Many of us in recent years have joined social networking websites like Facebook and Twitter to connect with college classmates, share interesting articles we’ve come across with friends, and see photos of the grandkids. While these platforms can be a great way to stay in touch with many people at once, most of us may not realize that they also pose a unique threat to workers, and particularly registered nurses. As our article in this issue’s news section explains, employers are monitoring and mining the wealth of personal information employees are publishing through these online networks and using that research to make hiring, firing, and disciplinary decisions. Hospitals may also be trolling social media sites as part of union busting campaigns. Registered nurses’ use of these sites is complicated by their obligation to protect patient privacy under HIPAA, a duty that hospitals are interpreting very strictly. We have learned of and are fighting cases of nurses getting fired or targeted by their employers for what seemed like an innocuous comment or photo that they have posted to Facebook. In some cases, it was friends or coworkers who publicized the content. The bottom line? You never know who may be listening or watching. While we and many experts believe that hospitals are, for the most part, overreacting to employees’ social network activity and are vigorously representing affected members, it may be wiser for the time being to err on the side of caution and refrain from posting information about work. You’ll also find a handy list of suggestions for using these networks to help you limit your exposure to prying eyes. Yes, please share this article with your Facebook friends and Twitter followers!

On the flip side, one area where nurses’ voices about their work is expanding is in book publishing. Every summer, we try to review any books we encounter about nursing, along with general healthcare titles nurses might be interested to read. This year, the common theme seems to be books featuring what registered nurses have to say, written by the RNs themselves. As the profession most trusted by the public, it makes sense that readers want to know our perspective on today’s nursing and healthcare issues. Each review is relatively short and easy to digest while you’re on a break or as a quick read before bedtime.

And as usual, our news section is filled with exciting reports about RN advocacy around the country. Veterans Affairs RNs are closer to restoring some of their bargaining rights, RNs in Massachusetts, Maine, and Minnesota are fighting mightily against concessions, and nurses nationally are lobbying relentlessly for ratios.

We hope you are enjoying your summer and recharging your minds, bodies, and spirits for all the great work we’ll be tackling this fall.

Deborah Burger, RN | Karen Higgins, RN | Jean Ross, RN
National Nurses United Council of Presidents
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In our annual summer book review, we find that nurses’ stories are taking off everywhere.
IN RECENT MONTHS, news reports have been piling up of registered nurses and other workers getting fired or disciplined by their employers for items they are posting on social networking websites such as Facebook, Twitter, and MySpace. While NNU is vigorously defending nurses in a number of cases and hopes to win, it’s a disturbing trend. Sometimes it’s a seemingly innocuous status update about “the grumpy guy in room 9” that hospitals fear may be used to identify a patient and run afoul of health privacy laws. Sometimes it’s a photo a nurse has posted of coworkers at the pub without realizing that someone was holding a union pamphlet—perhaps prematurely outing a supporter to union busters. And sometimes it’s a link to a tasteless YouTube video completely unrelated to work, but which causes human resources to question the good judgment and professionalism of the poster.

Many workers don’t understand that many constitutional rights, such as the First Amendment, don’t apply at work, and social media is making matters worse.

“Employees are using social media, both at work and at home, to publish a stunning

This article and suggestions are not meant to constitute legal advice.

SUGGESTIONS FOR SMART SOCIAL MEDIA USE

Consider adopting a policy of never posting anything about work or a shift. We mean anything. Not even “Tough shift at work today” or “So busy, no time for lunch!”

Think twice before you post anything, and then think again. The rule of thumb is: Would you want this statement, comment, picture, or video about you to appear on a public bulletin board?

Explore all the privacy and security settings in Facebook, Twitter, Flickr, and other sites. Though there’s no way to guarantee complete privacy, use “customize settings” in Facebook to set restrictions to the tightest available, usually “friends only” or “only me.” Check your settings regularly. Facebook is notorious for changing settings to more permissive defaults.

Regularly weed out your Facebook friends and Twitter followers. Delete any you are unsure about. Don’t worry, they won’t know they’re gone. And remember, others can view your friends and pass judgment based on the company you keep.

Log out of Facebook and search your own name to see what appears as your public profile or what results pop up in search engines like Google.

Prevent friends from being able to post on your Facebook “wall.” Use “customize settings” to disable this feature.

Don’t friend managers and supervisors, and reconsider whether acquaintances are really “friends.”

Don’t Facebook, tweet, or text on paid work time. We’re not talking just through your work computers, but also your iPhones and Blackberries. It’s wrong, and employers can use the date and time stamps for discipline.

Don’t ever, ever post or tweet anything about a patient, no matter how innocuous.

Don’t make disparaging comments about your coworkers, management, or employer.

Don’t list your employer or your work email and other contact information on your profile.

Check out the Electronic Frontier Foundation’s blog on how to maximize Facebook’s privacy controls: www.eff.org/deeplinks/2010/05/more-privacy-facebook-new-privacy-controls

Antisocial Behavior
amount of personal information online,” wrote Barbara Camens in a paper she presented at an AFL-CIO lawyers conference in June. “The speed and ease with which words, photos, and other graphic images are being electronically transmitted and widely disseminated…have greatly increased the opportunity for employer monitoring and greatly magnified the workplace risks to employees.” Furthermore, said Camens, use of social media platforms are also “blurring many of the old lines” between work time versus break time, work activity versus off-duty activity, and private versus public information.

Hospitals, other employers, and union-busting firms are using social networking sites to surveil and dig up dirt on employees, as well as screen job applicants. Some 43 percent of employers are actively monitoring employee email; 66 percent monitor employee website visits on company computers; and 10 percent monitor social network sites for employee posts and photographs, according to Camens’ paper. Software programs such as Social Sentry can be set to continuously search social media sites for keywords such as “union.”

Very little legal precedent governs what employers can and can’t do to employees based on their activities on social networking sites, said Lewis Maltby, president of the National Workrights Institute, a Washington, D.C. nonprofit. And patient privacy laws, such as HIPAA, complicate matters further for medical providers. Nonunionized, at-will employees are most vulnerable and, while exceptions exist, can normally be dismissed for any reason or no reason. Unionized employees can attempt to challenge discipline or termination through arbitration, but since few legal protections are on the books for workers, protections are on the books for workers, employers tend to have great latitude at the moment.

“The Internet is an incredibly dangerous area these days for workers,” said Maltby. “You cannot imagine the things that you can get fired for.”

So what is Maltby’s advice? While in most circumstances nurses have done nothing wrong and employers are just overreacting, it may be safer right now to err on the side of caution. “Don’t say anything about work,” he emphasized. “Just don’t do it.”

Maltby acknowledged that this type of self-censorship was not fair and, in the case of RNs, actually could hurt the public if nurses weren’t allowed to discuss how to improve their working conditions. But the ephemeral satisfaction of posting that Facebook comment might be cold comfort when you’re sitting around without a job. With Facebook, users may erroneously assume that they’re protected if they set all their privacy options to “friends only,” not understanding that if any friend reposts their content, it’s their friend’s privacy settings that then apply. Even users who have been careful to establish separate work and personal Facebook accounts may find that certain “crossover” friends who are not as rigorous about their privacy settings may expose the users’ content to unwanted eyes anyway, said Rebecca Jeschke, media relations director for the digital civil liberties group Electronic Frontier Foundation. “It’s really easy to forget who’s listening or who might be listening,” said Jeschke.

Maltby warned that it’s not too much trouble for people who are not your Facebook friends to gain access to your page anyway. “They can always make some pretense of losing your email address and asking one of your friends to login to see your profile,” he said. “If they ask enough people, I bet they’ll get in.”

If nurses can’t talk about work, which for most is such a big part of their lives, what’s the fun of using Facebook and other social media sites anyway? Many experts agreed, but cautioned that the law has simply not caught up to practice yet and until it does, users might want to be extra careful. “You can’t be human on the Internet,” said Maltby. “It’s terrible. If people knew that your constitutional rights go up in smoke when you go to work, it would be easier to get some laws passed.” —Lucia Hwang

Bill to Partially Restore VA Nurses’ Rights Advances

In early August, the Senate Veterans Affairs Committee approved legislation that would restore some essential rights for registered nurses who work at Department of Veterans Affairs facilities by allowing them to grieve pay issues. The committee passed the bill on a 10–6 vote.

The bill, S 3486, introduced by Sen. Sherrod Brown of Ohio on behalf of the 155,000-member National Nurses United, would expand collective bargaining rights for VA nurses on compensation issues, as VA clinicians and nurses who work for other federal agencies already have now. Under U.S. Code Title 38, registered nurses working for the VA are currently barred from bargaining over any issue related to competence, peer review, or compensation. Irma Westmoreland, RN and acting president of the National VA Council, an NNU affiliate, explained, for example, how a VA nurse practitioner who recently worked on a weekend setting up a clinic for flu shots was denied her differential pay.

“Having the right to grieve when a nurse is not paid correctly is the first step of equality for staff nurse rights in the VA,” said Westmoreland.

This isn’t the end game legislation for NNU in the arena of VA nurse collective bargaining rights, but it is significant progress. Two more comprehensive bills, S 362, sponsored by Sen. Jay Rockefeller from West Virginia, and HR 949, sponsored by Rep. Bob Filner from California, have gained large numbers of cosponsors. HR 949 alone has 50 cosponsors.

NNU represents 7,000 VA nurses at 22 VA facilities in a dozen states.

“I cannot wait to see the day when full bargaining rights will be restored for VA nurses,” said Westmoreland. —Donna Smith
After months of fruitless negotiations with the hospital’s recalcitrant anti-union lawyer, the 103 registered nurses of North Adams Regional Hospital are girding for a strike to protect their patients and their quality of life, as their management is refusing to relent in its demands for a host of concessions that would decimate the nurses’ union contract, while creating conditions that would compromise patient care.

The nurses have responded with an intensive public campaign within this small college town nestled in the Berkshires of far northwestern Massachusetts. Lawns signs picturing a crowd of nurses, with the slogan, “We are Family” are ever present outside homes and businesses throughout the small town, with billboards and radio ads carrying the nurses’ call for public support for their effort to “protect the quality of your care and the quality of our lives.” Support for the strike among the nurses themselves was virtually unanimous, with the job action authorized by a vote of 89–1.

Negotiations began in January when management put forth a series of concessions that would leave the union contract totally meaningless. “We have tried to find a way to convince management that the concessions would be very harmful to our patients and they haven’t wanted to hear,” said Ruth O’Hearn, an ICU RN and co-chair of the bargaining unit. “We have good contract language that protects our quality of patient care. Management wants to remove this language and other language that will protect our patients.”

“We have been offering for months now to work with management as they go through tough financial times. Instead of taking up our offer, NARH has given the nurses no option other than setting the strike date. We have absolutely no idea why the hospital has decided to force a strike, and the enormous costs that are associated with it, at a time when they claim to be in such financial trouble. The hospital is a very important resource and we are doing all we can to protect it,” said unit co-chair Mary McConnell, RN.

“We are willing to put ourselves on the
line for the safety of our patients and the quality of our lives. We don’t want to strike, but the issues are so important we are willing to take this action,” said O’Hearn.

“The hospital’s proposals would have a disastrous effect on the quality of patient care. Under their plan NARH once again would be allowed to use mandatory overtime to staff the hospital and patient care would suffer. NARH also wants to eliminate contract language that allows a nurse to decline overtime if she is exhausted or sick. As experienced professional caregivers, we know when we are unable to care for our patients, but the managers seem to think they know more than we do,” said McConnell.

Management also wants to ignore the posted work schedules, to be able to cancel shifts, to mandate extra shifts at their whim, to change the hours of a shift, and to mandate staff to come in early or stay late. This will leave the nurses unable to plan their lives and child care because they essentially would be on call 24/7.

“Currently our contract states that once a schedule is posted it cannot be changed—a nurse cannot request time off, nor can management make changes,” she said. “This new language would allow management to send you home, paying you for your time beginning at the start of your shift to when you were sent home, with an additional hour of pay.”

In addition, the contract would change the flow of weekend coverage and change a provision that gives nurses an additional day off each year.

“Nurses who work the floor in the medical units, critical care, intensive care, and maternity all work every other weekend,” O’Hearn said. “This would require us to work weekends, but they wouldn’t be set. It also would change our extra ‘family day’ to one every three years. As nurses, we become emotionally involved in the care of our patients. We need to be able to make decisions that take mental awareness. We need time to recharge and take care of our own health. This doesn’t provide that.”

According O’Hearn, “We need language to protect our patients and ourselves. We take this very seriously, and we all have a personal responsibility to our patients and ourselves. There is a correlation between personal health and job performance.”

—David Schildmeier

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**What’s Happening with NNU’s National Bills**

Even leading into the August recess and into the pre-midterm election campaign period, federal legislation critical to registered nurses continues to progress.

NNU’s safe patient lift bills, HR 2381 and S 1788, have made exciting progress in recent months. In the House, HR 2381 has garnered 41 cosponsors, and S 1788 in the Senate has three. During our May National Nurses Week events in Washington, D.C., Sen. Al Franken, sponsor of S 1788, hosted a hearing on the bill where testimony by NNU nurses played a critical part in advancing its legislative prospects.

NNU is also working with the disability community on more inclusive language that clarifies that this legislation is necessary to comply with the Americans With Disabilities Act, since having proper lifting standards and equipment is so critical for the care of those with disabling conditions. The disability community’s support will bring together an even wider group of allies to lobby for passage of this bill.

Another of NNU’s national legislative pushes is, of course, the effort to pass safe staffing ratios. Sen. Barbara Boxer of California has introduced S 1031 and Rep. Jan Schakowsky of Illinois has introduced HR 2273. NNU is working to include language in an appropriations bill to require a federal study of positive outcomes associated with ratios, a move which would build momentum for ratios in the next Congressional session. Action on these two bills before the midterm elections is unlikely, though.

Despite the slow pace of legislation, NNU is working to educate legislators in Washington, D.C. and around the country to secure their support for these critical bills that would allow nurses to more fully advocate for patients.

And as we approach election season, it’s important to make sure incumbents and their challengers know that registered nurses support life-saving NNU legislation and vote their values. This work will intensify after the election cycle closes. Nurses know that their patients need them as advocates no matter whether it’s before, after, or the middle of any campaign cycle.

—Donna Smith
The public trusts no profession more than registered nurses, and Michigan gubernatorial candidate Virg Bernero understands that. A week out from the primary election, his campaign team was on the phone. “We’re having a bus tour called ‘Women for Virg’ that will travel around Michigan for an entire day,” they explained, “and we want Michigan Nurses Association nurses on the bus. Can you help?” The call immediately went out and four members from four different hospitals responded.

The July 29 bus trip was created to reach out to Michigan women in support of Bernero’s pro-choice stance, a position which none of the other candidates had taken. Hosted by Bernero’s wife, Teri, and daughters Kelly and Virginia, the bus visited four different cities across Michigan’s mid-section: Lansing, Grand Rapids, Battle Creek, and Bernero’s campaign office in Detroit. The bus included a stop at the Sojourner Truth statue in Battle Creek and finished with a large rally in Detroit, where more than 200 women joined those on the bus, cementing Bernero’s rise in the polls.

“Every election time, you look at what a candidate stands for,” said Bonnie Nesbit, an endoscopy RN from Mercy Health Partners in Muskegon and MNA member, at the Lansing kickoff. “Virg has made it for easy for the nurses this year. On a personal and professional level, he’s the man that’s going to get the job done and that’s why I’m here today.” Other MNA members on the “Women for Virg” tour included RNs Gail Jehl from Sparrow Hospital in Lansing, Renee Curtis from University of Michigan Health System, and Donna Farrell from Borgess Health in Kalamazoo.

Bernero won his Michigan primary on Aug. 3 and is diligently preparing for the Nov. 2 general election. MNA will be supporting Bernero’s campaign with mailings, materials, and nurses to walk door-to-door distributing literature.

—Ann Kettering Sincox
Florida RNs Take Local Strategy with Ratios

Gwen Collins, RN, remembers sitting down and crying at the end of one of her first shifts as a traveling nurse in an Orlando hospital. She had been assigned nine patients and pressured to take a tenth, and she knew that the workload was too heavy for her to provide safe care.

Though Collins ended up refusing the additional assignment, that experience and others like it convinced her that Florida nurses couldn’t rely on hospital administrators to staff safely. They needed a law that would protect them and their patients.

This summer, in venues from city council meetings to grocery store parking lots, Florida RNs have adopted a local strategy in their campaign for that law, the Florida Hospital Patient Protection Act.

“We’re trying to get the public knowledgeable about the situation in hospitals,” said Collins, a member of National Nurses Organizing Committee Florida, which is leading the campaign. “We’re letting them know how important it is for them as potential future patients to keep our hospitals safe, our patients safe, and our nurses happy.”

Opposition from the hospital industry helped stall the bill, which would mandate specific minimum nurse-to-patient ratios in hospitals, in the previous legislative session. But nurses are undaunted. They’ve put together a pledge card that Floridians can sign in support of the bill, and hope to gather at least 7,000 signatures from concerned state residents. The cards read simply: “I am, have been, or will be a patient and I support the Florida Hospital Patient Protection Act.”

On July 20, Collins addressed the city council in her hometown of Gulfport, asking members to endorse the law and urge their state representatives to support it. She pointed to data showing that in California, where nurse-to-patient ratios are enshrined in state law, patients die at a lower rate than in comparable states.

“The hospital nurses in California care for fewer patients than in other states and mortality is lower,” Collins said. “One has to ask, why should we not save lives in Florida as well?” Council members responded favorably and set a date to continue discussing the issue.

The hearing in Gulfport is just one part of a broader push to pass resolutions in support of safe staffing in local jurisdictions around the state in advance of next year’s legislative session. Nurses are also meeting with community organizations, like the Florida Alliance of Retired Americans, and plan to speak at the August meeting of the League of Cities, a consortium of local governments.

Tina Bauer, a longtime nurse in St. Petersburg, is lobbying her city council to support the bill. “I have been a nurse for 33 years and I’ve watched our profession go downhill because of staffing problems,” she said. “So I feel pretty strongly about this issue.”

While nursing has never been an easy job, RNs report that understaffing in Florida hospitals, combined with an elderly population that suffers from a variety of health problems, can make working conditions particularly difficult compared to other states.

“At my hospital, we have many patients in medical-surgical units that are on ventilators and have multiple organ problems,” said Barbara Rivera, an RN in the St. Petersburg area. A typical staffing ratio in that unit is one nurse to seven patients, she said; ICU nurses can care for up to three patients at a time.

NNOC recently collected incident reports from 46 Florida hospitals and found that an overwhelming majority of adverse events were caused by understaffing.

“It’s out of control in Florida hospitals; it’s really abusive,” said Cheryl Lecher, another St. Petersburg RN. Lecher said that even the traveling nurse agency she works for has supported the nurses’ campaign, inviting her to give a seminar to recruiters about why hospital staffing ratios are important.

The issue is complicated, however, by a competing bill in the legislature supported by the Florida Nurses Association. Unlike the NNOC-Florida bill, it does not mandate specific staffing ratios and does not include any enforcement mechanism.

RNs said such a law would be insufficient.

As nurses prepare for hearings and canvassing across the state, some said they are finding that the experience of working together as staff nurses to influence policy can be its own reward.

“Working with NNOC has gotten me politically active and given me a flame that I had lost,” said Collins. “It helped me realize that I’m not just here as a doormat and I can actually work to make things better. Nursing went back to being a profession, instead of just a job.” —Felicia Mello
Maine
Registered nurses at Maine Coast Memorial Hospital have made guaranteed nurse-to-patient ratios a major feature of contract negotiations this year. Nurses and professional staff have been asking for provisions in the contract that would protect safe, effective, and therapeutic patient care and support the retention of experienced staff. RNs staged a candlelight vigil July 29 to educate the community about what’s at stake in their talks.

As cuts are made around the state, nurses believe patient care could be negatively impacted and want to get Maine Coast Memorial’s commitment to safe staffing in writing. Research has shown that nurse to patient ratios reduce patient mortality rates, assure nurses more time to spend with patients, and promote the retention of experienced RNs.

MCMH management has not agreed to these safety provisions, but has instead asked for wage cuts. MCMH has reported financial surpluses both on its website and in documents submitted to the state during the Certificate of Need process. MCMH has also been the recipient of federal stimulus funds. These cuts are not supportive of nurses and hospital professionals who have continuously delivered high-quality care to the community.

Minnesota
Some 1,350 nurses in Duluth, Minn., are still negotiating contracts at St. Mary’s Duluth Clinic (SMDC) and St. Luke’s Hospital. As of this writing, talks were at a critical juncture. Sticking points continue to be nurses’ concerns for patient safety issues due to inadequate staffing. At SMDC, nearly 900 RN shifts were un-filled during a 30-day stretch. In medical-surgical units at St. Luke’s Hospital, nurses are responsible for up to 13 patients on some nights. Nurses are also demanding to include unit closure language secured in the Twin Cities during negotiations in 2001.

Ohio
In July, NNOC joined other healthcare justice activists in celebrating Medicare’s 45th birthday in downtown Cleveland, complete with birthday cake, balloons, and speeches from elected officials. A special newsletter was produced for NNOC members about the growing attacks on Social Security and Medicare, linking these issues to nurses’ worries about their retirement security—a big issue in Ohio.

Texas
Nurse leaders in Texas say their numbers are not Texas-big yet, but they’re getting there. The RN Strategy Group is now renamed the RN Bargaining Leadership Council, bringing together nurse leaders from five recently organized HCA hospitals, Tenet’s Cypress Fairbanks Medical Center, and all the metropolitan committees.

On July 30, the new Texas council met in Houston for the first time. The day before, the national HCA Bargaining Council also held its inaugural meeting. HCA nurses from Missouri, Kansas, Nevada, and California joined Texas nurses in Houston.

RNs are also making statewide plans for expanded advocacy in anticipation of the 2011 legislative session.

And two more Texas offices are ready to open in Brownsville and McAllen. —Staff Report

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Healthcare Stat of the Month

300%

The number of states restricting use of mandatory overtime

Sources: University of Pennsylvania 2004 study “The Working Hours of Hospital Staff Nurses and Patient Safety”; National Nurses United

16

The increase in risk of errors when a nurse works a shift lasting more than 12.5 hours, compared to a shift of up to 8.5 hours

Sources: University of Pennsylvania 2004 study “The Working Hours of Hospital Staff Nurses and Patient Safety”; National Nurses United
Honoring Life

Nurses who value people over profits understand that their work of healing patients extends way beyond the bedside.

And Dock, like Wald, encouraged other nurses to be more active in social reform. “We owe the existence of our profession to the woman movement,” Dock said in a speech to a large meeting of nurses in Philadelphia in 1909. “We owe it all that we are, all that we have, of opportunity and advancement; we owe it our social and educational and economic status...and our loyal allegiance and our moral support.”

The leaders of National Nurses United today are the descendants of Wald and Dock. And of Clara Barton, most known for her pioneering work as a Civil War nurse and founder of the American Red Cross, but also called on the soldiers she had helped on the battlefield to support the right of women to vote, saying, “As I stood by you, I pray you stand by me and mine.”

It was their children and grandchildren who fought for nurses to have the right to form unions, to advocate for patients at the bedside, and in the policy arena, to fight for an improved quality of care for all. They understood that medical justice is inseparable from social justice, economic justice, political justice, and individual justice.

It’s a fight that begins at the bedside. To value and honor life over things, to value and honor the lives of patients over the commodities of a commercialized society or the profits of a hospital or insurance company. And to act on it.

Here’s how one of the greatest nurse activists of our time, California Nurses Association president emeritus Kay McVay, RN puts it:

“Each and every person is a fellow human being. No one chooses to be poor, disabled physically or mentally, to become ill, or to suffer. As an RN I know this and I act accordingly.”

“Nursing gave meaning to my life, allowed me to for the first time to feel I was worth something. I had value as long as I wore that uniform. I somehow was protected because I had value to others. To be able to give, to help other people who hurt, not just physically but mentally, socially. It is and should always be about others, not one’s self. I grew as a person, a human being through nursing.”

From there it’s a short step to the next level, of working to change things for others. Here’s the voice of NNU Co-President Karen Higgins, RN, who recalls her early days as a nurse:

“As I worked, I usually saw head nurses who said they would take care of things, and you’re just there to take care of patients. But as healthcare changed and the world changed, it became very clear that’s not true. I was seeing changes going on in healthcare and patient care that were not good for patients and those of us who were trying to take care of patients.

“That’s when I became active. To make changes, to be able to keep patients safe, to be able to practice safely, to do what you have to step up to. To make your concerns known, take it on, and own it, and be willing to go out there on the edge and make a difference. That’s what pushed me to get involved, and believing that kept me involved.”

Clara Barton once said, “The door that nobody else will go in at, seems always to swing open widely for me.” The active nurses of today who won’t accept inferior care for their patients or substandard conditions for their community are the true images of the values of the nursing profession. We should always honor the honorable.

Rose Ann DeMoro is executive director of National Nurses United.
Onward and
Consider the ongoing healthcare crisis, along with consistent poll results showing that registered nurses are most trusted by the public among all professions, and it’s no surprise that there’s a plethora of books being published now featuring nurses’ voices and stories. From new nurses to veteran nurses, from Katrina nurses to ICU nurses, it’s clear that people want to hear what nurses have to say. We have reviewed several in this year’s annual book special, and thrown several other healthcare titles into the mix. And be sure not to miss RN DeAnn McEwen’s review of A Short History of Nursing. It’s not a new book, but the seminal 1920 work by RN Lavinia Dock, a nursing education pioneer and suffragist, is well worth reading. After you finish these reviews, we hope your minds and hearts will be lifted, as ours were. Onward and upward.
GROWING NUMBERS of authors have criticized the drug industry’s influence on psychiatry, but Robert Whitaker’s *Anatomy of an Epidemic* stands out for its research, historical perspective, and more than anything else, its readability.

Most books in this genre to date have questioned whether anti-depressants and mood stabilizers are effective enough to justify their unpleasant side effects. Whitaker goes one step further by citing studies, unmentioned by the psychiatric industry, that show medications are actually making patients worse over the long term—and costing taxpayers billions of dollars. As Whitaker points out, every day 1,100 new people join the government disability rolls for reasons of mental illness, adding to the more than 4 million already there.

Whitaker makes three convincing arguments: Science has never conclusively proven that mental illness is a symptom of chemical imbalances in the brain; studies show medications actually introduce such imbalances once taken; and long-term studies show patients growing worse, not better, from medication regimens.

Whitaker, a journalist by trade, allows his deep reporting to make the case, but what I found even more fascinating was his ability to thread a narrative around psychiatry’s huge paradigm shift toward pharmaceutical silver bullets. This odyssey begins with science’s accidental discovery of drugs that seemed to ease the symptoms of mental illness, through the psychiatric industry’s internal struggle with the Freudian couch, to the forging of the unholy alliance with drug manufacturers that defines the landscape we know today.

Through this history, we discover the fallibility of an industry in which we have granted an incredible amount of faith.

“As a society, we put our trust in the medical profession to develop the best possible clinical care for diseases and ailments of all types,” Whitaker writes. “We expect that the profession will be honest with us as it goes about this task. And yet, as we look for ways to stem the epidemic of disabling mental illness that has erupted in this country, we cannot trust psychiatry, as a profession, to fulfill that responsibility.”

The story begins after World War II when science was making incredible breakthroughs with the discovery of antibiotics. It was an age in which the inventor of the frontal lobotomy, Egaz Moniz, won the Nobel Prize for medicine. Suddenly doctors were able to produce real antidotes, and money followed, with companies such as Merck, Rhone-Poulenc, and Wallace Laboratories employing massive budgets for research.

During this period of exhaustive chemical experimentation, scientists noticed curious side effects that seemed to affect patient demeanor. Some chemicals seemed to calm the agitated; others appeared to soothe the anxious or enliven the depressed. And it was from these side effects that scientists drew conclusions as to how the brain functions: Thorazine, for example, restricts dopamine; thus it stood to reason that schizophrenia is a symptom of excess dopamine.

“Researchers would identify the mechanism of action for a class of drugs, how the drugs either lowered or raised levels of a brain neurotransmitter, and soon the public would be told that people treated with those medications suffered from the opposite problem,” Whitaker writes.

As the author points out, however, this approach failed to prove that these imbalances were, in fact, the root causes of mental illness. Respected psychiatrists, for example, have convincingly debunked the theory that high dopamine levels cause schizophrenia.

What has been proven, on the other hand, is that medications irrevocably alter the brain’s chemistry upon their introduction, forcing it to undergo “compensatory adaptations” that steer it in an abnormal manner. “Rather than fix chemical imbalances in the brain, the drugs create them,” Whitaker writes.

The biological compensations often produce positive results—especially in the first six weeks, the standard length of a drug study—but almost inevitably, the responses diminish as the medications make “substantial and long-lasting alterations in neural function.”

Whitaker cites abundant evidence, through studies suppressed by psychiatry or formulated through his own analysis of public health data, that reveals the damaging effects of medications over the long haul, including addiction, brain deterioration, and often, compounded symptoms.

Whitaker also shows that the industry was aware of these long-term effects, but failed to act.

“Could [psychiatry] really now confess to the public, or even admit to itself, that the very class of drugs said to have ‘revolutionized’ the care of the mentally ill was in fact making patients chronically ill?” Whitaker writes.

Hardly.

In fact, as scientists were just beginning to discover some of the downsides to medication, the psychiatric industry was about to launch a new revolution as partners in the burgeoning pharmaceutical trade.

In the late 1960s and early 1970s, psychiatry faced threats on several fronts. Psychiatrists like Thomas Szasz were questioning the medical model on moral grounds. Talk therapy was growing in popularity, stealing patients.

In response, the industry remade itself by, counterintuitively,
explicitly emphasizing its ability to prescribe. “A vigorous effort to remedicalize psychiatry should be strongly supported,” a representa-
tive of the American Psychiatric Association said in 1977.

From these efforts came the third edition of the Diagnostic and Statistical Manual, which standardized the diagnosis process and radically expanded the field. A few years later the APA board of
directors voted to allow pharmaceutical companies to start sponsoring scientific symposiums at its annual meetings. Whitaker attended
one of these conventions in 2008
where he heard the incoming APA president ask the media to “help us inform the public that psychiatric illnesses are real, psychiatric treat-
ments work, and that our data is as solid as in other areas of medicine.”

Rather than submitting to her request, Whitaker does just the oppo-
site in a levelheaded and highly enter-
taining fashion.—Matt Isaacs

A Short History of Nursing
By Lavinia Dock, RN; G. P. Putnam’s Sons

Who among us hasn’t heard the curiously uninformed and self-serving pronouncement that it’s unprofessional for nurses to join and form unions? My use of the term self-serving isn’t meant to be cynical; I believe it accurately describes the manipula-
tive intentions of those who seek to restrain, control, and prevent nurses from exercising their legitimate power and right to engage in collective social and political advocacy on behalf of their profession, patients, and the public at large.

In order to cast aside any pretense and set the record straight regarding the role of the professional nurse as an educated and (as circumstances require) militant social activist, it’s instructive to revisit and review nursing history as documented by pioneering nurse historian, Lavinia Dock. Although A Short History of Nursing
was first written and copyrighted in 1920 by Dock, many used copies of the third and fourth edition, coauthored with Isabel Stewart, are available for sale through popular online booksellers such as Powell’s Books or Amazon.

In A Short History of Nursing, Dock and Stewart document a rich history of national and international activism by nurses who understood the importance for the nursing profession to retain the ability to regulate itself in order to control the practice of nursing. The authors show the global development of modern nursing and describe the implications for future nurses.

Dock was a contemporary and colleague of the first nurses, both nationally and internationally, who sought to organize and legitim-
ize the modern profession of nursing. She was also among the first of the so-called radical feminists and joined the Equality League of Self-Supporting Women in 1907 and worked with the New York Women’s Trade Union League. She walked picket lines in defense of workers, and in 1913 urged the American Nurses Association to support the union movement.

Stewart was an educator whose study of history strengthened her belief that women could not rise to the full demands of any vocation or profession without education and knowledge of the social condi-
tions and needs of their day. She also believed the fullest develop-
ment of professional nurses “was not possible without emancipation from the conditions of subjection under which women and nurses had suffered for so many years.”

In the introductory outline, the authors beckon us to study nursing history by stating, “The nurse who knows only her (sic) own time may be unable to estimate and judge correctly the current events whose tendency is likely to affect her own career.” In par-

cular, Dock believed it is important “to give workers an unfailing inspiration in the consciousness of being one part of a great whole.”

In this book Dock discusses the effect of the expansion of nurse training schools in England, the increasing number of nurses and the inevitable variation of professional standards which lead her to the realization of the need for nurses to become self-orga-

ized and self-governed. She advocated for the attainment of professional licensure, through state regulation of basic minimum standards of training as the “one portal” to professional life.

It became clear that the young profes-

sion needed leaders who could form a strong association of its members, yet until the year 1887 there was no organization of nurses in any part of the world. Even in Great Britain, nurses had remained more or less dependent on the large hospitals. As schools multiplied and as small or special institutions opened courses, often inadequate for sound training, both economic and educational standards fell.

In addition, the authors describe how numerous commercial middlemen preyed upon nurses and certain hospitals also exploited them in the private duty field. Dock credits some of the “younger” nurses who realized the danger and courageously set to work to organize to improve conditions and standardize educational programs. This was “the second revolution” in nursing, according to the authors, probably equal in its daring to Florence Nightingale’s well-documented reforms in hospital sanitation.

Dock and Stewart report that social conventions remained “stub-
born,” and the idea of professional autonomy for nurses was entirely new and objectionable. This was proved true by the immediate hos-
tility of the directors and governors of the large London hospitals.

The directors and administrators perceived the economic impli-
cations of the nurses’ demands and the impact on their ability to make a profit, should they lose control of their nursing “employees.” The authors presciently observed that this was to divide the hospital
Critical Care: A New Nurse Faces Death, Life, and Everything in Between

By Theresa Brown; HarperOne

I AM NOT A BOOK REVIEWER. I do, however, love to read and I am a hematology, oncology, transplant nurse, so when I was asked to review this book subtitled “a new nurse faces death, life, and everything in between,” I said, “Sure.” I read the book through in one cross-country flight. I enjoyed it; it was a good, quick read and I’d recommend it. It described much of what we do in clear, detailed terms: easy for a non nurse to understand but not boring for a nurse to read. I only found one technical error and actually wondered if Theresa Brown put it in to test all oncology nurses out here.

In her book, Brown chronicles her first year working as an adult oncology nurse on two different units. She relates stories about caring for patients and their families coping with the catastrophic illness that is cancer. She shares how she struggles to maintain dignity for her patients, such as how to make patients feel (as much as possible) at ease when facing the many consequences and difficulties of cancer treatment. Sometimes the treatment is as bad as the disease. And most of all, Brown discusses the challenge of seeing, in her words, “the frightening truths about just how frail the human body can be.”

I have already been where Brown was many times before. Reading the book was like comparing notes with a fellow RN. This is something we do on the job all the time and one of the reasons I love being a nurse, because on a great unit the nurses all work together and help and support one another. But if someone had not faced all of these issues before, how would the book read, I wondered? The realities of what we nurses do on a daily basis is not entirely understood by the general public so it might take someone else many tears to read this, or they might find it too much information.

My current motto is “None of us get out of here alive.” I’m not sure to whom I should attribute this quote so forgive me, but as an oncology nurse I face this daily, even with our great successes and advances in treating cancer and other chronic diseases of the blood. I try to help new nurses learn this before they fall apart as they experience their first deaths.

I do, of course, recall my first deaths, very, very clearly and I feel lucky that, in our society which denies the reality of death every day, I have been able to experience others’ deaths, understand, reflect, and get to this place. Death is nothing special; it is just a part of living. But most of us in our very antiseptic society that prolongs dying as long as possible with every possible technology don’t get to know this first hand. So as a nurse, in a healthcare system that just recently invented the term AND, Allow Natural Death, my first deaths were very difficult. ‘We learn from other more experienced nurses, we learn from patients and their families, and I hope we all feel lucky that we do get this lesson in life, death, and everything in between. Brown captures this very well.—Martha Kuhl, RN

Hungry: A Mother and Daughter Fight Anorexia

By Sheila and Lisa Himmel; Berkeley Books

HUNGRY IS AN APT TITLE for this book about an anorexic daughter and her food-writer mother, but not only for the reasons you think.

Sure, when Sheila and Lisa Himmell titled their book Hungry: A Mother and Daughter Fight Anorexia, they meant the kind of intense starvation anorexia experience. But they also mean our culture’s hunger for perfect female bodies, anorexic or not. And they’re referring to deeper hungers: The hunger to be seen, to be loved, to be able to say no, to fill an emptiness inside whose origins are mysterious. Finally, Hungry refers to one mother’s voracious need for answers to a disease that changes the minute you think you have a handle on it.

The book starts long before Lisa is born, beginning with Sheila Himmell, finicky baby. It leads the reader through the entertaining path of Sheila’s food awakening at the hands of her husband Ned’s culinary adventuring. It takes us through Sheila’s food reviewing with the San Jose Mercury News in California, the birth of their
finicky son and then their culinarily adventurous daughter, Lisa. And then it gets into the confusing world of food addiction: the love of food that turns into binging that turns into restricting and finally to purging, hospitals, and suicide attempts.

Along the way, the story is marked for its candor. In alternating points of view, simply marked “Sheila” or “Lisa,” we learn of Sheila’s body insecurities, Ned’s sister’s food obsession, Lisa’s teenage sex life, and her growing isolation from everyone in her family as her eating disorder takes over. We learn about the doctors and treatments and maddening tenacity of a disease that is all about a person’s mind but starves the body.

Sheila Himmel writes in the introduction that she hopes the book will be a special kind of resource for other families, “a sympathetic, articulate expert or parent who not only had been through this hell but also was interested about food in our culture.”

She does an excellent job of this. Like a good reporter, she peppers the reader with statistics that remind us that eating disorders are not isolated events. Ten million women and 1 million men have eating disorders like anorexia and bulimia, yes. But also: 89 percent of women want to lose weight and 24 percent women would cut their lives short by three years to lose weight.

She leaves no doubt that food and weight obsession is a national pastime. She explains the cultural basis of food refusal, from kosher and halal designations to food allergies to foodie refusal of anything that isn’t organic or local. It’s not just anorexics who refuse food, she insists. We all do. We’re all obsessed to one degree or another.

But here is where I quibble with the book. In Sheila Himmel’s need to couch her daughter Lisa’s anorexia in our “food negative” culture, she downplays that anorexia is a serious mental illness. It may be part of our culture but it’s not the same feeling as the low self-esteem that many women experience because they can’t lose those last 15 pounds. It’s crushing, not just physically but psychologically, and keeps the sufferer obsessed with food even as she doesn’t eat it.

Full disclosure: I have an eating disorder. It’s the opposite of Lisa’s primary problem. Instead of under-eating, I’ve overeaten past the point of being able to taste food, past the point of even wanting to eat. I relate to Lisa’s description of herself in her binge-eating phase: “I had no idea what hunger felt like, nor could I really recognize being full.” That was me. Yet I still ate.

It’s a compulsion, and it winnows your life down to a jagged point. It’s not the same as someone who eats chocolate to medicate every emotion. Yes, I did that too. But eating disorders are so much more complex.

So I was uncomfortable with the inevitable side effect of the book’s candor: Like it or not, we join Sheila as she asks herself in not so many words if she could have prevented Lisa’s eating disorder. There’s an absurd moment when Sheila struggles with having reading her daughter the Yummers! children’s books, about Emily the pig and her out-of-control appetite. “Emily is certainly a binge eater,” Sheila writes. “We didn’t see it that way at the time, but reading Yummers! and Yummers Too: The Second Course got me worried.”

Lisa’s simple answering entry is, “Emily is a pig! Is she binge eating or just a pig? I think it would be different if the Emily character was a person, but she’s just being a hungry pig. A child wouldn’t read that much into it. I loved this book as a kid.”

But that’s what eating disorders do to the family member of the sick person. Like the families of alcoholics and drug addicts, the disease compels family members to second-guess everything. It becomes its own maddening obsession.

Though I read it identifying with Lisa, most readers will identify with Sheila. Either way, the book offers a look into a disease that’s often misunderstood. It’s the most honest and engaging book I’ve seen on the topic and it is bound to help parents like Sheila, either by alleviating isolation or by giving readers hints for how to help their own children. It leaves the reader rooting for mother and daughter, praying that both get some peace. —Heather Boerner

I am a Teamster: A Short, Fiery Story of Regina V. Polk, Her Hats, Her Pets, Sweet Love, and the Modern-Day Labor Movement

By Terry Spencer Hess; Lake Claremont Press

A labor history book dressed up as a chick-lit novel, I Am a Teamster tells the life story of Regina Polk, the feisty, flamboyant organizer who brought union representation to thousands of white-collar women workers before she died at age 33.

Born in rural 1950s Arizona to a nurse mother and a farmer father, Polk grew up defying society’s expectations of a woman’s proper role: playing sports, flaunting her sexuality, and generally seeking recognition of her feminine nature.

What she wanted, it turned out, was to fight the boss. While working as a hostess at the Red Star Inn in Chicago shortly after college, Polk noticed the mistreatment and low wages that her coworkers endured. She called several unions asking for help to organize the place and finally got a response from Teamsters Local 743, at the time the largest Teamsters local in the country.
Polk lost the campaign, and her job, but not before becoming a staff organizer for the local. It was 1975, plants were closing, and blue-collar jobs were on the decline. Meanwhile, the service and clerical sectors were booming, but the mostly female, educated workers who filled those jobs tended not to identify with the labor movement. As one of the first female leaders of America’s most macho union, Polk set out to change that.

In election campaigns at Blue Cross/Blue Shield, the University of Chicago, and other state colleges, Polk used her patience, skill, and similar background as a woman with a college degree to build trust with hospital and clerical workers. The previously complacent workers at the University of Chicago stunned management by voting by 87 percent to authorize a strike, eventually winning dramatic salary increases and reclassifications with pay raises for close to 1,000 secretaries.

At 29, Polk became one of the local’s youngest-ever business agents. She simultaneously fought racism and sexism within her union, authoring and passing a resolution at the 1976 Western Conference of Teamsters that called on the union to launch a national organizing campaign specifically aimed at women workers, combat on-the-job discrimination, and promote women to leadership positions within the union, “as a crucial step in the struggle for a free and egalitarian society.”

One of the more intriguing parts of the book is its discussion of Polk’s sometimes-contradictory lifestyle. Married to a banker that she met in graduate school at the University of Chicago, Polk enjoyed a different standard of living—complete with lavish dinner parties and shopping trips to Elizabeth Arden—than the workers she was helping to organize. She and her husband had struck a deal: He would support her unconditionally in her work, helping out by making phone calls and walking picket lines, if she would keep the union away from his bank.

Despite her bourgeois home life, the Regina Polk the book portrays was a committed organizer who worked long hours and put the movement first, even losing a baby to a miscarriage during a particularly grueling campaign. On one occasion, the book recalls, “Regina chased an eighteen-wheeler truck whose driver had tried unsuccessfully to cross one of her picket lines. With angry Regina in hot pursuit, the driver eventually stopped the truck, got out of the cabin, and ran away from her on foot.” Polk chased the driver into a local bar, talked to him, and convinced him to support the strike.

A speech Polk gave at a 1981 training for union stewards, reprinted in the book in its entirety, gives a flavor not only of her uncompromising attitude, but of the political climate she was living in, one not unfamiliar to today’s. “It is not news to you that there is a tremendous wave of anti-unionism sweeping the country now,” she told the assembled stewards. “You can’t pick up a paper or a journal without reading that labor is too big—corrupt, lazy, unresponsive to its members—and that labor is some pathetic dinosaur whose time has come and gone. We hear one pronouncement after another which happily predicts the decline and collapse of the American labor movement.” Polk urged the stewards to vigilantly defend their contracts against the attacks of union-busters, whom she called “bastards with briefcases.”

The 1980s were also a time of corruption in the Teamsters, both real and rumored. In 1983, Teamsters president Roy L. Williams was convicted of conspiracy and fraud along with four other associates, one who was murdered while the verdicts were being appealed. The Teamsters’ decline bothered Polk, the book reveals, and she considered setting up a new independent union or joining with another union that represented service workers.

Just before her death, Polk was working on setting up job-training programs for thousands of people being thrown out of work as factories continued to close throughout the Midwest. She was heading to a meeting to ask for resources for the program when the small commuter jet she was riding in crashed into an Illinois field.

Written in a spare, chronological style, I Am a Teamster is a quick read, and an inspiring tribute not just to this little-known labor leader but to all those who dedicate their lives to helping women find a voice on the job.

The book has two minor weaknesses. First, the author sometimes displays a patronizing attitude towards the workers Polk helped to
organize, comparing her zeal for “nurturing” them to her affection for animals during her childhood on the farm.

And readers will tire of the constant references to Polk’s physical beauty: her “glamor,” “wide smile,” “strawberry-blonde hair,” and Imelda Marcos-esque penchant for shoes and hats.

Then again, as an old boyfriend of mine once let slip in an unguarded moment, “union chicks are hot.” And who, really, can argue with that?

—Felicia Mello

Inside the ICU: A Nursing Perspective
By Melody Stenrose, RN; Seaboard Press

Many registered nurses are very good at what they do. But not as many RNs are very good at explaining what they do. And it’s the rare RN who can reflect and write eloquently about every aspect of what she does—from the clinical care she provides, to the emotional support she gives patients and their family members, to the larger ethical considerations of her profession. Melody Stenrose is one of those nurses.

Stenrose, an intensive care unit registered nurse for nearly 30 years, said she wrote Inside the ICU to demystify the practice area for other nurses as well as for the average person. For years, she had been regaling her husband after every 12-hour shift with life-and-death tales; he suggested to her one day that she write them down as a book. Years later, after much persistence navigating the world of book publishing and even securing her employer hospital’s approval, she finally did.

Through the stories of actual patients she has cared for over the years, Stenrose discusses topics as varied as organ donation; the end of life; obese, paralyzed, and homeless patients; the role of nurses; and being a patient herself. We learn about Jim, a patient in the late stages of Amyotrophic Lateral Sclerosis (ALS) disease, who could barely move any part of his body besides his feet. Stenrose rearranged Jim’s entire ICU room, including moving most of the equipment, so that the call pad could be positioned near his foot. We learn about Ronald, an 87-year-old man who was resuscitated against his wishes because neither he nor his family had told the medical staff early enough. Ronald was finally allowed to die in peace, but not before Stenrose had to go through four different doctors to get the Do Not Resuscitate order written.

In the book, Stenrose often juxtaposes stories from earlier in her nursing career with those that came later, to highlight lessons she has learned and how she has evolved as an RN. One particularly important chapter, titled “Who Calls the Shots?,” gives the reader great insight into the incredible autonomy as well as responsibility of the registered nurse’s scope of practice. While it’s true that nurses carry out a doctor’s orders, Stenrose explains how the RN’s own assessments and subsequent suggestions heavily influence those orders. After all, the RN is the one constantly at the patient’s bedside. And when a doctor is not around, RNs must sometimes jump in to save a life and inform a doctor later.

Ultimately, every story is a discussion of what it means and what it takes to be a strong advocate for patients so that they not only receive the best medical treatment possible, but receive it with dignity and compassion.

My only criticism of the book is that Stenrose, a California Nurses Association member, does not mention the role that collective action with coworkers through the union must surely have played at some point in her career in advocating for patients. She also does not critique the overall, profit-driven healthcare system.

Otherwise, Stenrose’s book is quite an accomplishment: informative, thought-provoking, colorful and full of dialogue, and inspiring to read. —Lucia Hwang

Normal At Any Cost: Tall Girls, Short Boys, and the Medical Industry’s Quest to Manipulate Height
By Susan Cohen and Christine Cosgrove; Tarcher

Many parents claim they will do everything within their power to shape their children in a way that provides them with the greatest opportunities in life. But what happens when that quest for success drives parents to forever alter the physical attributes of their daughters and sons who are predicted to be too tall, or short, to meet societal norms? And what happens when parental fears about their children’s height are encouraged and enabled by medical and pharmaceutical industries that stand to gain prestige and profit from experimental treatments designed to inhibit or enhance physical growth?

In Normal at Any Cost: Tall Girls, Short Boys and the Medical Industry’s Quest to Manipulate Height, Susan Cohen and Christine Cosgrove chronicle decades of medical attempts to alter the height of young girls and boys through the controversial use of hormones. The book raises thought-provoking questions about how society defines what is normal, the intersection between scientific breakthrough and medical ethics, and the ability of the pharmaceutical industry to manufacture and market treatments that are really in search of a disease.

Cohen and Cosgrove open the book with stories of prepubescent girls growing up in the 1960s and 70s whose parents worried that their tall stature would be socially disadvantageous and would prevent them from finding suitors. Seeing media reports of a new
“treatment” called diethylstilbestrol, also known as DES, that could suppress a child’s growth to a more socially acceptable height, many parents flocked to their daughter’s doctors hoping to capitalize on the latest medical breakthrough.

DES, a synthetic estrogen, would stunt the growth of young girls by accelerating puberty, thus allowing their bodies less time to grow. Although DES was not approved by the U.S. Food and Drug Administration for this use, worried parents had no trouble finding doctors, many of them pediatric endocrinologists affiliated with prestigious teaching institutions, who would treat their daughters with the hormone.

While some in the medical community casted doubt on the safety of DES, and raised ethical questions surrounding the notion of treating tallness as a medical condition, thousands of young girls across the globe were prescribed heavy doses of DES. Many of them suffered both short- and long-term side effects from the hormone, and eventually a clear link between DES and cancer emerged. Still, the medical establishment continued to offer DES for tall girls, and, sadly, their parents readily accepted.

Cohen and Cosgrove also chronicle the history of the development and use of human growth hormone to spur growth in short boys. The authors detail the painstaking efforts by physicians and chemists to harvest human growth hormone (hGH) from the pituitary glands of cadavers during the late 1950s and early 60s to treat children with dwarfism. A lack of quality control in the processing of hGH afflicted some treated with the hormone with a dementia-like condition called Creutzfeldt-Jakob disease. Others developed antibodies to the hormone that in some cases decreased growth rates. However, as with DES, these dangerous and deadly side effects did not stop the industry from its quest to find a cure for short stature.

The 1980s gave rise to the development of synthetic hGH, which could be used not only to treat dwarfism, but also to boost the height of healthy children. Pharmaceutical manufacturers of the new “therapy” argued that it was equally as justifiable for parents to want to

Celebrating Nurses: A Visual History
By Christine Hallett, RN, Ph.D; Barron’s

At first glance, Celebrating Nurses looks like an oversized coffee table book, filled with beautiful black-and-white and color photos, illustrations, and other images of nurses and their practice. The book holds merit for just the images alone; it’s hard to find in one place so many depictions of nursing spanning so many centuries and countries. These range from photos to oil paintings to commercial advertisements. Our resident designer clapped her hands in glee to find such large reproductions of historical nursing images she had viewed before only as tiny thumbnails on the Internet.

But if you read in between the pictures, you’ll find that British RN Christine Hallett also provides a rich overview of the evolution of nursing from ancient and medieval times, through early modern times, to the 19th and 20th centuries. Nurses in early societies were women healers, then became connected to religious orders, and eventually professionalized through nursing schools and registration (licensing). What’s nice about Hallett’s explanation is that she not only correlates the development of nursing with the rise of modern medicine, industrialization, and various wars, she covers nursing in Europe, the Americas, Australia, and beyond. In every chapter are short profiles of notable nurses. Of course she describes Florence Nightingale and Clara Barton, but Hallett also includes public health nurse Lillian Wald, frontier nurse Mary Breckinridge, and birth control crusader Margaret Sanger.

Predictably, Hallett does not mention the important role of nursing unions such as the California Nurses Association, UNISON in the United Kingdom, or the Canadian Federation of Nurses Unions in the history of the profession but, sadly, it is not that kind of book. —Lucia Hwang
improve the attractiveness and self-esteem of their children as it was to correct physical defects that undermine their looks and social function. Sales skyrocketed as doctors were bestowed with financial incentives to prescribe the drug, and as parents sought to give their boys a chance to become what it is to be “male”—tall and strong.

The book later documents what happened to some of the children treated with DES or hGH, and details the long-term physical and psychosocial effects of their treatments. It also provides insight into the pharmaceutical industry’s ongoing lobby to gain FDA approval to use hormonal treatments to manipulate the height of otherwise healthy children. But, more importantly, by the end of the book, Cohen and Cosgrove provide a historical perspective on the lengths many of us will go in order to fit in, and rightly label their book “a cautionary tale.”

—Kelly Green

Nursing in the Storm: Voices From Hurricane Katrina
By Denise Danna, RN and Sandra Cordray; Springer Publishing

The authors of Nursing in the Storm interviewed dozens of RNs at six New Orleans hospitals to create this compendium of nurses’ stories about working through Hurricane Katrina and the massive flooding of the city, one of the worst disasters to hit a metropolitan area in the history of the United States. Many of the RNs interviewed worked in administration, however, so the book is somewhat heavy with their managerial perspectives. As usual, the voice of sanity comes from staff nurses, as in the example of Rae Ann Dereoché, an RN at Chalmette Medical Center who questions her nurse supervisor before the storm hits about why the hospital isn’t being evacuated. “I am thinking, ‘What the hell is wrong with you people?’ I am a staff nurse who is asking, why aren’t these people out yet? What do you have going on? What are the plans?”

But the book still fascinates simply for its raw documentation of the dreadful events and conditions endured by nurses, doctors, and ancillary staff as they struggled to care for critically ill patients without electricity, running water, air conditioning systems, and other resources.

Five years after the levees broke, the horror and chaos of Katrina is still fresh in these accounts. Through the stories, readers are transported into the hospitals as nurses heroically work together to evacuate babies from NICUs and vented patients from ICU, try to calm patients, family members, and coworkers, and make do with the equipment and supplies they’ve got. Many of the hospitals lost critical resources because their generators, power systems, and food services were located on flooded basement levels.

Besides chronicling the nurses’ actions, part of the authors’ intention in telling these stories is to remind readers of the suffering and death that ensues when we are not prepared for emergencies and disasters. Danna and Cordray include in their “Lessons Learned” chapter an interesting section on the fragility of the nation’s levees.

From an interview with Sandy Rosenbal, founder of a nonprofit educational website, Levees.org, readers learn that 39 of America’s 50 largest cities lie partly on floodplains. Dallas and Sacramento are just two examples.

Anyone unconcerned about the next disaster need only read one or two stories from Nursing in the Storm to be quickly scared into action.

—Lucia Hwang

Reflections on Doctors: Nurses’ Stories About Physicians and Surgeons
Edited by Terry Ratner, RN; Kaplan Publishing

You might call this book “doctors through the eyes of nurses.” It’s a small book, the core of it being only about 132 pages, and is essentially a collection of short pieces featuring nurses’ reflections on their relationships with physicians. There are some interesting stories here, and some decent writing. Unfortunately, the book fails to live up to its potential.

As I said, there is some good work here: nurses reflecting on lessons learned, both by themselves and physicians, some accurate accounts of the stresses of nursing that any nurse can relate to, and some hints at how the profession has changed over the years, for better and for worse.

We hear from nurses who work in academic centers about the process by which young doctors learn to respect nurses in that setting. We hear stories of egomaniacal doctors learning lessons in humility. We see a nurse muster the courage to refuse a doctor’s order—and how the doctor learns from it and apologizes. We see a neglectful medical director of a skilled nursing facility replaced with an excellent and caring physician. And we are treated to a number of hagiographic descriptions of outstanding physicians doing selfless work in the difficult circumstances of low-income clinics and war-torn countries. Lots of these stories leave you with a nice Chicken Soup for the Soul sort of feeling.

Unfortunately, what this soup lacks is the spice of hard reality. Virtually every story, if conflict exists at all, comes to a happy and heartwarming resolution. Nowhere in this book do we find the nurse who stands up to a bullying doctor, is fired for her trouble, and finds...
herself with no recourse. Nor do we find the nurse struggling with knowing a physician is not acting in the interests of the patient and not knowing what to do about it within the confines of a business-oriented system and “at will” employment. Neither are there any instances of nurses standing together as a group and taking concerted action to change doctor behavior in the face of institutional indifference. By and large, the stories in this book seem to take place in isolation—in a world divorced from a larger context of a healthcare system, from the reality of healthcare mergers and for-profit medicine that often rewards the most “productive” physician, while penalizing the most caring and compassionate.

I would love to have read the story of the nurse who lost her job after she reported a physician who made a policy of torturing Medicaid recipients during labor to “teach them a lesson” not to have babies while on public assistance. It would have been interesting to have heard from the nurses who knew their hospital’s respected cardiologist was sending patients with normal hearts to surgery, but were afraid to speak out about it in the context of a corporate system that supported the doctor—right up until he became the subject of a 60 Minutes segment. Those stories are out there. And they should not be that hard to find.

I really don’t want to be too hard on this book. It’s a good-hearted book. Nearly all of it is quality writing from excellent nurses. I enjoyed reading it. But it was the enjoyment of a sweet dessert or a tasty appetizer. I wanted a richer, spicier, and more provocative main dish. —David Welch, RN

When Chicken Soup Isn’t Enough: Stories of Nurses Standing Up for Themselves, Their Patients, and Their Profession
Edited by Suzanne Gordon; Cornell University Press

Noted nursing author Suzanne Gordon edits and writes introductory prefaces for each chapter of When Chicken Soup Isn’t Enough, but the bulk of this book consists of 71 stories about registered nurses written by the nurses themselves. Several stories are written by RNs connected to National Nurses United and CNA, including RN Karen Higgins, an NNU copresident and former president of the Massachusetts Nurses Association and RN Vicki Bermudez, who was a former regulatory policy specialist for CNA.

Nurses are shown advocating for themselves and their patients from daily or–the-floor issues to the realm of applied research. Gordon doesn’t present one topic as more important than the other. She covers them all with equal attention. The titles of the different submissions from the nurses are attention grabbing: “An Inconvenient Nurse,” “Gloves Off,” “We Rained On Their Parade,” “One is One Too Many,” and more.

I was intrigued by the stories of nurses asking to share research, confronting doctors, saving patients, and mentoring new nurses. Bermudez’s essay, titled “Taking on the Terminator,” focused on California governor Arnold Schwarzenegger’s failed 2005 challenge to the state’s RN-to-patient ratio law, the first in the country, and on CNA’s role in stopping him. Higgins’ entry described how the dangers of hospital restructuring pushed her to overcome her fear of public speaking and realize that staff nurses are the experts and “the backbone of healthcare.”

What caught my eye the most, however, was the chapter at the end of the book called “We Are Still Fighting.” In this chapter, Gordon and her contributors share some examples where nurses were not successful, and she states why: “Patient advocacy doesn’t only involve taking occasional risks; it means being ready to lose a battle or two along the way but still continue the struggle...Real progress is made only when some people continue to stand up for what’s right, regardless of the odds against them and without any guarantee of success that (much to the surprise of everyone) may be right around the corner.”

Perfect for busy nurses, most of the submissions are two to three pages in length, easy to pick up and read in short bursts. I’m not a nurse but I found that after reading the first several submissions, I was energized and felt more confident. There was something about reading the words of people who dared to take a stand and make a difference that was inspiring. I think you’ll have the same reaction. —Ann Kettering Sincox
CNA/NNOC members in good standing are hereby notified of and encouraged to submit their names as candidates for the following offices and positions to be filled in a membership election conducted in spring 2011, the results of which shall be read at the Convention in September 2011.

All eligible members in good standing seeking office or position in this election shall file a consent-to-serve and biographical sketch, including a list of organizational experience, present employment, and position. Such forms for consents-to-serve and biographical sketches are available from and should be mailed to the CNA/NNOC Administrative Office, Attention: 2011 Elections, 2000 Franklin Street, Oakland, CA 94612.

The CNA/NNOC Ballot Committee will meet at least one year prior to the Convention to consider the CNA/NNOC ticket. This is a preliminary list. A final list of offices and positions shall appear in future issues of *National Nurse*. There is one position available for each title unless otherwise noted in parentheses ( ).

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**Ballot Committee**

At-large (5 positions)

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90TH ANNIVERSARY

19TH AMENDMENT

AUGUST 26, 2010

CARING
COMPASSION
COMMUNITY

1920 1970 2010

CALIFORNIA NURSES ASSOCIATION
National Nurses United