are at a point of inflection, where we can see the true costs of technology and start to take action. She makes a credible claim that we have already unknowingly embarked on an experiment, indeed, a whole series of experiments: robots for children and the elderly, and technologies that denigrate and deny privacy, deskill, and replace people with a seductive form of electronic simulation. We are unwitting human subjects in a technological matrix. As human beings, we deserve better. When we remind ourselves that it is we who decide how we should use technology, we shall have better.

—DeAnn McEwen, RN
**My Imaginary Illness: A Journey Into Uncertainty and Prejudice in Medical Diagnoses**
By Chloë G.K. Atkins; Cornell University Press

As nurses well know, medicine prefers that patients’ illnesses be easily identified, named, and treated—essentially, neatly boxed and wrapped with a bow on top. Unfortunately, many people’s health issues rarely present themselves that way. Such was the case with Chloë Atkins. Starting at age 21, Atkins began suffering numerous health issues, including extreme fatigue, loss of muscle control, and other symptoms of a major neurological problem. Doctors could not conclusively diagnose what was wrong with her, though, and classified her disease as psychosomatic—a label in her charts that would doom her to life as a medical pariah. No medical providers would take her illness seriously, and some even acted cruelly towards her as if to punish her for wasting their time and resources. Over the coming years, she continued to deteriorate and bounced from physician to physician, hospital to hospital, and medical crisis to medical crisis without receiving the help she needed. Eventually, she became a quadriplegic and was confined to a wheelchair for years. Her body was at times so paralyzed that she could not breathe on her own and had to be intubated.

Only after more than a decade of mistreatment by the medical profession did a doctor finally suggest that Atkins suffered from an autoimmune neuromuscular disease called myasthenia gravis. Atkins, however, still did not pass all the tests used to officially diagnose myasthenia gravis. Through persistence, however, she was finally able to find specialists who were willing to treat her as if she had myasthenia gravis and to prescribe her the medications she needs to suppress her immune system. The results were extraordinary. Though she still suffers from muscle weakness and tires easily, Atkins regained the ability to walk and perform all the other functions of daily life. Today, she is an associate professor at the University of Calgary.

Atkins’ story offers many lessons to nurses and other medical providers. Especially with modern medicine’s emphasis on “evidence-based practice,” patients who do not fit a standard, textbook presentation of a disease may fall through the cracks and be denied the treatment they desperately need. Atkins’ experience also provides insight into what might happen to a patient who is written off as psychologically causing their own illness and whether those labels are more often, and unfairly, applied to women versus men. You can’t help but wonder if a middle-aged man suffering from Atkins’ same symptoms would have been told “it’s all in your head”?

Besides evoking many ethical questions and dilemmas for the medical profession, Atkins’ story is also, at its heart, a compelling read about a patient struggling against a mysterious illness. Along the way, she finds love, hope, and the closest thing to a cure that she can get. —Lucia Hwang

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**When Nurses Hurt Nurses: Recognizing and Overcoming the Cycle of Bullying**
By Cheryl Dellasega; Sigma Theta Tau International

Every nurse has seen it at some time. We all know that sometimes nurses are our own worst enemies. We’ve all heard that “nurses eat their young.” At one time or another, most of us have had a bullying coworker, charge nurse, or supervisor—the nurse who seemed to live to make others miserable. So when I saw the title of this book I had great hopes for it. And the author gets quite a lot right.

Her analysis centers around “relational aggression,” defined as “gossip, exclusion, teasing, tormenting, undermining, cyber-slaming, and a host of other verbal and social behaviors designed to wound another person.” This is described as being mainly a female phenomenon which caused me, as a male RN, to approach this reviewing task with some sense of diffidence.

I found considerable interest in the description of the problem, the examination of its extent, and the damage it causes: excess turnover, young nurses leaving the profession, even possible increased risk to patients from poor communication among caregivers. The author presents quite a number of anecdotal examples and case studies, several of which would be familiar to almost any nurse.

There is also some thought-provoking work on the root causes of the problem. Reading some of those comments kept my hope alive for what this book might have been: “Perhaps a sense of overt powerlessness leads to more subtle struggles through aggressive behavior.” Here’s another: “According to the theory of oppressed groups (Fanon, 1963; Friere, 2000), people who are dominated by others turn on each other and become self-deprecating because they have internalized the values of the group in control.” And here’s a good one: “What other profession expects employees to go for hours without food, drink or bathroom breaks?”

But despite explicitly recognizing these causes of nurse-on-nurse aggression, the author entirely fails to take the next step. To tell us that taking power in our profession and changing those conditions is a critical part, perhaps even the critical part, of the response to relational aggression.

Instead, she offers a recipe for individual transformation. Rather than working to change oppressive conditions, nurses are to learn to endure them in a more functional way. Even though she makes clear that much of this aggression can be attributed to the unreasonable stresses of our work, the author—typifying the academic nurse’s anti-union bias—shies away from the next logical step: banding together to change those stresses through collective action.

In sum, there’s a lot in this book of interest. It’s too bad it fails to fulfill its full promise. —David Welch, RN
During this Great Recession, as we’re talking to registered nurses across the country about our campaign to win a Main Street Contract, it’s clear that many RNs are financially supporting more people than they ever have in the past. Some are now the sole breadwinners of their households as husbands or partners have lost their jobs. Others are supporting adult children and grandchildren, either keeping them in their own homes or sending money every month. And some younger nurses of Baby Boomers with inadequate retirement incomes are helping their parents out as well.

Listening to their stories, it’s clear that living-wage jobs are desperately needed, secure retirement systems are needed, national single-payer healthcare for every individual is needed—all key components of the Main Street Contract that nurses are demanding for all Americans.

Here are two stories of two nurses at completely different stages in their careers, but who have one thing in common: They are both supporting family members who otherwise would not be able to make ends meet or have access to basic needs such as healthcare.
Sue Cannon, RN

Investment advisors often tell those approaching retirement age not to put all their eggs in one basket, and registered nurse Sue Cannon is taking that advice quite seriously. Like many other RNs in their late 50s and early 60s, Cannon’s retirement nest egg is not quite what she had hoped, so she’s counting on real eggs, from the chickens she raises in her backyard, to supplement her diet when she eventually has to stop working.

“I figure that they’ll lay eggs and at least I’ll always have something to eat,” said Cannon, as her three hens, Omelette, Quiche, and Fugitive, pecked at the ground around her ankles. Just a few feet away, Cannon, a novice gardener, is trying her hand at growing vegetables and herbs.

Cannon is 58 and nursing is a second career for her. She became an RN some 14 years ago after raising two children, earning a doctorate degree in German literature and folklore, and a few stints in other jobs. In 2004, after working seven years as an RN, Cannon took one look at her practically nonexistent 401(k) account and realized that she should find a job that offered a real pension, the kind of defined-benefit plan that guarantees a retiree a fixed amount of income every month. She also wanted to work at a unionized hospital where conditions were safer and nurses had a say about their practice. So Cannon found a surgical ICU position at UC Irvine Medical Center, one of a group of hospitals run by the statewide University of California (UC) system.

UC pensions have traditionally been good. The pension funds are managed by investment professionals and overseen by a public board. In recent years, however, officials ranging from former Gov. Arnold Schwarzenegger to the UC Regents have tried to eliminate these guaranteed pensions, either proposing to convert them into 401(k) accounts (which individuals would have to manage themselves) or to have new hires get the inferior 401(k) accounts.

Around that time, Cannon also felt real pressure to make more money. Her 20-something daughter, Emily, who had been studying for her master’s degree in education and teaching in New York City, developed a painful illness that prevented her from working. To keep her health insurance when she needed it the most, Emily had to pay $500 a month for COBRA—money she didn’t have. So Cannon paid the premiums. Emily was eventually diagnosed with interstitial cystitis, and over the next few years, Cannon helped cover many of her medical bills as well as her rent when she could not work or was between jobs, sometimes up to $1,000 a month.

Though Emily now has health insurance through her job at a nonprofit that recruits professionals in math and sciences to become teachers, it can still be expensive to manage her condition and Cannon contributes $400 a month toward her care. In July, Emily learned that her work was changing health plans and that her rheumatologist would no longer be in her network; she may need to pay 40 to 60 percent of out-of-network costs for the doctor to keep overseeing treatments she is receiving.

Cannon’s youngest, Jonathan, also needed financial help. After graduating from the University of California Los Angeles in 2004, he has had difficulty finding a full-time job. He now works 28 hours per week as a teacher’s aide for the princely sum of $15 an hour.

Cannon and her ex-husband also supplement Jonathan’s income: She sends him money toward rent, pays for his cell phone and auto insurance, and her ex-husband subsidizes his car.

To pay for all these extra expenses on top of supporting herself, Cannon worked furiously, picking up extra shifts and pulling a lot of overtime. A few years ago, Cannon made a strategic decision to move to the Bay Area and transfer to the UC medical center in San Francisco, where she would ultimately qualify for a greater pension because the wage scales are higher than at her previous facility. She figures that at her current rate, she’ll need to work to at least age 68 in order to cover all her expenses. That’s assuming she can sell her house in Irvine and buy a place to live outright where she can raise chickens and maybe sheep. And assuming she is no longer sending money to her children. “When I’m retired, I’ll still be working,” said Cannon. “That’s the idea of keeping the chicken and the sheep and the garden—that I’m doing something practical that I can also live on.”

Cannon says she’s “blessed” to be able to help her daughter and son, but her contributions have not come without some cost to herself. She lives very modestly, in a one-bedroom cottage in Petaluma. Though her car has logged 190,000 miles on the odometer and she’s probably due for a new one, she holds off. She hasn’t been able to travel as extensively as she’d like to, settling for short weekend and day trips. “I just keep making it work,” said Cannon. “I’m not replacing things.”

Though everything is fine for the moment, Cannon lives with a nagging fear that if she gets sick and can’t work, or loses her job, that her life—and her kids’ lives—will crumble. She’s also concerned that she may need to start supplementing the income of her 85-year-old mother, who lives in a Salt Lake City assisted living home, if her Medicare and Medicaid benefits are cut. “One of the things I worry about is being two paychecks away from devastation,” she reflected. “If I lost my job, or had an accident, things devolve very quickly for my kids and myself. It’s not that far away for me to end up on the street.”
Worse, Cannon is afraid that that her children’s financial and work futures will never improve. “I worry for my kids that they might just never be able to work at their full potential, to have a full-time, satisfying job that allows them to give all they have as well as support themselves,” said Cannon.

Cannon says she’s disappointed that government has let the corporate sector run amuck, hoarding billions of dollars while entire generations of young people amass tens of thousands of dollars in school debt, then can’t find meaningful, living-wage jobs and have few opportunities. “Our country is not broke. We’re just as rich as we ever were,” said Cannon. “It’s frustrating for me to see that it’s no longer important for us to take our wealth and invest it in our kids, much less the arts, smooth roads, bridges, and parks. I grieve that our society has lost its way on those things.”

In 2008, Sager’s father came down with some health problems. First he got diverticulitis and had to have part of his colon removed. That prompted a series of other surgeries. Plus he had to have a hip replacement. Though he had health insurance through his wife’s job, they still had to pay deductibles, copays, and 20 percent of the medical bills. Sharon cashed out part of her 401(k) savings to pay those, so there’s not a lot left to retire on. They will be almost completely dependent on Social Security when they can no longer physically work.

“Those few years when he was having all those surgeries really put them back,” said Sager. To keep their health costs down, Sager’s mother avoids going to the doctor if she can help it. Though she’s borderline diabetic and herself suffers from diverticulitis, she controls those conditions through her diet. But she just endures the arthritis, occasional cold, or pulled Achilles tendon.

“I worry about them for sure, whether they’re going to be able to support themselves when they retire,” said Sager when asked about their future. What will happen to their household arrangement when her parents can’t work or when she wants to start her own family?

“We just kind of deal in the moment,” said Sager. “I’m not sure what’s going to happen. I don’t think Mom knows, either.”

About six years ago, Sager noticed that her father’s income kept shrinking each time the music store he worked for got bought out by a different, larger company. It got to the point where her parents weren’t able to meet their expenses. Sager’s mother started asking her for small loans to bridge the gaps every month, and eventually Sager offered, after securing a full-time nursing position at Menorah Medical Center, to pay the mortgage.

“I’m sure it’s really hard for a parent to ask their child for money,” said Sager, “but she’s good and works so hard. Until I got my nursing salary, I couldn’t really afford to live, either. Fortunately, we get along really well together.”

For more information and to join the campaign, go to www.mainstreetcontract.org. Tell your own story and learn how you can help heal America.

Lucia Hwang is editor of National Nurse.
CE Home Study Course

HIPAA—The Health Insurance Portability and Accountability Act What RNs Need to Know About Privacy Rules and Protected Electronic Health Information

This home study CE is part one of a two-part series. Look for the second installment and the CE quiz to appear in the next issue of National Nurse.

Description

This home study course provides a review of pertinent HIPAA definitions, and the legislative history and intent of relevant privacy rules and regulations as they relate to the collection, use, and disclosure of protected, individually identifiable electronic health information. It describes the appropriate safeguards that RNs must follow to protect the privacy of patients’ health information and discusses the rationale and strategies for protecting RN professional practice and credibility with the public. In addition, a selected review of publicly reported HIPAA violations and penalties are included to increase awareness and help RNs avoid the risk of discipline by the employer, their professional licensing board, or the imposition of penalties and fines imposed by civil or criminal courts.

Objectives: Upon completion of this home study RNs will be able to:
- Describe the intent of HIPAA regulation
- List identifying information that is protected under HIPAA
- Describe how HIPAA affects provider communications and electronic medical records
- Describe how HIPAA impacts patients’ right to privacy and confidentiality
- Identify strategies to prevent privacy and data breaches from occurring and reduce risk of personal, professional, and organizational liability

Introduction

Protecting patient confidentiality has always been an important responsibility of the nursing profession, and few government regulations have generated as much anxiety among healthcare providers as the federal medical privacy rules. Nurses are in a unique position; they are often the first contact patients have within healthcare systems. Patients share personal and intimate details and may have to reveal embarrassing information about their lifestyle, living conditions, past medical history, and personal habits during the assessment process so an accurate diagnosis and care plan can be formulated. The assumption is that nurses won’t disclose the information in a less-than-professional and respectful manner to anyone who isn’t involved in their care.

The HIPAA regulations were instituted to protect the privacy of individuals by safeguarding individually identifiable healthcare records, including those housed in electronic media. Protection of individual medical records extends not only to clinical healthcare sites but also to all ancillary healthcare providers, such as pharmacies, laboratories, and third-party payers. Each healthcare provider dealing with client healthcare data must provide for secure and limited access to the information. The intent of HIPAA regulation includes four main components: 1) Establishes limits for appropriate use and release of healthcare information; 2) Provides individuals with more control over their health information; 3) Requires the majority of healthcare providers and their agents to comply with safeguards to protect individual privacy related to healthcare information; 4) Delineates a set of civil and criminal penalties holding HIPAA regulation violators accountable if the patient’s confidential healthcare privacy is compromised.

Getting HIPAA with IT (Information Technology). When physicians profess the Hippocratic Oath, they make a solemn pledge: “What I may see or hear in the course of the treatment…, which on no account one must spread abroad, I will keep to myself, holding what I may see or hear in the course of the treatment…, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.” Lo, Dornbrand, and Dubler (2005) asserted that Hippocrates could never have envisioned the world today, with telephones, faxes, and e-mail communications, or the number of other healthcare providers and administrators involved in the care of a patient.

Historically speaking, confidentiality isn’t just a legal issue; it’s also a matter of ethics. Ethically, overriding confidentiality to prevent harms to third parties is warranted when several criteria are met: the potential harm to identifiable third parties is serious and likely (necessity); the breach of confidentiality allows effective steps to prevent harm (effectiveness); there is no less restrictive alternative for protecting those at risk; disclosure is limited to what is essential to avert harm and harms to the patient are minimal and acceptable (proportionality), and policies are justified publicly (transparency).

The concept of confidentiality also appears in documents published by the National League for Nursing, the American Civil Liberties Union, and the American Association of Colleges of Nursing. In addition,
patients also have other rights to privacy which predated HIPAA that cover a broader area than just their medical information. In general, a patient’s right to privacy falls within one of four domains:

(1) Use of the patient’s likeness or name without his or her consent for the commercial benefit of the defendant. This refers to use of photographs or names that may be included in advertising for the healthcare agency or provider without the patient’s permission;

(2) Unreasonable intrusion into the patient’s private affairs and seclusions. This involves observation of patient care (such as by medical device vendors, nursing, medical, and technical students) or taking of photographs for any purpose without the patient’s consent.

(3) Public disclosure of private facts about the patient. Private information provided to others who have no legitimate need or right to know that information.

(4) Placing the patient in a false light in the public eye. This type of invasion involves publishing information that is normally considered offensive and is untrue.

HIPAA standards for the privacy and confidentiality of individually identifiable protected health information is congruent with our ethical obligations as professionals; the regulations reinforce behaviors that should already be second nature for most RNs. Nurses are legally and ethically obligated to keep information about their patients confidential. Confidentiality is crucial to the provision of nursing care and is an important part of the basis for a trusting patient/family and professional nurse relationship. If confidentiality is broken, patients may experience great harm and may not seek needed medical care. They may not provide a truthful medical history if they believe that others will know about their medical condition. Patient confidentiality is an important value to the nursing profession.

Nurses should not discuss a patient’s examination, observation, conversation, or treatment with other clients or staff not assisting in a specific patient’s care. Only the staff directly involved in a specific patient’s care has legitimate access to the patient’s records. Patients and/or their legally designated representatives frequently request copies of their medical records and they have the right to read those records. Each institution has policies for controlling the manner in which records are shared. In most situations, patients are required to give written permission for release of medical information.

Nurses are responsible for protecting records from all unauthorized readers. When nurses and other healthcare professionals have a legitimate reason to use records for data gathering, research or continuing education, appropriate authorization must be obtained according to agency policy. Student nurses and faculty may be required to present identification indicating access to the record is authorized. The nurse assigned to the patient should know the location of the record at all times.

HIPAA’s roots began in the United States Senate in 1995 as an insurance reform bill introduced by Sen. Edward Kennedy (D-Massachusetts) and Sen. Nancy Kassebaum (R-Kansas). The bill became known as the Kennedy-Kassebaum bill, and it was remarkable for garnering unique bipartisan support, considering the fact that its main goal was to curb market indiscretions and abuses in the health insurance industry. Cosponsors included liberals such as Paul Wellstone (D-Minnesota) and conservatives such as Richard Lugar (R-Indiana). The final version passed the Senate by unanimous consent. The Senate bill was an extension of the insurance reforms passed in the Consolidated Omnibus Budget Reconciliation Act (COBRA) a decade earlier. COBRA enabled workers to continue to purchase the same health insurance coverage they had under their employer-based plan upon leaving their job. The Kennedy-Kassebaum bill constrained payers from limiting or excluding employees from coverage for preexisting medical conditions.

The House bill, introduced in 1996, contained what would become the “administrative simplification” provisions of HIPAA. The House version reflected recommendations made by a special committee assembled by the first Bush administration, known as the Work Group for Electronic Data Interchange. Their charge was to find ways to reduce healthcare administrative costs. HIPAA passed the House of Representatives by a vote of 421 to 2 and President Clinton signed HIPAA into law on Aug. 21, 1996.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limited the extent to which health plans may impose preexisting condition limitations and prohibits discrimination of health plans against individual participants and beneficiaries based on health status. One of the ways that insurance companies protect their profits is by not insuring certain preexisting conditions that patients have when they obtain group health insurance coverage. For example, if a patient has heart disease, an insurer may agree to provide health insurance for the client for all medical problems except heart disease. HIPAA requires insurers to only limit coverage for a preexisting condition for 12 months in most cases. This means that if an employee has group health insurance coverage with his job for at least 12 months and then changes jobs, the second employer cannot impose preexisting condition exclusion on the individual.

The advantages of HIPAA are that employees can change jobs without losing coverage as a result of preexisting coverage exclusion as long as they have had 12 months of continuous group health insurance coverage.

HIPAA (Public Law 104-191) provided the first comprehensive federal protection for the privacy of individually identifiable health information (IIHI). Until Congress passed HIPAA, personal health information (PHI) was protected by a patchwork of state and federal laws. In many circumstances, patients’ health information could be distributed without their consent for reasons having nothing to do with their medical treatment or healthcare reimbursement. Sections 261 through 264 of HIPAA required the Secretary of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy, and security of health information. Collectively these are known as the “Administrative Simplification” provisions.

HIPAA required the secretary to issue privacy regulations governing individually identifiable health information. HHS developed a proposed rule and released it for public comment on Nov. 3, 1999. The department received more than 52,000 public comments, and on Dec. 28, 2000, the Privacy Rule was published. Legislation to protect patient privacy for health information (HIPAA) became a final rule in April 2001 and took effect in April 2003. This legislation governs all areas of information management, including reimbursement, coding, security, and client records. Healthcare providers (e.g. hospitals, clinics, physicians’ offices, clinical laboratories, and pharmacies) are required to provide their clients with greater control over personal healthcare information. Under newer regulations, in order to eliminate barriers that could delay access to care, providers are required only to notify clients of their privacy policy and make a reasonable effort to get written acknowledgment of this notification.
**HIPAA Violations: Consequences, Terms, Conditions, and Enforcement.** Failure to comply with HIPAA can result in civil and criminal penalties (42 USC § 1320d-5).

**Civil Penalties.** The “American Recovery and Reinvestment Act of 2009” (ARRA) that was signed into law on Feb. 17, 2009, established a tiered civil penalty structure for HIPAA violations (see sidebar). The Secretary of the Department of Health and Human Services (HHS) still has discretion in determining the amount of the penalty based on the nature and extent of the violation and the nature and extent of the harm resulting from the violation. The Secretary is still prohibited from imposing civil penalties (except in cases of willful neglect) if the violation is corrected within 30 days (this time period may be extended).

**Criminal Penalties.** In June 2005, the U.S. Department of Justice (DOJ) clarified who can be held criminally liable under HIPAA. Covered entities and specified individuals, as explained below, who “knowingly” obtain or disclose individually identifiable health information in violation of the Administrative Simplification regulations face a fine of up to $50,000, as well as imprisonment up to one year. Offenses committed under false pretenses allow penalties to be increased to a $100,000 fine, with up to five years in prison. Finally, offenses committed with the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm permit fines of $250,000, and imprisonment for up to 10 years.

**Covered Entity and Specified Individuals.** The DOJ concluded that the criminal penalties for a violation of HIPAA are directly applicable to covered entities—including health plans, healthcare clearinghouses, healthcare providers who transmit claims in electronic form, and Medicare prescription drug card sponsors. Individuals such as directors, employees, or officers of the covered entity, where the covered entity is not an individual, may also be directly criminally liable under HIPAA in accordance with principles of “corporate criminal liability.” Where an individual of a covered entity is not directly liable under HIPAA, they can still be charged with conspiracy or aiding and abetting.

**Knowingly.** The DOJ interpreted the “knowingly” element of the HIPAA statute for criminal liability as requiring only knowledge of the actions that constitute an offense. Specific knowledge of an action being in violation of the HIPAA statute is not required.

**Exclusion.** The Department of Health and Human Services (DHHS) has the authority to exclude from participation in Medicare any covered entity that was not compliant with the transaction and code set standards by Oct. 16, 2003 (where an extension was obtained and the covered entity is not small) (68 FR 48805).

**Enforcing Agencies.** The DHHS Office of Civil Rights (OCR) enforces the privacy standards, while the Centers for Medicare & Medicaid (CMS) enforces both the transaction and code set standards and the security standards (65 FR 18895).

**Practice Points.** It is important for RNs to be aware of identifying information that is protected by HIPAA which may not be initially perceived as health information. The Privacy Rule allows a covered entity to de-identify data by removing all 18 elements that could be used to identify an individual. Examples include name, address, phone number, account numbers, medical record numbers, fax numbers, website address, Social Security number, all geographic subdivisions smaller than a state, all elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death, and biometric identifiers including voiceprints and fingerprints. Age also becomes an identifier in seniors older than age 89! The Privacy Rule protects all individually identifiable health information (PHI) held or transmitted by a covered entity or its business associates, in any form or media, whether electronic, paper, or oral. There are no restrictions on the use or disclosure of de-identified health information.

De-identified health information neither identifies nor provides a reasonable basis to identify and individual. There are two ways to de-identify information according to the United States Department of Health and Human Services: either (1) a formal determination by a qualified statistician; or (2) the removal of specified identifiers of the individual and of the individual’s relatives, household members, and employers is required, and is adequate only if the covered entity

<table>
<thead>
<tr>
<th>HIPAA Violation</th>
<th>Minimum Penalty</th>
<th>Maximum Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual did not know (and by exercising reasonable diligence would not have known) that he/she violated HIPAA</td>
<td>$100 per violation, with an annual maximum of $25,000 for repeat violations (Note: maximum that can be imposed by state attorneys general regardless of the type of violation)</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation due to reasonable cause and not due to willful neglect</td>
<td>$1,000 per violation, with an annual maximum of $100,000 for repeat violations</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation due to willful neglect but violation is corrected within the required time period</td>
<td>$10,000 per violation, with an annual maximum of $250,000 for repeat violations</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
</tr>
<tr>
<td>HIPAA violation is due to willful neglect and is not corrected</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
<td>$50,000 per violation, with an annual maximum of $1.5 million</td>
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has no actual knowledge that the remaining information could be used to identify the individual.

**Public Health and Safety Reporting Provisions.** Most state and federal jurisdictions have a variety of statutes that impose a duty to report selected confidential patient and/or client information, which falls into one of four major categories: (a) vital statistics, such as births and deaths; (b) infections and communicable diseases, such as diphtheria, tetanus, syphilis, and active tuberculosis; (c) child or elder abuse and neglect; and, (d) violent incidents such as gunshot and knife wounds. The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission. The rule also recognizes that public health reports made by covered entities are an important means of identifying threats to the health and safety of the public at large, as well as individuals. Accordingly, the rule permits covered entities to disclose protected health information without authorization for specified public health purposes.

Generally, covered entities are required to reasonably limit the protected health information disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose. A “public health authority” is an agency or authority of the United States government, a state, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with a public health agency. Examples of a public health authority include state and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA).

**Yes, they can! Workplace Medical Surveillance.** A covered healthcare provider who provides a healthcare service to an individual at the request of the individual’s employer, or provides the service in the capacity of a member of the employer’s workforce, may

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### References


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disclose the individual’s protected health information to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of State laws having a similar purpose. The information disclosed must be limited to the provider’s findings regarding such medical surveillance or work-related illness or injury. The covered healthcare provider must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided).

**Ensuring Confidentiality of Electronically Stored PHI on Computers.** A data security breach can have devastating consequences for healthcare organizations as well as patients and clients. To reduce the risk of such an occurrence, healthcare agencies have developed policies and procedures to ensure compliance with the HIPAA Security Rule which has been mandatory since 2005. This rule governs the security of protected health information. Suggested guidelines and policies for covered entities and professional providers include:

- **A personal password is required** to enter and sign off computer entries, orders, files, along with policies against sharing this password with anyone, including other health team members.
- **Never leave a computer terminal unattended** after logging in.
- **Do not leave patient information displayed** on a monitor where others may see it.
- **Shred all** computer-generated work sheets.
- **Know the facility’s policy and procedure for correcting an entry error.**
- **Follow agency procedures** for documenting sensitive material such as a diagnosis of AIDS.
- **Information technology (IT) personnel must install a firewall** to protect the server from unauthorized access.
- **Covered entities and healthcare employers are required to keep all policies and procedures regarding HIPAA compliance in written format. All changes to policies and procedures must be distributed to affected employees.** And any violation or employee sanction and the issue resolution must be documented. For example, except when treating or caring for the patient, any access of friends, relatives, or your own personal records will generally be reportable.

**The Patient Safety and Quality Improvement Act of 2005.** (PSQIA) establishes a voluntary reporting system designed to enhance the data available to assess and resolve patient safety and healthcare quality issues. To encourage the reporting and analysis of medical errors, PSQIA provides federal privilege and confidentiality protections for patient safety information, called patient safety work product. PSQIA authorizes HHS to impose civil money penalties for violations of patient safety confidentiality. PSQIA also authorizes the Agency for Healthcare Research and Quality (AHRQ) to list patient safety organizations (PSOs). PSOs are the external experts that collect and review patient safety information.

The Patient Safety Rule was published in the Federal Register on Nov. 21, 2008, and went into effect on Jan. 19, 2009. The Patient Safety Rule implements select provisions of PSQIA. In summary, the secretary of Health and Human Services adopted rules to implement certain aspects of the Patient Safety and Quality Improvement Act of 2005, Pub. L. 109–41 (Patient Safety Act). The final rule establishes a framework by which hospitals, doctors, and other healthcare providers may voluntarily report information to patient safety organizations (PSOs), on a privileged and confidential basis, for the aggregation and analysis of patient safety events. The final rule outlines the requirements that entities must meet to become PSOs and the processes by which the secretary will review and accept certifications and list PSOs. It also describes the privilege and confidentiality protections for the information that is assembled and developed by providers and PSOs, the exceptions to these privileges and confidentiality protections, and the procedures for the imposition of civil monetary penalties for the knowing or reckless impermissible disclosure of patient PHI.

The Patient Safety Act focuses on creating a voluntary program through which healthcare providers can share information relating to patient safety events with PSOs, with the aim of improving patient safety and the quality of care nationwide. The statute attaches privilege and confidentiality protections to this information, termed “patient safety work product,” to encourage providers to share this information without fear of liability and creates PSOs to receive this protected information and analyze patient safety events. These protections will enable all healthcare providers, including multi-facility healthcare systems, to share data within a protected legal environment, both within and across states, without the threat that the information will be used against the subject providers’ safety work product.

The Patient Safety Act is clear that it is not intended to interfere with the implementation of any provision of the HIPAA Privacy Rule. The statute also provides that civil monetary penalties cannot be imposed under both the Patient Safety Act and the HIPAA Privacy Rule for a single violation. In addition, the statute states that PSOs shall be treated as business associates, and patient safety activities are deemed to be healthcare operations under the HIPAA Privacy Rule.

When the Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law by President Obama on Feb. 17, 2009, it included a new definition of “breach” and requires business associates of covered entities to comply fully with the HIPAA Administrative Simplification Security Rule beginning Feb. 17, 2010. The new definition of breach follows and the Security Rule is available on the HIPAA.com website.

**Breach Notification Rule.** Interim final breach notification regulations, issued in August 2009, implement section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act by requiring HIPAA-covered entities and their business associates to provide notification following a breach of unsecured protected health information. Similar breach notification provisions implemented and enforced by the Federal Trade Commission (FTC), apply to vendors of personal health records and their third-party service providers, pursuant to section 13407 of the HITECH Act.

**HITECH Act definition of “breach.”**

(A) In General. The term “breach” means the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

(B) Exceptions. The term “breach” does not include:

(i) Any unintentional acquisition, access, or use of protected health information by an employee or individual acting under the authority of a covered entity or business associate if -
flags include:
but not criminal penalties, for violations. Failure to comply can mean civil monetary penalties, subject to compliance with the rule because of their billing and collection practices. Failure to comply can mean civil monetary penalties, but not criminal penalties, for violations.

Red Flag Rules. In response to these new privacy laws effective on Jan. 1, 2009, as well as other recent developments including Centers for Medicare and Medicaid Services (CMS) performing proactive auditing and enforcement of the HIPAA Security Rule, and the issuance of the Federal Trade Commission (FTC) Red Flag Rules, which requires organizations to implement an identity theft detection and prevention program, many employers are re-evaluating their privacy/security policies, computer access strategies and procedures. It's been well established that many healthcare entities are subject to compliance with the rule because of their billing and collection practices. Failure to comply can mean civil monetary penalties, but not criminal penalties, for violations. According to the FTC, a red flag is “a pattern, practice, or specific account activity that indicates the possibility of identity theft.” Red flags include:

Alerts or warnings from a consumer reporting agency;
Suspicious documents and/or personal identifying information e.g., an inconsistent address or nonexistent Social Security number);
Unusual use of or suspicious activity concerning a patient account; and,
Notices of possible identity theft from patients, identity-theft victims, or law enforcement agencies.

However, there's a twist that complicates compliance. The Joint Commission requires healthcare organizations to meet National Patient Safety Goals (NPSGs) to improve patient safety. Among other things, healthcare organizations, including acute-care and post-acute care facilities, must “reliably identify” the individual as the person for whom the service or treatment is intended. The Joint Commission requires healthcare organizations and providers to obtain two patient identifiers in order to reliably match the service or treatment to a specific individual.

Because of the economic downturn and the growing population of uninsured, identity theft, or co-opting someone's financial identity in order to receive medical care will continue to be a growing concern. Nurses must also remain vigilant in order to protect patients from unscrupulous practitioners who perform procedures that aren't medically indicated for financial gain.

HIPAA's Effect on Research. For purposes of research and education, most agencies allow staff nurses, students, quality liaisons, and graduate health professionals access to patient records. The records are used in client conferences, clinics, rounds, studies, and written papers. The students and researchers are bound by strict legal and ethical obligation to hold all information in confidence. This holds true for RNs, NPs, and MDs who may plan to participate in morbidity and mortality conference for identification and mitigation of risk factors and evaluation of standards of care for compliance, or for debriefing and analysis after a sentinel event. RNs should not assume they have the authority as an individual to review and evaluate a patient's plan of care once they are no longer caring for a patient who has expired, transferred off the unit, or has been discharged.

However, many researchers have reported that HIPAA restrictions have affected their ability to perform retrospective, chart-based research as well as their ability to prospectively evaluate patients by contacting them for follow-up. A study from the University of Michigan demonstrated that implementation of the HIPAA Privacy Rule resulted in a drop from 96 percent to 34 percent in the proportion of follow-up surveys completed by study patients being followed after a heart attack. Another study, detailing the effects of HIPAA on recruitment for a study on cancer prevention, demonstrated that HIPAA-mandated changes led to a 73 percent decrease in patient accrual, a tripling of time spent recruiting patients, and a tripling of mean recruitment costs.

In addition, informed consent forms for research studies now are required to include extensive detail on how the participant's protected health information will be kept private. While such information is important, the addition of a lengthy, legalistic section on privacy may make these already complex documents even less user friendly for patients who are asked to read and sign them.

These data suggest that the HIPAA privacy rule, as currently implemented, may be having negative impacts on the cost and quality of medical research. Dr. Kim Eagle, professor of internal medicine at the University of Michigan was quoted as saying, “Privacy is important, but research is also important for improving care. We hope that we will figure this out and do it right.”

The complexity of HIPAA, combined with potentially stiff penalties for violators, can lead physicians and medical centers to withhold information from those who may have a right to it. A review of the implementation of the HIPAA Privacy Rule by the U.S. Government Accountability Office found that healthcare providers were “uncertain about their [legal] privacy responsibilities and often responded with an overly guarded approach to disclosing information than necessary to ensure compliance with the Privacy Rule.” Reports of this uncertainty continue.

In addition, it should be noted that HIPAA provided a floor under the States regarding privacy, but it did not impose a privacy ceiling. It specifically empowered states to keep or pass their own privacy laws under certain circumstances. For example, many states single out certain classes of medical information for special handling. The most common include records of patient care involving mental health treatment, drug and alcohol abuse or addictions, and certain diseases such as HIV/AIDS. Although HIPAA usually preempts contrary state law, there are four situations in which state law preempts HIPAA. The exceptions are for: 1) state reporting laws; 2) health plan reporting and information; 3) specific exemptions determined by the HHS secretary; and 4) when state health privacy provisions are more stringent.

HIPAA versus Hype: The Role of Professional Judgment. Although abuse of electronic databases and communication created the need for explicit standards, as we now know, HIPAA standards are not limited to electronic information transfer. They apply to all personal health information—electronic, written, oral, and visual. In part, because of hefty fines associated with violations, many healthcare organizations have invested substantial resources to educate providers and employees.
about HIPAA. It's become apparent that many of these “education” programs have been more focused on communicating threats of discipline and warnings to staff about the law rather than the proper place of privacy and confidentiality in patient care.

As nurses and other providers consider the restrictions on information transfer, whether based on HIPAA or on the precepts of professional ethics, one basic rule should be remembered: Patient care and patient safety come first! It should be noted that HIPAA contains explicit exclusions for payment, healthcare operations, and treatment. PHI that is required for these three purposes is exempt from HIPAA’s restrictions. When HIPAA appears to compromise good patient care or safety it most likely indicates a misunderstanding of HIPAA. Apparent conflicts between HIPAA and patient safety often reveal underlying unsafe practices that can disrupt workflow and put patients at risk. One often cited area of confusion and conflict that poses a conundrum for staff is between privacy and safety.

Our obligation to respect patient privacy is an ethical imperative, but we must also act in our patients’ best interests. The ethical precepts of beneficence and nonmaleficence require that we ensure our patients’ safety in the things that we, as clinicians, do for them. We also have a duty to identify and change system problems that increase the risk of medical errors and harm. For instance, because recovery rooms and intensive care units are examples of patient care settings that should enhance our ability to observe and monitor immediate post-operative and critically ill patients for subtle signs and symptoms of deterioration and complications, one must judiciously question the use of privacy drapes in these settings, unless staffing permits continuous direct observation.

Incidental Uses and Disclosures. Many customary healthcare communications and practices play an important or even essential role in ensuring that individuals receive prompt and effective healthcare. Due to the nature of these communications and practices, as well as the various environments in which individuals receive healthcare or other services from covered entities, the potential exists for an individual’s health information to be disclosed incidentally. For example, a hospital visitor may overhear a provider’s confidential conversation with another provider or a patient, or may glimpse a patient’s information on a sign-in sheet or nursing station whiteboard.

The HIPAA Privacy Rule is not intended to impede these customary and essential communications and practices and, thus, does not require that all risk of incidental use or disclosure be eliminated to satisfy its standards. Rather, the Privacy Rule permits certain incidental uses and disclosures of protected health information to occur when the covered entity has in place reasonable safeguards and minimum necessary policies and procedures to protect an individual’s privacy. How the Privacy Rule Works. The Privacy Rule permits certain incidental uses and disclosures that occur as a by-product of another permissible or required use or disclosure, as long as the covered entity has applied reasonable safeguards and implemented the minimum necessary standard, where applicable, with respect to the primary use or disclosure. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a result of another use or disclosure that is permitted by the rule. However, an incidental use or disclosure is not permitted if it is a by-product of an underlying use or disclosure which violates the Privacy Rule.

Reasonable Safeguards. A covered entity must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule, as well as that limit incidental uses or disclosures. It is not expected that a covered entity's safeguards guarantee the privacy of protected health information from any and all potential risks. Reasonable safeguards will vary from covered entity to covered entity depending on factors, such as the size of the covered entity and the nature of its business. In implementing reasonable safeguards, covered entities should analyze their own needs and circumstances, such as the nature of the protected health information it holds, and assess the potential risks to patients’ privacy. Covered entities should also take into account the potential effects on patient care and may consider other issues, such as the financial and administrative burden of implementing particular safeguards.

Minimum Necessary Standard. Covered entities must implement reasonable minimum necessary policies and procedures that limit how much protected health information is used, disclosed, and requested for certain purposes. These minimum necessary policies and procedures also reasonably must limit who within the entity has access to protected health information, and under what conditions, based on job responsibilities and the nature of the business. The minimum necessary standard does not apply to disclosures, including oral disclosures, among healthcare providers for treatment purposes.

LIVE TO TELL

(Continued from page 9)

suffering that those on Wall Street and inside the Beltway prefer not to see or hear. But we are not going to let them suffer in silence any longer.

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—Washington State RN

“I never thought it would happen to me, but it did. Through a series of mismanagement and overtime being cut out, I find myself losing my home to foreclosure. The cost of living is so great I am considering moving to another state. At this point in life to have to start over is so difficult. While I would never ever harm myself, I do have to admit that to go to sleep and not wake up would be a relief; no struggling to pay the bills, no worries about working it out and finding my way.”

—Rhode Island RN

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