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THE VOICE OF NATIONAL NURSES UNITED

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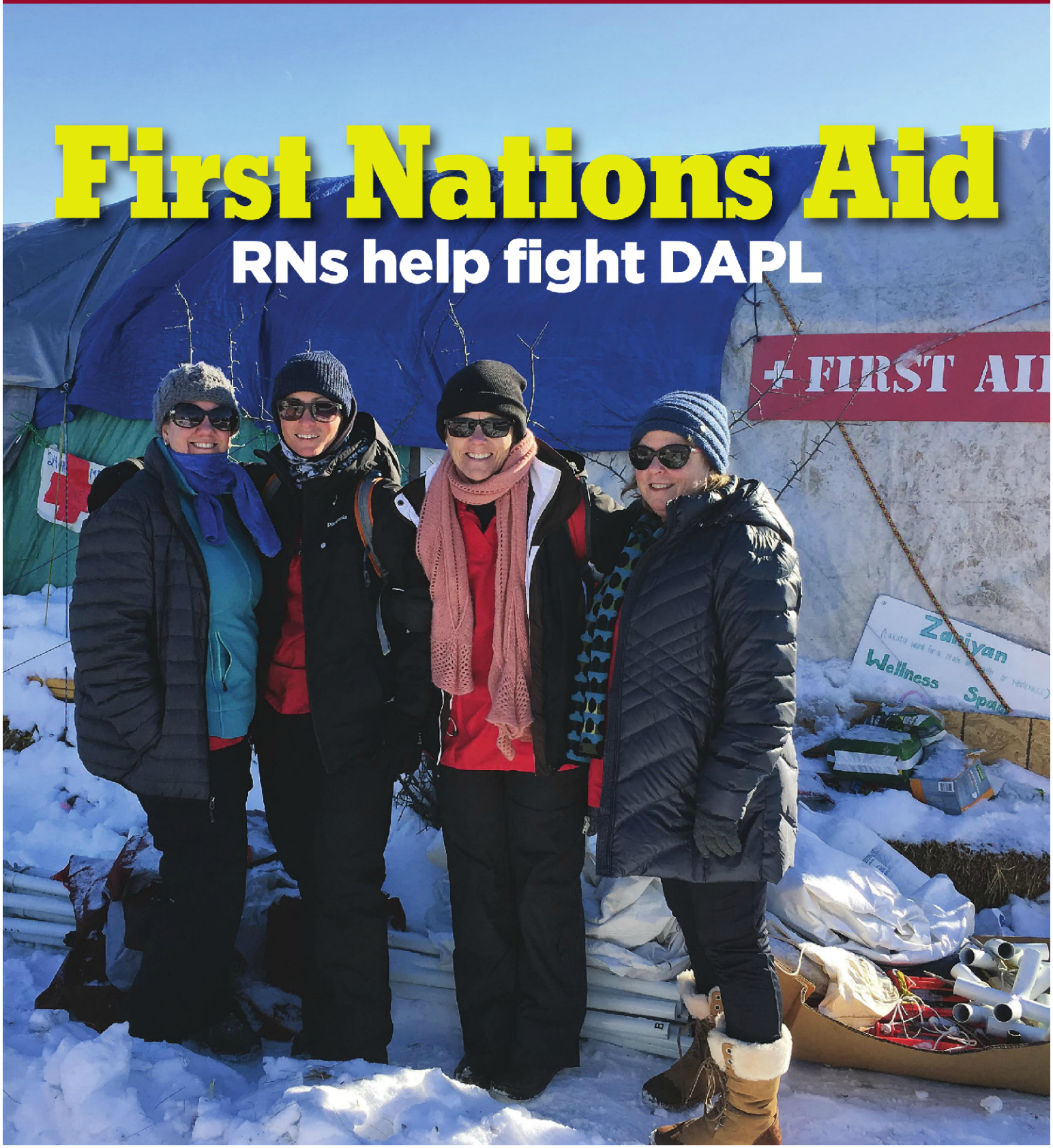


First Nations Aid

RNs help fight DAPL

THE BOOKISH TYPE

From ADHD to Zentiva, check out our reviews on the latest healthcare titles relevant to nurses.

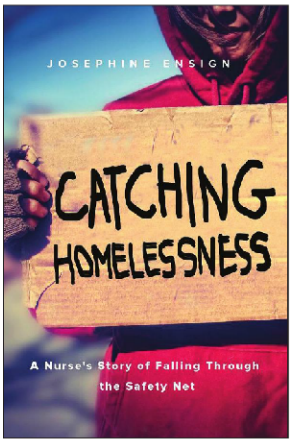
Book reviews? That involves reading books, right? How quaint. No, but seriously, we know that in the hectic lives we all lead today, reading long-form anything—much less nonfiction—can seem like a luxury we just don't have the time, or attention span, for anymore. But that's why books are so fulfilling. In this era of surface knowledge, books help us go deeper. We look forward to this annual magazine issue where we get to review books for you. We're embarrassed to admit it, but we find it's also often the only time during the year when we ourselves commit to read a book from cover to cover. We hope these reviews pique your curiosity and inspire you to read more in the coming year.

are, in fact, patients' best allies in any new quest to overhaul our high-priced system." We'd argue that nurses are, in fact, patients' best allies.

So while her book is a great foundational read on how every sector of the healthcare industry works, don't depend on Rosenthal to draw the right political conclusions or advocate for the type of system where healthcare is treated as a human right. —*Lucia Hwang*

Catching Homelessness: A Nurse's Story of Falling Through the Safety Net

By Josephine Ensign
SheWrites Press, 2016



Like most readers, I've read books I've enjoyed so much I never wanted them to end. Rarely do I read a book however, that from the moment I finish it, I want to read it again. Josephine Ensign's *Catching Homelessness: A Nurse's Story of Falling Through the Safety Net*, is one of those books.

I confess that prior to reading this book, I had grown frustrated with the many profiles of homeless people in the media. While most of these treatments are trying to humanize the subject and instill empathy in the audience, the net effect has been to objectify the poor and solidify the notion that homelessness and poverty are chronic, incurable conditions.

This book is not a book of solutions, but it does contain important clues for those of us who desire an end to poverty and homelessness and welcome a path to connect or reconnect with these issues.

Ensign uses her life story, including her nursing practice to the homeless and her own eventual homelessness, as a plot line around which to describe the rise of homelessness during the 1980s in the United States and especially in her hometown, Richmond, Va. She describes where she was raised, by devout white Christian parents, as a former Confederate battlefield, riddled with bullets and arrowheads, and mixed with the bones of the Powhatan tribe, African slaves, and Confederate soldiers. Long before the recent waves of homeless, she reflects, the land was "heavy with the remains of the displaced."

Ensign moves away from the South for college but returns to Richmond to attend nursing school. After graduation, she imagines she will follow in the footsteps of many of her relatives, pursuing missionary work in another country. As a nursing student, however, she soon discovers through volunteer work in a storefront clinic for the homeless that there is "missions-type" work to be done in her own hometown. She admires the clinic doctor's "quiet personal faith" and is attracted to the clinic's mission, providing "basic healthcare for free to poor people."

By contrast, she finds nursing training "stultifying" and "dehumanizing," with instructors that seem "intent on extinguishing any compassion or empathy we came in to school with." Ensign's descriptions are vivid here, as they are throughout the book. The students are forced to wear heavy navy-blue cotton uniforms and use "decaying black leather nursing bags" that "crackled when opened, emitting a moldering smell." What's more, the instructors insist that the student nurses use "proper bag technique," and demonstrate exactly "how to open and extract contents." Unwilling to use the bag, Ensign's instructors threaten to fail her for insubordination.

After graduation, she pursues her dream of working in community health, by landing a job with the clinic she volunteered for as a student nurse. Soon the clinic relocates to a massive homeless shelter. Although the clinic is still a project of the Christian clinic, and under the remote supervision of a Christian doctor, for whom this is a ministry, she is basically on her own. During this period, she assents to what she calls "a sort-of-arranged marriage" to a seminary student picked out by her parents. She has a baby in short order, but goes back to work, as she is the sole breadwinner for her family, while her husband continues to study.

At first, she sees her work with the homeless as virtuous and fulfilling, recognizing herself as one of the "1000 points of light" President H.W. Bush was promoting as part of the Republican effort to cut social services and privatize the rest. His plan includes ignoring the separation between church and state and allowing federal grants to faith-based social services. Meanwhile, Ensign's family questions the Christian value of her work. Quoting the bible, her husband accuses her of "throwing pearls before swine." She decides to separate from him.

Like the Southern vine Kudzu, a recurring visual in the book, more oppressive forces begin to close in on Ensign. The Board of Medicine, run by all white men, representing the social and political status quo of Virginia, instigates an investigation to determine whether or not she is exceeding her scope of practice as a nurse. Her employer, the clinic board, then reprimands her for lacking piety and failing to proselytize patients. They complain that she is too supportive of women who want abortions, too willing to treat people with HIV. They demand that she take a month off, to pray and reflect and consider returning to her husband. While she is gone, they will retool the clinic to focus on serving the "working poor" rather than the homeless, who they deem without virtue.

usually cannot even get accurate information from fracking companies about what their patients have been exposed to because the companies claim the chemicals are secret, proprietary information.

The Frackopoly is important to understand not just for the actual human, environmental, and overall climate damage that their enterprises cause, but because their unchecked dominance and control over the energy debate, public perception, and the political process unnecessarily creates demand for fossil fuel products, removes incentives to reduce energy usage, and blocks the sustainable energy transition from "blossoming," as Hauter explains.

The book also details some of the victorious and important fights communities have waged against the Frackopoly, most notably the state ban against fracking won by activists in New York state in 2014 and the growing movement by local municipalities, such as Santa Cruz, Mendocino, and Monterey counties in California, to ban fracking within their boundaries. The anti-fracking movement is gaining traction. She urges us all to organize, organize, organize to pressure our elected officials to ban fracking and keep all fossil fuels in the ground, as well as to truly support the development and transition to renewable energy.

This is not light reading, but Hauter does a good job of writing clearly and weaving in stories where appropriate. Frackopoly is an eye-opening book, and represents yet another important contribution Hauter has made to our shared goal of global public health. —*Lucia Hwang*

These are the conditions that precipitate Ensign's own homelessness, unique in one sense, but similar to what triggers homelessness for so many. When the very network, family, and job you most depend on for support reject you or when you are compelled to reject them because they are abusive, you are left with few options. If you want to find out what happens, you'll have to read the book!

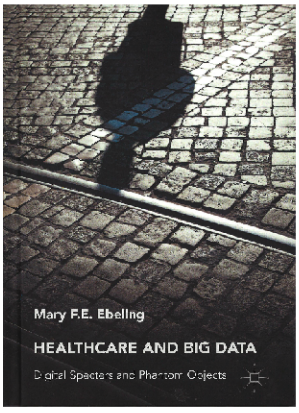
In the book's introduction, Ensign writes, "Stories analyze us if we pay attention to what attracts or repels us while reading or hearing the stories, and if we reflect on why that is so. Stories we easily understand are stories we easily forget."

I highly recommend you read this book. You won't forget it.

—Martha Wallner

Healthcare and Big Data: Digital Spectors and Phantom Objects

By Mary Ebeling
Palgrave Macmillan US, 2016



In *Healthcare and Big Data: Digital Spectors and Phantom Objects*, author Mary Ebeling investigates the birth of what she calls her phantom "marketing baby." This phantom baby's digital birth in a marketers' database coincided with her very real miscarriage. Ebeling's phantom baby returns to haunt her everyday life, resulting in an endless, emotionally draining stream of mailings, sales calls, and online advertising that she receives after being wrongly tagged as a new mother by some unknown, but influential marketing database.

Healthcare and Big Data's aim is to show "how patients and users of healthcare in the USA are subject, with or without our consent, to massive data surveillance, collection and commodification." The book examines how a large, yet nearly invisible industry of data brokers collects and resells hundreds of data points gleaned on each of us daily from both online and off-line behavior. When a service on the internet such as email, a search engine, a social media platform, or a website such as WebMD, is offered to you at no cost, that means that you and the data you generate are what is for sale on the back end. Data brokers collect information on individuals from more than 50,000 sources that are packaged into an estimated 200 records on average for every U.S. citizen. This vast trove of records collected in massive databases that grow larger by the nanosecond is what is meant by "Big Data."

Big data is sold to the public as a means to revolutionize healthcare and improve our lives and our health. But big data is a huge business enterprise intended to generate profits from what many of us believe mistakenly is our personal health information. For Ebeling, big data "means mass surveillance, and intrusion into what we consider private." Ebeling argues that patients in the United States do not give informed consent to how their information is used or shared and that "the power over health data and digital personhood has never been in the hands of the patient."

While many healthcare providers think of the goal of HIPAA as being to keep patient data confidential, Ebeling points out that HIPAA was designed to facilitate the sharing and disclosure of patient data. In many cases, all the care that a nurse may take to protect a patient's individual privacy is rendered meaningless with the act of entering the patient's data into an EHR! This is because many EHR companies require hospitals and physicians to sell or release patient data to the vendor, making all the information input through the software the vendor's property, which the vendor can resell to data brokers or other third-parties. This means that EHR vendors operate essentially like Facebook when it comes to owning and controlling the data we generate.

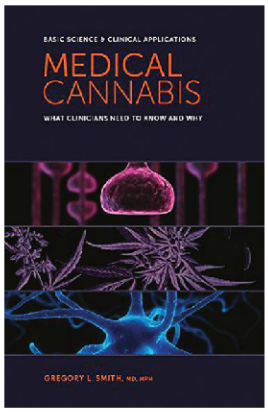
While the public is continually assured that our personal health records have been scrubbed of the data that would identify us, Ebeling calls this faith in de-identification a "collective delusion." Ebeling cites studies where privacy scholars have demonstrated conclusively that supposedly anonymized hospital records can be re-identified with individual patients using just a handful of data points. For example, privacy scholar Latanya Sweeny's 1997 and 2013 studies re-identified the hospital records of individual patients at rates of 87 percent and 43 percent respectively.

Ebeling and others believe that credit bureaus and other data brokers are seeking to combine social media behaviors, health risk factors, and ethnicity in credit risk scores and similar reporting. If such data is combined with our re-identified medical records, and all our credit card and ATM transactions, this data can become even more threatening to our health, privacy, and financial well-being.

Healthcare and Big Data provides the reader with a wealth of references and resources for further study, but parts of the book read like they were rushed to publication. While the chapters focusing on HIPAA and the role of EHRs are written much more clearly than others, useful information often lies amid impassable thickets of academic writing. Even so, the book complements other recent books that explore the endangered species that is individual privacy in a high-tech world, such as Frank Pasquale's *Black Box Society* (2015), and Cathy Oneil's *Weapons of Math Destruction* (2016). *—Nate Johnson*

Medical Cannabis: What Clinicians Need to Know and Why

By Gregory L. Smith, MD
Aylesbury Press, 2016



Timing is everything!

In 1996, with the passage of Proposition 215, California became the first state in the nation to approve the use of cannabis as a medicine. Although medical cannabis has been legalized in 23 states and the District of Columbia, many clinicians continue to hold onto misconceptions about its addictive risks and reputation as a "gateway drug." Most recently in the November 2016 election, California legalized personal marijuana use for people over age 21, so the more knowledgeable a clinician is, the better.

According to Dr. Gregory Smith, 11 other states are in the process of enacting, or are likely to enact medical and/or recreational cannabis laws with varying kinds of restrictions, by the November 2016 election. Rapidly expanding scientific data regarding the beneficial and therapeutic effects of medical cannabis gives credence to decades of anecdotal reports made by patients and their caregivers.

Topics include a brief history of the human use of cannabis, conditions and symptoms that respond to medical cannabis, cannabis