Nurses' guide to single-payer reform

Eaton takes congressional committee on an RN's view of health care changes

The following testimony was presented by Sandy Eaton at a recent congressional hearing at Faneuil Hall in Boston that was part of a country-wide series called for by Congressman John Conyers (D-MI) and the single-payer caucus. The aim of the series was to receive testimony on the state of health care in the country and to build support for HR.676—the Medicare for All Bill—in preparation for the 2006 congressional elections.

There were three panels of testifiers, one each on access, cost and quality. This testimony was given as part of the panel on quality.

My name is Sandy Eaton. I reside in Quincy, Mass., and I work as a staff nurse in critical care at the Quincy Medical Center. I've been a registered nurse since 1981, and I've worked at the bedside in one capacity or another for over 40 years. I've seen it all, at least in the acute care sector here in Massachusetts.

I also happen to be the secretary of the Massachusetts Nurses Association; the chair of MASS-CARE, the Massachusetts Campaign for Single Payer Health Care; and the treasurer of the Alliance to Defend Health Care, formerly the Ad Hoc Committee to Defend Health Care since this mighty battle is anything but "ad hoc."

I remember when good care was the norm; when you were expected to spend time with the patient and do a thorough, careful assessment; when you had the time to get to know your patients and their families, when you had time to teach them about their disease processes, tests, treatments, medications; and when you had time to tell them what to expect and what to do at home.

In 2003, however, the Institute of Medicine reported to Congress and the public that 98,000 people die each year of medical errors in the nation's hospitals. Far more people die from medical mistakes each year than from highway accidents, breast cancer or AIDS.

That same year the Massachusetts Department of Public Health reported a 76 percent increase over the prior seven years in the number of medical errors, patient falls, complications and complaints by Massachusetts hospital patients, with the majority of complaints related to the quality of nursing care.

Today you take your life in your hands when you gain access to this dysfunctional health care system. You're no longer a person, but a widget on an assembly line.

What, you may rightly ask, has happened to let things get so bad?

In order to cut labor costs in 1988, Boston University Medical Center and Quincy City Hospital (QCH) brought in job reengineering consultants, who redefined nursing as a laundry list of tasks to be performed—many of which could be delegated to unlicensed personnel. QCH experienced a massive layoff in 1989 and, when the dust settled, the typical nurse on a medical/surgical unit wound up caring for at least eight patients, assisted by a nursing technician. This became a statewide, and national, pattern.

Also in the late '80s, the privatization of state health care facilities began during the second Dukakis administration. This trend toward privatization reached a fever pitch under Governors Weld and Cellucci, extending to county and municipal facilities as well.

The newly rebuilt Boston City Hospital was privatized in 1996 and turned over to the BU Medical Center to form the Boston Medical Center. Most county hospitals were sold to for-profit specialty chains.


Sandy Eaton

In 1991, Chapter 495 was passed, deregulating hospital finance and putting the insurance industry in the driver's seat. Senator Ed Burke, then senate chair of the Joint Health Care Committee, remarked that this would put all the scorpions (meaning the Boston teaching hospitals) in the same bottle so we could see who'd survive. So far all the "scorpions" have survived, some over the corpses of affiliated community hospitals, but scores of those community hospitals—with their acute and critical-care services and emergency departments—haven't.

On Dec. 7, 1993 the first of the mega-mergers took place with the announcement of the formation of Partners Healthcare, which brought Brigham & Women's Hospital and Massachusetts General Hospital together.

In 1995 for-profit, acute-care hospital chains finally found it advantageous to enter the deregulated Massachusetts health care scene. Columbia-HCA, the largest for-profit chain in the world, took over MetroWest Medical Center, which is now experiencing its third for-profit owner in ten years.

Throughout the '90s, especially during and after the hoopla surrounding the Clinton espousal of "managed competition," managed care was seized upon by employers as the preferred way to cut health care costs.

No one thought that care should be random or disorganized, but care increasingly became managed by bean counters and gatekeepers using pre-established recipes for approved care, in direct substitution for clinical judgments by professionals.

Assuming one could be admitted for treatment, hospital stays increasingly were measured in hours instead of days. The increased number of patients that a frontline nurse, for example, would be responsible for—or, to put it more appropriately, would be liable for—were on average much sicker, entering the hospital later in the course of illness, and discharged before fully recovered.

I recall a night shift I worked not too long ago. There were four RNs on, all of us experienced, with 16 patients among us on this 20-bed, step-down unit. We got a call that an elderly woman who had been transferred off our unit earlier in the day to the rehab unit was experiencing chest pain unrelieved by sublingual nitroglycerin and, since she had a definite cardiac history, would have to come back to us.

The medical house officer was with that patient. Each of us on the step-down unit had at least one unstable patient at the time and no one thought they could handle a fifth patient, especially one that would be in need of close attention and swift intervention. I called the house officer to suggest that he reevaluate the situation because things were already unsafe on our unit.

We all rushed to stabilize our own patients and do whatever else necessary before that additional patient came to us. By midnight two of us veteran nurses were literally in tears and I had stuck myself with a used needle in my haste to settle in my existing patients.

That patient never came to us from rehab, we found out later, having been sent to another hospital with facilities to care for her properly. Later I was spoken to, both by my supervisor for daring to call the MD and by the infection control nurse for being careless in getting stuck. My patient turned out to be negative for hepatitis and HIV, but the added stress was unwelcome. Too many of my colleagues have been infected under such circumstances.

As the system began to unravel in the early '90s, nursing administrators were fond of telling us to "shift our paradigm," to adapt to the brave new world of free-market medicine and competition for market share. We were assured that there were many roles for us to play in the managed care bureaucracy, or perhaps in advanced practice rolls or in "leadership" if we went on for graduate degrees.

Organized nursing in Massachusetts did not shift its paradigm. We fought back.

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In June 1993, RNs, LPNs and student nurses held the first of many rallies for patient safety on the steps of the State House in Boston. In September 1994, we launched the Statewide Campaign for Safe Care, alerting our colleagues and the public of the pattern of devastation that was emerging everywhere. We formulated a legislative package, the centerpiece of which was our attempt to legislate safe staffing norms. Even this first mild piece of legislation was sneeringly referred to by representatives of the industry as "the full employment act for nurses." How dare we not march in step with our betters!

We also pushed for safe staffing across the bargaining table and in the streets. In 2000 the newly organized MNA bargaining unit at Saint Vincent's Hospital in Worcester went on strike for 49 days against the Tenet Corporation—the second-largest for-profit chain in the world—to block mandatory overtime. In 2001, the nurses of Brockton Hospital went on strike for 103 days because the CEO refused to allow language in the contract promising a good-faith effort to staff safely, thus blowing a $6 million surplus and a chance to become a regional heart center.

Our strong sense of patient advocacy led us to tackle the health care system itself. In the fall of 1993, the motion to adopt a single-payer universal healthcare system lost by two votes at convention, amid calls to unite around the Clinton fiasco. In the fall of 1994, the motion to support single-payer won almost by acclamation. The Massachusetts Nurses Association has supplied cadre and cash to MASS-CARE ever since.

When, in 1997, many physicians finally had enough of the second-guessing by managed care bureaucrats which rendered them unable to follow their best clinical judgment in caring for their patients, their rebellion took the form of a reenactment of the Boston Tea Party with the jettisoning of insurance forms into Boston Harbor; the publishing in the *Journal of the American Medical Association* of the "Call to Action: For our Patients, Not for Profits;" and a stirring teach-in on the evils of market medicine right here in Faneuil Hall.

Nurses were with them right from the start at this birth of the Ad Hoc Committee to Defend Health Care, insisting that all disciplines and our patients needed to be involved in any winning movement for change.

This impetus continued into the 2000 General Election, with the placement on the ballot of Question 5, which aimed to establish a bill of rights for patients and providers, to set a date certain by which the legislature must establish a system of universal health care in the commonwealth (that date being July 1, 2002), and to set a moratorium on any further conversions of health care entities into for-profits until the universal system was established.

Organized nursing in Massachusetts stayed the course with Question 5, which came within four percentage points of winning, being outspent 50-to-one, even after the coalition split over the legislature's partial enactment of its demands.

The Ad Hoc Committee and MNA were the first two groups to endorse the campaign to amend the Massachusetts constitution in order to make health care a right for all residents. We see a universal system of health care as the best matrix in which to eliminate disparities in care and in which to win the fight for a safe patient environment. But we realize that we cannot wait for that universal system in order to fight for equality of access and for patient safety.

MNA and over 90 other patient advocacy groups are vigorously pushing for the passage of H.2663, which will create a flexible system of enforceable, minimum RN-to-patient ratios in all acute-care hospital settings, with a standard acuity system for improving staffing as patient conditions warrant, without reducing vital support staff, without mandatory overtime, and without floating into unfamiliar territory.

And we vigorously support S.755, An Act to Establish the Massachusetts Health Care Trust, as the way to realize the right to quality health care for all who reside here.

Although the frontline nurses of Massachusetts have been reengineered, laid off, sped up, deregulated, privatized, merged and managed, we remain unbowed and committed to the fundamental change we all cry out for. ■