



HEALTH CARE

VOL. 4, NO. 1 | SPRING 2023
aft.org/hc

A BIENNIAL JOURNAL ON HEALTH AND COMMUNITY WELL-BEING



CODE RED

As workplace violence escalates and the staffing shortage grows more dire, patients are unsafe and healthcare professionals are at the breaking point.



CODE RED

Understaffing = Patient Care Crisis 

American hospitals are on the critical list. All across the country, a staffing crisis is jeopardizing quality care. Frontline caregivers are burned out, exhausted from the moral injury of being forced to provide inadequate care—and they are leaving hospital employment in record numbers.

But we can turn things around with:

- + Safe patient levels
- + Fair working conditions to improve morale and retain experienced clinicians at the bedside
- + More incentives to hire, train and competitively pay nurses and other healthcare providers
- + Standards to hold corporations accountable when it comes to patient care

Driven to maximize profits, too many hospital executives have long put the economic bottom line ahead of patient care and the safety of their frontline healthcare workers.

The AFT and our healthcare affiliates around the country are leading efforts to secure safe patient limits and other crucial protections to improve the quality of care our patients receive.

**To learn more about
the Code Red campaign, go to aft.org/CodeRed.**



Fighting for a Better Life for All

RANDI WEINGARTEN, AFT PRESIDENT

THE JOB OF THE AFT, indeed the labor movement, is to fight for a better life for all: Quality health-care and education. Good jobs with decent pay, safe working conditions, and retirement security. An economy and a democracy that enable freedom and fairness. We shouldn't have to fight for these things, but far-right extremists—privatizers and profiteers—would rather cut corporate taxes, and enrich themselves, than invest in the American people. Their agenda threatens the bedrock of our country: our healthcare system and our public schools.

Even before COVID-19, American healthcare was deteriorating under untrammelled corporatization and consolidation. Now, nurses and other healthcare professionals are under siege: burnt out by too many patients, not enough staff, minimal safety precautions, mandatory overtime. By exhaustion, workplace injuries, and skyrocketing rates of violence that make hospitals one of the most dangerous places in America to work. By the moral injury of not being able to properly care for your patients.

As if on parallel tracks, educators in public schools are under siege too. The school privatization movement is trying to methodically starve public schools of funding while stoking fear and division (even claiming that teachers are groomers), aiming to destroy public education as we know it. Culture war operative Christopher Rufo put it bluntly: "To get to universal school choice, you really need to operate from a premise of universal public school distrust." To this end, he says, his side has "to be ruthless and brutal."

The AFT is fighting this scorched-earth mentality. Standing up to hospital CEOs who put profits ahead of patients and against the division of communities and defunding of schools. At the same time, we are trying to strengthen both healthcare and public schools with real-life solutions that help patients and children. In my recent national speech* defending public education, I outlined a four-part plan to help kids' recovery and to reclaim the purpose and promise of public education: 25,000 community schools, experiential learning for all kids (including career and technical education that could feed the healthcare workforce), the revival and restoration of the teaching profession, and deepened partnerships with parents and the community.

In healthcare, we know safe patient limits are key. That's why we launched Code Red, our \$1 million national, multiyear campaign to support our healthcare workforce and protect patients by ensuring safe staffing, investing in recruitment and training, and addressing student debt and violence in all venues—from the hospital floor to collective bargaining to state and federal legislation. A recent study in New York found that if medical-surgical staffing in hospitals were four patients per nurse (instead of about six to seven per nurse), then at least 4,370 lives and \$720 million would be saved over two years (largely because of shorter stays and fewer readmissions). The "savings" for those patients' families and the nurses healing them are incalculable.

Federal legislation sponsored by Sen. Sherrod Brown and Rep.

Jan Schakowsky would specify minimum nurse-to-patient staffing requirements, study best practices for nurse staffing, and ensure whistleblower protections for nurses who advocate for patients' safety.

And we are fighting state by state. In Connecticut, we are seeking to create staffing requirements at hospitals, ban mandatory overtime for nurses, and add protections from workplace violence. In Washington state, we are pressing for a bill tasking the state Department of Labor and Industries with setting staffing standards for healthcare workers. In Oregon, passage looks hopeful for a bill codifying hospital nurse-patient ratios into state statute.

Over 100 AFT healthcare locals are involved in this campaign, many seeking to address staffing through collective bargaining. Staffing ratio language has been negotiated at sites including Ohio State University and Kaiser Permanente and in agreements at SUNY Downstate Health Sciences University, NYU Langone Health, and NYU Langone Hospital—Brooklyn in New York City.

We're also involved in workforce development—helping to create pathway programs and providing mentoring to not just bring people into healthcare professions but also help them stay. This is what the skilled trade unions do with apprenticeships; we need to carve out the same role in healthcare.

This is union work—raising the issues of safety and fairness, and engaging in these campaigns to get these issues addressed. Together, we'll achieve victories we could never achieve alone. +

Code Red is our \$1 million campaign to support our healthcare workforce and protect patients.



ALEX PALOMBO

*To watch my speech, "In Defense of Public Education," go to go.aft.org/94k.

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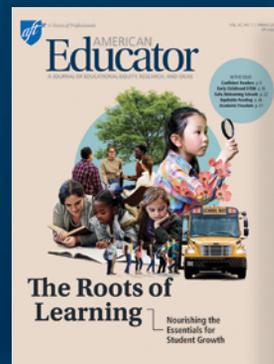
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American Educator, available at aft.org/ae, is a quarterly journal for educators and policymakers from early childhood through higher education. *AFT Health Care*, available at aft.org/hc, is a biannual journal with articles of interest to professionals in healthcare, public health and health policy.



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CODE RED

Corporate greed is putting patients and staff at risk. Together, healthcare professionals are fighting back.

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Our Mission

The **American Federation of Teachers** is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

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AFT HEALTH CARE (ISSN 1063-7710 print / ISSN 1562-6865 online) is published semiannually by the American Federation of Teachers, 555 New Jersey Ave. NW, Washington, DC 20001-2079. 202-879-4400, aft.org

Letters to the editor may be sent to the address above or to hc@aft.org.

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MEMBERS: To change your address or subscription, notify your local union treasurer or visit aft.org/members.

POSTMASTER: Send address changes to AFT Health Care, 555 New Jersey Ave. NW, Washington, DC 20001-2079.

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Cover photo: C.J. BURTON / THE IMAGE BANK / GETTY IMAGES

Ending the Scourge of Workplace Violence

Four Union Leaders Share Their Experiences and Strategies



Healthcare workers help all of us in our darkest hours—relieving our pain, restoring our health, and comforting us and our loved ones. They deserve respectful, dignified, and safe workplaces. But more and more, they fear coming to work. Workplace violence has been increasing, making hospitals among the most dangerous places to work. Driven by the corporatization of care, which puts profits over patients (and which you can read about on page 16), and exacerbated during the COVID-19 pandemic, the staffing crisis is feeding into this crisis of violence.

To better understand the extraordinary challenges facing healthcare workers, we spoke with four union leaders about their experiences with workplace violence and the changes—both institutional and legislative—needed to keep healthcare workers safe: Donna Phillips, an intensive care unit nurse with Providence Alaska Medical Center, the labor council chair of the Alaska Nurses Association, and an AFT vice president; Stacey Sever, a former emergency room and flight nurse with Providence Health & Services and the health and safety committee chair of the Alaska Nurses Association; Jill Hasen, a physician assistant in the University of Michigan's Rogel Cancer

Center and the president of the United Physician Assistants of Michigan Medicine; and Carolyn Cole, a community mental health nurse with the Broome Developmental Disabilities Services Office and an executive board member and council leader of New York state's Public Employees Federation.

As these four leaders make clear, we can't count on hospitals and healthcare systems to protect workers. We have to fight for the changes that will keep healthcare workers safe through collective bargaining and legislative action. That's why the AFT, led by its Healthcare Staffing Shortage Task Force, is calling for passage of the federal Workplace Violence Prevention for Health Care and Social Service Workers Act. Passed by the House of Representatives in 2021 but stalled in the Senate, this bill would require the Occupational Safety and Health Administration (OSHA) to issue a standard on workplace violence prevention planning and implementation. Join the fight for passage by checking out our toolkit: go.aft.org/cl9.

—EDITORS

EDITORS: What experiences have you and your members had with workplace violence?

STACEY SEVER: I've been a nurse with the same hospital here in Anchorage for 25 years. Most of my clinical experience is in the emergency department (ED), but I have also been an ED flight nurse and a nurse educator. Now I'm working a desk job, and one of the things that pushed me to this job was the increasing violence that I've seen over the years. Of course, earlier in my career we'd see violence in the emergency room from a patient who was under the influence of drugs or alcohol or who had mental health issues, but that happened maybe once every six months. Now, it happens once a shift in different departments, and it has become a serious issue. Staff are getting hurt and losing days on the job because of their injuries.

DONNA PHILLIPS: I am a nurse in the ICU of the same facility, and I've been here about 28 years, so I've seen the same increase in violence with little done to give workers increased protection. There are no metal detectors in our hospital, and we've had patients come into the ED with firearms in their backpacks. Hospitals can be highly emotionally charged environments. When patients or their loved ones are in a health crisis and they feel they're not getting the one-on-one attention they need, they get upset—understandably—and can easily be pushed to the brink. I've had people grab my arm so hard that I thought it was going to be broken.

JILL HASEN: My department is orthopedic oncology, but I know we've also had some violent incidents in the ED here in Ann Arbor. There have been two incidents recently in which psychiatric patients have assaulted healthcare workers: in one case, a physician was punched, and in the other, a nurse was tackled by a naked patient. Both of these incidents occurred because the more contained area of the ED where psych patients are seen was full. So these patients were in an area that was not monitored as closely, and they were able to leave their rooms and assault the clinicians.

STACEY: We're also seeing increased violence in our outpatient clinics and in other units in our hospital. Up on the floors, some patients who are at risk for falling must have a patient care tech (PCT) sit in the room with them. Sometimes those patients are violent, and then I'll read in my hospital's safety reports about PCTs getting punched or kicked.

And the obstetrics area has seen increased violence from the partners who come in with our patients. Verbal altercations are a daily occurrence. Staff are quite frequently subjected to verbal abuse, including racial slurs. And staff are increasingly unsafe even off the job, when they're in the community. One patient recognized a caregiver at the mall and threatened them.

These incidents are happening so often now that they almost blur together.

CAROLYN COLE: Over the 40 years of my nursing career, I've experienced my share of workplace violence: I've been kicked, punched, shoved, peed on—you name it. But in my time as a community mental health nurse for New York state, I've experienced workplace violence at levels I've never seen before. My caseload is primarily patients with a dual diagnosis of mental illness and developmental disabilities. I travel out in the community alone to visit them, and it can be dangerous.

One of my patients, a 79-year-old woman with a history of aggression, headbutted me and broke my eye socket, nose, and cheekbone. She was having cardiac issues, and I'd gone with her to the emergency department because I knew the experience would be confusing and scary for her. The ED nurse who was helping me take care of her left the room to get her a sedative, and as he returned, she caught me good. A month later, I was called to the home she was living in, and she was chasing a staff member around the room, trying to beat them with a walker. Thankfully, in these instances, no one was gravely injured, but other healthcare workers in my agency have been injured so badly by patients that they've been put permanently on disability.

EDITORS: Give us the bigger picture as you see it. What underlying problems are driving workplace violence?

JILL: One key problem is that hospitals and EDs have been severely understaffed and overworked with the numbers of patients with COVID-19—and now RSV—and the numbers of people who use emergency care as their primary care. Of course, staffing shortages aren't just a pandemic problem, but the last few years have seen these shortages worsening.

DONNA: And they're worsening at the same time that issues with mental health and substance abuse are growing. As Stacey mentioned, we used to see occasional violent incidents in the ED from patients under the influence or with mental illness, but we're seeing so many more patients with these issues than we used to. We have seen many patients become aggressive and verbally abusive because they're having withdrawal symptoms from alcohol or opioids.

We're also seeing increased violence among patients without these issues. In healthcare, we've given patients the expectation of zero pain. So when they have a surgery or treatment and we can't completely take their pain away, they become frustrated or agitated. And then if we can't meet their needs right away because of inadequate staffing, their agitation is compounded. Patients don't know that while they're waiting for you to help them out of bed or to the bath-



Share your workplace violence story: go.aft.org/ezy.

room, you're down the hall prioritizing someone who can't breathe. And inadequate staffing also means that there's no help when you have a crisis with a patient. When you have somebody who's getting violent and you need to get them anti-anxiety medicine and you're holding onto them so they don't pull out their lifesaving breathing tube, you look out in the hallway for help and there's nobody there. So staffing is a huge part of the reason that violent incidents are increasing.



"Under the corporate model, administrators push and push and push people until they crack."

—Donna Phillips

hospitals no longer have psych units, so now the closest unit is about 80 minutes away, and the nearest outpatient clinic is over 45 minutes away. And once the pandemic hit, we had a plethora of mentally ill people in the community who couldn't get services anywhere for weeks or longer. When you're in crisis and you can't be seen by a mental health professional or you're asked to drive 80 minutes to get help, what are you going to turn to? Alcohol or drugs. And that's a "perfect storm" scenario for violence.

STACEY: An additional problem I see is that when patients come in, they are sicker than they have ever been before. But hospitals keep cutting staff while putting constraints on our time with patients. We've seen an increase in pressure ulcers and other hospital-acquired conditions because we're being pulled away from being able to give the extra care that we are used to providing. For example, we've got elderly patients who aren't very mobile, and we need to be able to take our time with them. Something as simple as a trip to

the bathroom can take 30 minutes or more just to get them upright in bed and make sure that they're not lightheaded and won't pass out because they've been lying down a lot. But management has unrealistic expectations of what can be done with the number of staff on a unit and is even adding patients to already overworked nurses.

In nursing school, you learn how important it is to develop trust with your patient and their family, but you can't do that if you can't spend time with them. Patients are putting their lives in your hands. How do they trust you if you're always rushing in and out, essentially saying, "Oh, here are your pills. I've got to go," or "Here, let's change your bed. I've got to go"? Most nurses want to be able to give the type of care that we would want our children or mothers to receive. When we're not allowed the time to do that, it can feel like we're cutting corners. And going home after a shift thinking "I wish I'd done something more" really weighs on nurses.

JILL: It weighs on us, too. In the old days, physician assistants could actually spend time with our patients—we could sit and talk and really connect to build that trust. I mean, I knew where my patients spent their summer vacations every year. I think that's all lost now in this push to get more patients and more profits in the door. Now I get just 15 minutes with each patient, and I have to see so many patients per shift because management says that's the national benchmark, but does that make it right? I just saw a patient who'd had a hemipelvectomy, where we'd removed half of their pelvis and the rest of the leg because of cancer. It's not right that I only get 15 minutes with that patient, or that I have to tell them, "I know we just cut off half of your body—and by the way, there's a positive margin in there, so we might have to take more—but I've got to go."

And it does feel like cutting corners, especially when patients aren't getting the education that they need to stay healthy after they leave us. I see that with my post-op patients. When they're discharged, they get an envelope of written instructions as part of their discharge summary—but those summaries are done by a resident, a learner with less experience than nurses on the floor who have been here a long time. But the nurses don't have time to sit down and talk to them. Or if they do, there's no time to also talk to the family member who comes to pick up the patient, and the patient forgets the instructions because they're on oxycodone for pain or they assume their family members will handle everything. It's a huge problem. Education is falling to the wayside because our nurses don't have enough time.

DONNA: And we're also not considering the consequences of omission of care—when I give my patients their meds on time but can't help them go for a walk,

for instance. That all adds to why people end up staying in hospitals longer. Studies have shown that increased staffing decreases length of stay, helps people get better, and decreases mortality in hospitals.* But it's hard to get hospitals to do the right thing, and as a union leader it's very frustrating when you know that violence and moral injury are happening because there's not enough staffing. It all ties together and revolves around having enough people taking care of those patients.

CAROLYN: Not having enough time and resources to do your job is incredibly stressful for staff, which creates another concern for workplace violence. Over the last years of the pandemic that we've been dealing with inadequate staffing, exhaustion, and burnout—and being afraid for our health and the health of our loved ones because we weren't being provided PPE—we've seen more nurses struggling with addiction and mental issues and a spike in bullying and violent incidents between staff members. Some staff were working doubles, triples, even staying for days because there was no one else to cover shifts in our 24-hour care facilities. The strain of overwork can cause tempers to flare, and without management taking this problem seriously and providing needed mental health services and support, things can escalate. We had a group home staff member instigate an altercation with a colleague. Luckily, no one was hurt, but management should've addressed the overwork that led to that situation long before it escalated. We have a great employee assistance program (EAP), so when I heard what happened, I contacted EAP and they went to the group home to support the rest of the staff.

JILL: That just underscores the ripple effect of the lack of staffing. We're in a pressure cooker, and emotions get high on all sides. Patients and family members who were already fearful because of the health issue that brought them in for care get agitated and angry when they have to wait a long time to be seen or have their questions answered. And they're yelling at a manager in the lobby or shoving a staff member—or worse. On the clinician side, I'm stressed because there's not enough time to see patients, and I have a heavier workload because all the medical assistants in our clinic have quit due to the bad work environment. When I'm an hour behind and patients are yelling, I feel like I'm failing. And I end up in the bathroom at work crying, being snippy with a nurse, or yelling at the lady in the car beside me as I drive home. None of us set out to react in these ways, but stress can push people to do things they wouldn't do under normal circumstances.

DONNA: Managers don't really have it easier. They want to prove their value to the administration, but their solutions don't address the problems that are creating these circumstances. And I think these large healthcare systems put pressure on the managers of frontline staff, until they end up doing things that they wouldn't normally do if they weren't also under tremendous stress. Under the corporate model, administrators push and push and push people until they crack.

STACEY: It's a vicious cycle because this downward pressure is reflected in the care that is given to the patient. And it's reflected not only in the way patients or family members lash out but also in the lack of support and coping mechanisms to deal with it when they do. When a patient or family member is yelling at a manager and the manager's only recourse is to offer them a coupon for a free cafeteria meal, how is that really dealing with the issue? Solving this crisis is going to take something much bigger. It's going to take legislation and a huge culture change to make sure that the healthcare environment is a safe place to be—for patients and clinicians.

EDITORS: How are you and your members fighting to make your workplaces safer?

JILL: We organized to get the changes we need. I actually started our union from the ground up. I stood up in a meeting and held up the word "union" on a piece of paper like Norma Rae because our working conditions had become untenable. Employees hated their jobs; everyone was burnt out and wanted to quit. Honestly, if I weren't president of this union, I would've retired this year. The strain of being pushed from patient to patient without having enough time or resources to do my job is just too much.

We got our first contract in June 2021, so this work is new and hard, but we're making progress. We're having the necessary conversations in labor-management committees and workgroups and bringing attention to the workload issues that our frontline workers are experiencing so that we can get a resolution.

I'm pleased to say that Michigan Medicine is stepping up and trying to address workplace violence and the issues that lead to it. They put proactive measures



"I have to see so many patients per shift because management says that's the national benchmark, but does that make it right?"

—Jill Hasen

*For more details on the importance of safe staffing, see the excerpt from the AFT's Healthcare Staffing Shortage Task Force report on page 23.

in place even before the Joint Commission revised its workplace violence prevention guidelines in January 2022.* One of the most beneficial measures is the workplace violence prevention team, a multidisciplinary group that meets regularly to debrief about any incidents and make sure people are getting the communication, help, and resources they need in the aftermath. The team also provides training and education and develops prevention strategies that influence policies and procedures related to workplace violence and safety. We've seen positive changes as a result, such as hospital-wide town halls following the ED

assaults to provide employees with de-escalation training and added security in the ED areas that previously weren't being closely monitored.

Management is also stepping up in some ways. They're providing resources for employees who've been involved in a workplace violence incident and getting training to better address incidents of aggression between staff. In the old days, the default management response for employees involved in an altercation was discipline. Now they're really trying to give employees the resources they need to improve communication with their colleagues.

STACEY: As a union, we've also pushed to increase safety measures in our facility. The hospital brought us all together to talk about workplace violence incidents in what they called Caregiver Cafes. One of the topics we talked about is scene safety, which I was already

familiar with because of my background as a paramedic. Scene safety is one of the first things you learn while becoming an EMT, but it's not routinely taught in nursing. A nurse's job is to care for their patient, so if a patient falls out of bed, the nurse's first instinct is to rush into the room to stop them from getting hurt. But if the patient has a history of aggression and the nurse is alone, that's an incident waiting to happen.

So I felt it was imperative that we work to change the nursing culture to include scene safety. Fortunately, the hospital has slowly embraced this concept and put in some measures to help identify patients

who are at risk for violence. Now, there's a red banner that is placed in a patient's electronic medical record to indicate they have violent tendencies, and there's talk of using discreet signs outside these patients' rooms directing ancillary staff to check with nurses before entering the room, so no one goes in alone.

But we need to do far more. Tragically, Doug Brant, a Providence Home Health Care nurse, was murdered in December by a patient's grandson during Brant's first visit to the patient's home. That horrific incident seems to have motivated our administrators to revitalize workplace violence prevention programs systemwide. Here at Providence Alaska Medical Center, they've hired a quality program manager for workplace violence prevention who is reestablishing our workplace violence committee. When that committee was initially formed before the pandemic, I had to fight to join it; this time, I've been invited—so I'm hopeful that now we'll see meaningful action. We cannot continue to put nurses, or any staff, in harm's way.

DONNA: When I was in my early 20s, I worked in a psychiatric ICU with a patient who had jumped from a parking garage and broken his back. He was in a plaster cast from his neck to his groin. I was in the room interviewing him for his psych intake, and he started telling me how much he hated women and getting very verbally aggressive. He may have been in a body cast, but he was a big guy, and I was sitting in a corner with him between me and the door. I was scared that I was going to die.

Recently, I saw a communication from one of our managers reminding staff to protect themselves and never place themselves in a situation where an escalating patient or family member is between them and the door. It's common sense, but it's something I had to learn the hard way, so I'm glad that management is now emphasizing scene safety in this way. Nurses tend to just want to do good, but not everyone who walks into a hospital has the greatest intentions. And sometimes people with the greatest intentions get pushed to the brink.

STACEY: We dedicated the spring 2019 issue of our *Alaska Nurse* magazine[†] to workplace violence. We surveyed our members to find out how they're impacted by violence and spoke with nurses throughout the state to bring awareness to how dangerous workplace violence makes our jobs. I also wrote about the need for scene safety and a culture change around this issue. We are starting to see that culture change, although we had to force it through legislation. In 2018, Alaska enacted workplace violence protection legislation with HB 312, which allows healthcare facilities to press charges for assault on healthcare workers.

"It's going to take legislation and a huge culture change to make sure that the healthcare environment is a safe place to be."

—Stacey Sever



*To learn more about the new Joint Commission requirements, see go.aft.org/68e.

[†]To read the issue, visit go.aft.org/jic.

Trying to win federal legislation, Donna and I went to Washington, DC, with a few other members in 2019 and met with our state legislators—Sen. Lisa Murkowski, Rep. Don Young, and the staff of Sen. Dan Sullivan. We asked them to support the Workplace Violence Prevention for Health Care and Social Service Workers Act, which demands an OSHA standard on workplace violence. During Nurses Week, we asked all our nurses to write postcards to their legislators. That bill passed in the House (in 2019 as HR 1309 and again in 2021 as HR 1195), so now we need to focus on the Senate.

DONNA: This legislation is critical because hospitals are not going to move on this issue unless they are forced to. I say that having lived through the fight for bloodborne pathogen needlestick legislation*—back then, the hospital claimed they wanted frontline caregivers’ voices to help find a solution, but when the solution cost money, they backpedaled. And in a town like Anchorage without another large health system, there’s less competition for hospital workers, so there’s less incentive to do right by your employees. Now we’re slowly starting to see a culture change in our hospital, like increased arrests for violent incidents and the safety alerts in the electronic medical records, but it took more than us saying, “We need scene safety.” It took the state legislation, the American Hospital Association reversing its position that hospitals could be accountable to themselves on workplace violence, and the Joint Commission issuing its standard.

STACEY: The hospital was definitely not moved to make changes out of the goodness of their hearts. They were losing staff over this issue, and it was costing them money. It’s unfortunate that this is what makes businesses do the right thing. The worker has to be the one to push for change, but it has to be legislated and regulated in order to actually put changes in place.

CAROLYN: Where it’s possible, a labor-management partnership can also help push those changes. It’s taken a lot of hard work, but my union came together to make our workplaces safer. I’ve been part of the Public Employees Federation (PEF) for 30 years and was active as a steward before coming to this agency, so I already had background and great training from PEF on labor-management meetings, workplace violence, health and safety, grievances, and being a good steward. When I became a council leader, representing the members in my region at the executive level in the union, I developed good relationships and open communication with management, and they came to know me as someone who respects their position but also wants to work as a team toward a resolution.

Several years ago at my agency, we had a long discussion about the increasing number of violent assaults in the workplace. We worked with our human resources department to get risk assessments and other tools in place to address workplace violence. That served us well during the pandemic. We’ve had struggles getting everyone fit tested for respirators (and they even had the nerve to fit test administrators before caregivers), but overall, the six counties in my region did very well through the worst part of the pandemic because we had weekly management and union meetings, not just on workplace violence but on everything related to health, safety, and labor management. We found that the number of workplace violence complaints decreased because we had such great rapport with our management that they got involved in developing solutions. They hired additional staff for our group homes, increasing our ability to provide one-on-one care for clients who need closer monitoring. And as these clients are able to get out more, the staff are also calmer and less distressed.

The agency has become diligent about tracking our workplace violence incidents. The one piece we are still working on is workplace bullying. We’ve been pushing for legislation to start identifying bullying, because we’ve found that bullying and harassment are often precursors to more egregious violence. We have encouraged our members to report harassment and bullying as workplace violence, which not only helps address the issue with staff, but also helps reassure our clients, who can become confused and retreat to defending themselves if they see employees arguing. So with our partnership, we’ve been making progress.

EDITORS: What other changes are needed to help prevent violence and keep healthcare workers safe?

DONNA: We need to deal with our recruitment and retention problem. We hire lots of new graduate nurses and put them through training, but the nurses responsible for training are also doing their best to care for a full patient load. How do they have time to teach and really support these new graduates so they can provide the best care? I have never trained as many people as I have where I currently work, but it’s not enough to hire people and



“We need to restore respect to the healthcare field and to those of us who have devoted our lives to caring for patients.”

—Carolyn Cole

*To learn more about union efforts to win worker protections against bloodborne pathogens, see “How OSHA Can Better Protect Healthcare Workers” in the Fall 2022 issue of *AFT Health Care*: aft.org/hc/fall2022/barab.

Become a champion for ending workplace violence: go.aft.org/cl9.



put them through a great training program; you have to create an environment where they want to stay. One way to increase retention is to legislate a reasonable nurse-patient ratio, with fines for noncompliance. Legislation would be huge for improving workplace violence, moral injury, and retention. Because what we're doing now—trying to fill holes with a revolving door of new hires and recruiting nurses internationally (creating shortages in other countries)—just isn't working.

STACEY: When I was an educator many years ago, a nursing preceptor who was training a new employee would have a lessened patient load so they had time to teach the orientee the job. That doesn't happen anymore. Frequently of late, I'll hear a report in a safety huddle of an orientee being pulled off the floor to work an assignment because "they were close to coming off orientation anyway" and management needed the staff. That's pretty scary. And it leads to burnout for both the new and experienced employees. And now, we've got even more experienced nurses who are moving to part-time, moving out of bedside care altogether (as I did), or retiring because we're exhausted, and we want to come home to our families at night. Who will replace us?



It comes down to being valued as an employee. When our facility has a 25 percent turnover rate in the first year of employment, it's clear that the hospital doesn't see the value of experienced nurses. They'd rather offer huge sign-on bonuses for new hires than do the work of creating a supportive environment for those of us who stay. We also have a lot of leadership turnover, and the inconsistency that comes with that leads to staff confusion and upheaval. And unfortunately, it does take legislation and a whole culture change to show that nurses are valuable and the patients they take care of are valuable.

JILL: I agree; retention and recruitment are huge issues we need to address. We've also lost good, experienced people: nurses who've been providing care for 30 years, clerical staff who have 20 years of institutional knowledge, and all of our medical assistants. They left because they can no longer work in this stressful environment. And the new people coming in are so young and inexperienced; there's not enough staff to mentor or even fully train them. They're thrown out into patient care sooner than they used to be, sometimes before they're ready, and that pressure has a snowball effect.

Valuing workers starts with recruitment and means paying all staff—including medical assistants, nurse assistants, patient care associates, custodial staff,

lab techs—a living wage with work flexibility and time off, which means resolving workload issues to improve work-life balance. Nurses cannot do their jobs if they don't have enough medical assistants, and they cannot spend time with their patients if they're consistently responsible for tasks outside their scope of practice. My members have also been pushing for a workload review for over a year. Full-time physician assistants (PAs) are supposed to work 40 hours a week, but some of us are working up to 60 hours without receiving extra pay or an extra day off, because that would just add extra work to the other PAs in the department. Uncompromising managers are working people ragged, and their "business way" of handling these issues does not include what we clinicians think.

If we're going to continue to see change on workplace violence, communication is key, as is working with labor and management in committees and work groups to make sure they understand what's actually happening with the frontline workers providing patient care. If they want to keep us here and keep our operations functioning, they have to think about our work-life balance. We can't continue working like this.

CAROLYN: I've had similar conversations with management; I told them plainly that if they continue to beat down nurses and cause them to leave, management will eventually be out of jobs as well. You can't run a healthcare agency without nurses. So direct staff need to be paid what they're worth. And we need to ensure that staff have the resources and support—including policies on PPE and expanded access to mental health services—to do their jobs well, without the fear of violence. In the unfortunate event that they experience violence, they need to be taken seriously—not treated as if being assaulted is in their job description.

What's also needed is greater awareness about managed healthcare. It's real, and it's affecting our patients in big ways as corporations and insurance companies are increasingly dictating things like length of stay and other important care decisions. We need legislative change that gives the healthcare team a voice in these decisions. Medical professionals, not insurance companies, have one-on-one histories with patients. They provide appropriate care based on each patient's individual needs, not a profit algorithm.

My mother died of cancer when I was 20, and I still remember how wonderful her healthcare team was, how great they were in caring for her and helping us cope. Forty years later, it's scary to wonder who would care for me if I became sick. This is a national problem, and I think a lot of it is due to healthcare becoming more about profit than people. Corporations can make a great profit and still invest in healthcare worker safety. We need to restore respect to the healthcare field and to those of us who have devoted our lives to caring for patients. A lot has been taken from us. But we are fighting back. 

Do No Harm

Organizing as a Physician



When I was a child, I dreamed of being a doctor. I wanted to provide care to the sick and injured. That's part of why, many years later, I chose to specialize in emergency medicine. I wanted to be able to see anyone, anytime, with any problem, regardless of their ability to pay. Serving my community in that way felt like a higher calling.

I entered medicine with a certain level of idealism, and while more than a decade of experience has tempered it in some ways, those values still drive me. That's why seeing this profession that I have held in such high regard be demeaned by pressure toward corporatization has been so disheartening. Healthcare workers are essentially being transformed into cogs in a profit-making industry at the expense of patient care and at the expense of the people who have given years of their lives to train for a purpose. That was a big part of why my colleagues and I organized the clinicians at PeaceHealth's Eugene-Springfield urgent care facilities.

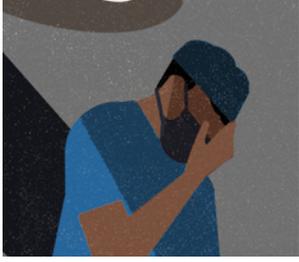
Building a Community and a Career

Community and family have always been at the heart of my medical practice and at the heart of the choices I've made about how I practice. My extended family lives in Medford and Oakridge, Oregon, and I graduated medical school from Oregon Health and Science University, so returning to Oregon in 2016 after I finished my residency in Pittsburgh felt like a natural choice. My husband and I moved back and started putting down roots, and it's been a joy to grow our family here.

When we had our first child, I found that the schedule of an emergency physician disagreed with the needs of my family, so I transitioned into urgent care in 2018. That's when we came a couple of hours south to Eugene, where I began working at PeaceHealth's West Eugene urgent care clinic. PeaceHealth was an appealing employer because it is the only urgent care provider in the community that accepts Medicaid. Other urgent care clinics in the Eugene-Springfield area only take online appointments and do not accept Medicaid, so people with low incomes and those with-

By Morgan Garvin

Morgan Garvin, MD, is a board-certified emergency medicine physician in Eugene, Oregon. She is a founding member of PeaceHealth Providers United.



We were not willing to endanger our patients or sacrifice our families so that PeaceHealth could increase its profits.

out internet savvy get shut out. At PeaceHealth, I felt I could continue seeing everyone regardless of their status and live into my values.

Initially, working at PeaceHealth was just what I was looking for. We had a very strong team with clinicians who had been there for a long time. We were a much-needed support for both the primary care clinics and the emergency department (ED). But retirements happen, and people move. Then the pandemic came, and we found that while our numbers were starting to dwindle, staff were not being replaced at the same rate.

In late 2020, we started sounding alarms to our managers and to our administration, especially because they had the power to open up positions and hire people. But the response was lackluster. We continued to lose staff, and it turned into a serious crisis in late 2021 as people started leaving in protest because their concerns were not being addressed. PeaceHealth had named us the 2020 Clinic of the Year, yet the administrators were allowing our clinic to wither. With high turnover and a lengthy onboarding process (about six months), administrators should've taken a long view of where the workforce was and where they wanted it to be. But instead of getting out in front of this clear problem, PeaceHealth watched the provider group shrink to a third of its former size. Worse, it refused to offer per diem contracts to departing clinicians, even when they expressed interest (and even though we already had some clinicians on such contracts).

A Mounting Crisis

When I joined PeaceHealth, we offered urgent care at three locations—West Eugene (my clinic), Gateway, and Valley River—plus some limited services at the Woodfield Station walk-in clinic. Before COVID-19, each clinician could see 30 patients on a busy shift, such as during the height of the flu season; with three clinicians, we could see around 200 patients a day among us across the four clinics. COVID-19 changed how we approached patients, especially in terms of the personal protective equipment we had to use, and for a time the demand for non-COVID-related concerns decreased. But patient numbers picked up again in 2021. We found ourselves unable to meet the renewed demand: Valley River had to close in fall 2021, then the Gateway clinic in November 2022, because we couldn't keep enough providers. So two-thirds of our urgent care clinics have closed in response to continuing deteriorating staffing, which is a serious blow to the community.

These closures affect more than just wait times in our clinic. We have heard from our ED physician colleagues that the census of low-acuity patients, people who could have been seen by us, has gone up. According to one figure, the number of those patients

doubled in the ED after Gateway closed. I have also seen patients who developed preventable complications—such as wound infections and simple urinary tract infections that turned into kidney infections—days after they were turned away from our clinic.

We have wonderful staff who are all committed to making sure our patients receive excellent care, even under these circumstances. Our patient access representatives who staff the front of the clinic are trained to recognize red flag symptoms like chest pain, stroke-like symptoms, or abdominal pain in pregnancy. Our nurses effectively triage these patients, and in many cases, patients can be redirected to the ED if they are stable and there is nothing meaningful we can do for them. But a few will need stabilizing care and safe transport to the ED, and then one of us will drop what we're doing to attend to the emergency.

Frequent task-switching becomes burdensome when we find ourselves working as solo providers, which was a serious problem when we were most short-staffed. Procedures and conversations get interrupted, adding to the frustration of our patients. Wait times become egregiously long, and some patients take their frustrations out on our staff.

The overwhelming demand also puts a strain on us when we get only 30 minutes for lunch in an 11-hour shift. And it can be hard to find time to stay hydrated or take a bathroom break when you're trying to see three patients an hour and some of them need breathing treatments, x-rays, or additional testing. In spite of these challenges, I have remained determined to meet the needs of my patients; I can't just steamroll through them like they're assembly line products. I wouldn't want that for my family.

PeaceHealth's Failed Response

PeaceHealth's administrative response to the closure of the Valley River clinic only made these problems worse. The administration unilaterally rolled out an "Urgent Care Recovery Plan" in late March 2022 to address census and "productivity" issues.

One of those changes involved mandating that we see, evaluate, and bill every patient who walked in through our doors, regardless of whether they were appropriate for our clinic. People with clearly complex injuries, pregnant people with abdominal pain, and people with stroke symptoms that we were not equipped to evaluate, who all should have been triaged immediately to the ED, would suffer the double injury of delayed care and an extra medical bill. We found that to be exploitative, unethical, and harmful.

Another policy instituted without our buy-in disallowed us to close a clinic based on our capacity. So an unlucky clinician working solo might find themselves staying hours past the end of their scheduled shift to see every patient still in the waiting room. Eleven-hour shifts became 13-plus hours—we could no longer tell our families when we'd be home. It was instantly

demoralizing. Per-diem providers who had previously worked regularly, even covering for clinicians who were ill, abruptly stopped taking shifts. Others simply looked for work elsewhere.

I can understand why my colleagues may be actively looking for other jobs. When every day can be a battle and hope for meaningful improvement remains in the distant future, the motivation to stay can be hard to maintain.

Organizing for Patient Safety

PeaceHealth's distressing decrees prompted us to take collective action. We were not willing to endanger our patients or sacrifice our families so that PeaceHealth could increase its profits.

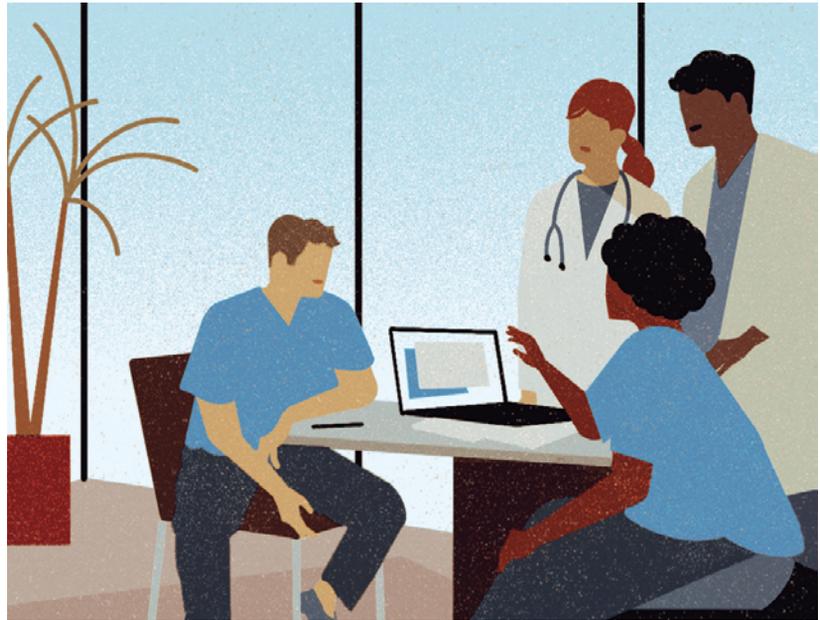
In April 2022, my clinician colleagues and I had a meeting to discuss the policy changes. I had brought my laptop to this meeting, and together we composed a letter signed by 85 percent of the clinicians affirming the values we were committed to and the practices that we would refuse to abide. It informed the administration that we would continue to act in the interests of our patients before profits. (To read the letter, go to aft.org/hc/spring2023/garvin_letter.)

After receiving the letter, the administration compromised on triaging patients but did not initially relent on the issue of clinic closure due to being over capacity. Their decision made it clear that real change could only be secured by forcing them to bargain with us—and that meant unionizing.

To be honest, I didn't think unionizing was a possibility in March 2022, even though it was something I supported. Then I heard that the PeaceHealth hospitalists had unionized at Sacred Heart in 2015, so I contacted the hospitalist founder, David Schwartz, and set up a Zoom meeting with our team so we could talk about our concerns. He told us about his experience and put us in touch with the AFT organizer who had helped him.

We chose to form PeaceHealth Providers United as a new bargaining unit of the hospitalists' union, the Pacific Northwest Hospital Medicine Association. The Woodfield Station walk-in clinic joined with us because we provide similar services and there has been a lot of cross-coverage between our locations—when they need a clinician, oftentimes one of us will cover, and vice versa. And with only two full-time clinicians at Woodfield, stabilizing working conditions and staffing is critical.

The AFT's organizing staff was really helpful in leading us through the process of gathering signatures on authorization cards and rolling out the voting campaign. We had a lot to learn about unionizing, our legal rights, and the importance of a clear mission statement. The signature collection took place in late May and early June 2022; by early July, we had our election scheduled. The ballots (we did vote by mail) were counted on August 18, 2022, and the result was unanimous.



Claiming Our Seat at the Table

We're now waiting for complete information about PeaceHealth revenues and expenses as we prepare for contract negotiations. We hope we'll be able to right some of the wrongs, such as increasing pay for advanced practitioners so we can recruit and retain the best providers. If other urgent care facilities can afford to pay their advanced practitioners the market rate, so can PeaceHealth. Money that has been paid to bring in expensive temporary providers could be used instead to retain the experienced local workforce we have.

Fundamentally, we want changes that will stabilize our staffing and contractually secure basic working conditions, such as specified shift lengths. I would like to see us reopen some clinics, too. This last year has been terrible for respiratory viruses. Some of the patients I see thank me for being there or apologize about how busy it is, but it is the patients' experience that has changed the most—they used to be able to walk in and be seen within two hours, and now wait times are far longer. That some will still wait six hours to be seen is a testament to the desperate need for care.

Despite our struggles, PeaceHealth doesn't seem to be working hard to prioritize recovery for us. In December 2022, it only had two open positions advertised on its website for urgent care in Eugene: one physician and one physician assistant (PA). Why hasn't PeaceHealth opened more of those vacant positions? Why were departing providers who were interested in per-diem contracts not given them? Why is the base pay for our PAs and nurse practitioners (NPs) still significantly below the current market average? And why do our executives earn bonuses amid this failure?

We want changes that will stabilize our staffing and secure basic working conditions.

PeaceHealth has chosen to play games, attempting to deny us our annual base pay increase after we unionized. We were able to call out this unfair labor practice immediately, and within a few weeks PeaceHealth relented, but not before losing yet another NP who had been hired only three months before.



Putting My Values and My Patients First

When I interviewed for PeaceHealth in 2018, I told them that I wanted to join a place where I could stay, and that's still my intention. I've worked at different places, and I know that for an emergency physician, what's out there for me in Oregon is a lot of independent contracting positions that offer even fewer protections to me as a worker. I'm certainly not eager to uproot my family either.

To meet the needs of our patients and to protect our profession, we physicians have to step up and organize.

I work hard, seeing as many patients as I can. Yes, work is hectic, but I'm not the one being asked to wait for six hours to be seen for an illness. I know I can leave if I want, but what I will find in another large health system or contract medical group is the same thing: a relationship based on extracting maximum value for minimum expense. Here, I have a chance to be a part of something new, to actually work in a unionized clinic. That's something I never thought was possible when I became a physician. Not only can we make this a really special place to work and a great place to be a patient again, but the standards we establish can also start to put pressure on other clinics to create positive changes.

A New Paradigm for Physicians

Many physicians are not used to thinking of themselves as part of labor. I did see myself as a worker because emergency physicians traditionally have done shift work in hospitals. But for much of modern history, physicians have owned their own practices or worked in hospitals with physician CEOs, so decision-making at the executive level was informed by best medical practices. However, as healthcare has been transformed by corporate America in the last several decades, that model is becoming rarer.

Now, healthcare systems are increasingly modeling their behavior on for-profit corporations. Their concern is increasingly with the bottom line and with extracting more labor from fewer workers. We physicians need to recognize that we are seeing our role deprofessionalized, like many other professions and trades have been transformed in the industrial era. To meet the needs of our patients and to protect our profession from being degraded any further, we have to step up and organize.

I want to see this union succeed because I want to take this message to other people. I see clinicians sharing on social media about the despair they feel working for what feels like a sickness-billing indus-

trial complex, and I want to show them that something better is possible. I don't think unionization will solve every problem—for example, I think we also need Medicare for All to get rid of the insurance profit motive—but it's important to give power over how hospitals and clinics are run back to clinicians.

Unfortunately, our healthcare system has become enthralled to a cult of efficiency, sacrificing resiliency at every level. And that hyperfocus on efficiency has consequences. We see it reflected in systems like Ascension Health, which (according to a *New York Times* investigation*) continued to cut staff as it raked in billions in profits. And we see it reflected at the individual level as clinicians burn out, leave their professions, and even die by suicide. We see patient care sacrificed as patient-nurse ratios get pushed higher in the hospital setting. I saw it a few months ago as we were hit by one of the worst respiratory viral seasons I have ever witnessed, and we had to turn away dozens of patients each day for lack of staff.

With higher union density across the healthcare system, those bare-bones, "efficient" staffing levels can be changed. And that leads to better patient care, better outcomes, and better morale among healthcare workers. This in turn translates to better healthcare worker retention and less utilization of expensive and climate-costly travel nurses and clinicians. And we can have better support. The nurses at the Eugene hospital succeeded in creating a committee for workplace violence, which we also encounter in urgent care. Our union plans to address that, too.

To other physicians who have thought about organizing, I want you to know that it's worthwhile, it's possible, and it can be easier than you think. The first step is just to contact a union representative and start asking questions. If you find yourself complaining to your colleagues about working conditions in almost every conversation you have with them—and especially if they're voicing the same concerns—then it's time to organize. If there's a common reason people are looking for other work, take action around it. Having at least one concrete issue to rally around is essential. For us, it was being able to say, "No, I will not make a patient wait for me and then bill them for simple triage advice if they have an emergency medical condition beyond my ability to treat because that is antithetical to my oath." It wasn't like everyone was itching to unionize before that. We started with a letter, but now we're standing alongside the 1.7 million members of the AFT. We created our own seat at the table, and we're looking forward to bargaining our first contract. +

*R. Robbins, K. Thomas, and J. Silver-Greenberg, "How a Sprawling Hospital Chain Ignited Its Own Staffing Crisis," *New York Times*, December 15, 2022.

Forming a Union in Nine (Not So Easy) Steps

Healthcare workers form unions when they feel ignored, unheard, or denied the ability to advocate for their patients, themselves, or their professions. Moving from initial, quiet conversations with coworkers to winning recognition and negotiating a contract may seem overwhelming—but it doesn't have to be.

If you and your colleagues are considering forming a union, the AFT has you covered. While each organizing campaign is unique, they all follow the same process.

1. Something happens on the job.

Unionizing doesn't happen in a vacuum. There may be something big that pushes healthcare workers over the line, many small things that compound over time, or a realization that unionized workers nearby are making progress.

We start to grumble quietly among ourselves. Talking with coworkers, we start to question our working conditions and how care is delivered in our facility.

Our trust in our coworkers grows, and so does our respect. We speak with our managers, but our words are ignored. We begin to worry about our patients in a whole new way.

2. We decide to organize with AFT Nurses and Health Professionals.

After connecting with an AFT healthcare organizer by emailing formaftunion@aft.org, we start to use words like *voice* and *power*. We spread the news quietly.

We learn about our right to organize, which is protected under federal law, and carry a union rights wallet card to share with our coworkers.

We form an organizing committee of coworkers to lead us. We observe coworkers in a new way: Who is a natural leader? Who has useful skills—like public speaking, caring for children, writing, or making snacks—for organizing meetings?

We form subcommittees for events, social media, outreach, and more. We all have a role to play. And we know that what's most important is showing up.

3. We survey our coworkers.

In one-on-one and small-group conversations, we ask: What do you care about?

- Quality of patient care
- Scheduling that hurts our families
- Safe staffing
- Better wages
- Mandatory overtime

- Workplace violence
- Pension and retirement
- Injury on the job
- The need for high-quality training
- Compassion fatigue and anxiety
- Unfair dismissals

The answers shape our campaign.

4. We discuss: "What is a union card?"

When organizing, the union card is each individual's signed commitment to joining the to-be-formed union.

As momentum builds, we sign cards and collect them from our coworkers. We write a mission statement so our colleagues, managers, and the community know what we stand for. Or we just keep talking.

5. We prepare for opposition from our employer.

Our managers will feel threatened and be directed to dissuade us. Some will recruit our coworkers to dissuade us from unionizing. (But others will quietly support us.)

We keep talking to coworkers at times when non-work conversations normally occur. (The union rights wallet card has helpful information on this.) We keep collecting cards.

6. We go public at work.

When a supermajority of our coworkers has signed the cards, we deliver the cards to the nearest regional office of the National Labor Relations Board, the federal agency that will oversee our union election.

We wear stickers and buttons. We continue to sign up our coworkers. We are visible. We know there's safety in numbers.

7. We mobilize our community.

Building community support is an important way to create momentum, so we inventory our contacts. Everyone is interested in healthcare because everyone gets sick!

We talk to

- Social issue committees at our places of worship;
- Friendly local businesses;
- Other unions at our facility;
- A neighbor on dialysis;
- A cousin who frequents the ED; and
- Patients, past and future!

We reach out on social media, sharing and liking our campaign on Facebook, Instagram, and other sites. We keep collecting cards.

8. We prepare to vote.

When the labor board announces the date and place of our union election, our countdown begins.

Management may hire attorneys, post flyers, and seek one-on-one conversations to challenge us. To remind ourselves, our community, and management of our strength, we publish brochures with our stories and our faces. To encourage each other, we wear stickers.

Remember, we are the engine that drives our facility.



9. It's election day!

We vote early. And then we check with coworkers to be sure everyone has gone to the polls.

When the polls close, we all attend the vote count. Then we celebrate!

Now that we have organized our union, our real journey begins. We will

- Elect the contract bargaining team;
- Create a support network;
- Throw a holiday party;
- Bargain the contract;
- Vote on the contract;
- Elect leaders;
- Set our own dues;
- Enforce the contract together;
- Meet in labor-management teams; and
- Continue to care for our patients and our families.

—Staff of the AFT's Nurses and Health Professionals Division

Email formaftunion@aft.org to connect with AFT Nurses and Health Professionals organizing staff.



Bedside Medicine to Corporate Medicine

How Working Americans Have Paid the Price

By Robert W. Derlet

Robert W. Derlet, MD, a professor emeritus of emergency medicine at the University of California, Davis, is the author of *Corporatizing American Health Care: How We Lost Our Health Care System* and over 100 articles. The former chief of emergency medicine at the UC Davis Medical Center, he has published research on healthcare delivery for the past 30 years.

Late one afternoon, an office staff member at the rural clinic where I was a physician asked if I would double-book a patient who injured her back. Less than an hour later, a 62-year-old woman struggled down the clinic hallway to get to the exam room, using a pair of old walking canes her husband had relied on before he passed away. She had bent over to lift a heavy trash can and felt a sudden tear in her back, followed by severe pain and back spasms. The diagnosis was clear from my exam: a herniated disc of the lower spine. She needed an MRI and a referral to a spine surgeon.

The staff member called the patient's health plan to get approval for both, but they were denied. We were told she needed bed rest and pain medications. When I personally called the health plan for a doctor-to-doctor appeal, I could not get through. I recommended she go to the emergency department (ED), but like many of my determined rural patients, she refused. I then told her I would call her health plan the following morning to get the needed approvals, and that she should have her neighbor drive her back to the office the following afternoon.

The next morning, I spent well over an hour arguing with the health plan. Their answer again: bed rest,

pain medications, and physical therapy (PT). PT was impossible; she could not even roll over when lying down, needing to use her arms for almost any movement as though she were paralyzed from the waist down. So, I sent her to the closest hospital ED that had spine surgeons on staff. She had her MRI, and a spine surgeon operated on her the next day.

Although her medical outcome was good—after recovery she resumed normal activities—her financial outcome was disastrous. She was stuck with an out-of-pocket bill of over \$100,000. The true cost of her care was a fraction of that, but it's routine for hospitals to charge outrageous fees for every last IV push and bandage. And her health plan only contributed a small sum because she went to an "out-of-network" hospital. This is our American system of corporate medical care.

Healthcare is now just like any other industry: its goal is to maximize profits without regard to the harm caused.¹ With Wall Street and private equity lurking behind the scenes, profit is increased by denying needed medical care to patients.² Administrators may determine what medical care a person receives. Patients' experiences are worse and healthcare professionals are suffering, but why would that matter to people who see illness and injury as opportunities to get even richer?

When I completed medical school in 1975, the US healthcare system was relatively simple: Need a doctor's appointment? Call one of many doctors, and you'd get an appointment the same week or even the same day. Some doctors' offices would even take x-rays and perform simple tests. Most physicians, both primary care doctors and specialists, worked in independent offices owned by a single physician or a small group of partners. If you needed additional care, your doctor would oversee it at your locally controlled hospital,* which was likely nearby; in 1977, there were more than 7,000 hospitals.³

Fast-forward to today. Healthcare has morphed into a world of detours, roadblocks, frustrations, and long waits.⁴ The number of hospitals has declined to about 5,000,⁵ leaving many people in rural and low-income communities dangerously far away from necessary services.⁶ And under the profit-driven corporate culture that now dominates what has been termed the *healthcare industrial complex*, the very idea of caring for people is all but forgotten by industry leaders. Now prior authorizations from insurance companies may be required for medications, specialists, procedures, surgeries, and imaging such as MRIs and CT scans. When a patient finally sees a clinician, the clinician is forced to focus on the computer, not the patient. And a confusing array of in-network versus out-of-network physicians and hospitals exists, along with outrageous out-of-pocket expenses that too often cause bankruptcy and even homelessness.⁷ The negative consequences for patients are obvious. More subtle is the toll these changes are taking on the doctors, nurses, and other health professionals who are suffering burnout and moral injury. My colleagues and I chose healthcare to heal people, not to funnel gold to Wall Street.

How did we evolve to such a horrible system of healthcare in the United States? I wrote a book on this topic, *Corporatizing American Health Care: How We Lost Our Health Care System*, that traces my time as a physician over the past 40 years.⁸ The book explains how our system of healthcare has transitioned from caring for people to putting profit first. In the book, as well as in this article, I also explain how we—healthcare professionals and voters—can take our healthcare system back.

By my estimate, about half of our costs in healthcare are unnecessary. How do I know? Just look at our peers across the Atlantic. The United States spends \$12,000 to \$13,000 per person per year to provide healthcare.⁹ But Western European countries, where care is equal or better, spend about \$6,000 per person per year, and out-of-pocket costs for individuals tend to be much lower than in the United States.¹⁰ Hospitals are run efficiently, and healthcare professionals make decent wages—but

these countries' lawmakers have prevented anyone from making an abusive profit from illness and injury.

I began my career as a physician in the summer of 1980. I had already completed medical school, a residency in internal medicine, and a 30-country circle-the-globe trip with not much more than a backpack and an airline ticket. I had my first introduction to the European system of healthcare after needing vaccines for travel to Africa, and I refreshed my training in tropical medicine by working in a remote jungle area of Sierra Leone.

My choices in 1980 were endless. I could take out a loan and start an independent practice in primary care or continue training to become a specialist (I was offered a fellowship in cardiology). But I chose to become a hospital-based ED physician at the University of California Davis Medical Center in Sacramento. I loved it, especially in the early years, and served as chief of emergency medicine for 18 years. My final eight years of clinical practice were as a primary care physician in a rural clinic in the foothills of the Sierra Nevada mountains, where most of my patients heated their homes with firewood cut from the surrounding forests. Those were my best years as a physician. Getting to know my patients well and helping them in their struggles with an ever more complex health system was fulfilling.

Throughout my professional life, I have also been fortunate to serve as a visiting professor at multiple hospitals in eight Western European countries. The more American medicine is consumed by profit seeking, the more thankful I am for having seen firsthand that there are ways to provide excellent, affordable care.

Profits Over Patients

Walking home from the grocery store, my 95-year-old father was run over in a crosswalk.[†] Bloodied and almost unconscious, he was taken by ambulance to the Los Angeles County+University of Southern California Medical Center and hospitalized for five days. Soon, a \$2,000 bill arrived for the ambulance. My father's health plan clearly covers ambulances, minus a \$100 deductible. So why did he receive a bill? Because the ambulance was not preauthorized. But who, exactly, could have called for preauthorization? The kind stranger who called 911? The paramedics concerned with stopping his bleeding and his, as they put in their report, "altered mental status"? Perhaps my father was supposed to call?

But that wasn't the end of this saga. Next, his health plan deemed the medical center out of network and denied coverage of his hospitalization. After many hours on the phone struggling with the health plan, my sister paid the ambulance bill from my father's bank

The goal of today's healthcare industry is to maximize profits without regard to the harm caused.

*Throughout this article, I refer to medical centers, health systems, and hospitals as *hospitals*.

[†]For more details on this incident, see my book *Corporatizing American Health Care: How We Lost Our Health Care System*.

account and hired an attorney to handle the hospital bill. Only then did the health plan relent on the medical center. My family was not bankrupted by this experience, but far too many of my patients are. The denial of coverage—even for true emergencies—is outrageous. (As noted later in this article, the No Surprises Act of 2021 should prevent this in the future, but it may be challenged in court.)

Sadly, I know that all healthcare professionals have stories like this. We need to share them. We need our fellow community members and voters to know. We need our elected officials to know—and to act. So I'll share a couple more stories.

Dave, an acquaintance of mine, recently told me about his struggles getting cataract surgery to avoid losing his driver's license. The eye surgeon, in independent practice, required him to have a medical exam, laboratory tests, and an x-ray as part of a pre-op evaluation. He had two weeks to complete these tasks, but the soonest appointment he could get with a primary care physician (PCP) was in four months! In his town, all independent PCPs had vanished, swallowed up by the single hospital system where administrators made the rules on how medicine would be practiced. Desperate to keep his license, Dave waited in a long line in the hospital's urgent care clinic to have his forms completed by the doctor. He then had to make appointments for laboratory work and x-rays. His bill: \$1,800. His health plan refused to pay because they considered his visits unnecessary; they claimed he was healthy.

Susan, a patient of mine at the rural clinic, was stung by a bee. Luckily, a neighbor saw her faint and called 911. The paramedics gave her epinephrine and took her to the ED, where with just a little more treatment she was soon ready to go home. Advising her to wear an emergency bracelet, the ED doctor prescribed an EpiPen. He also showed her how to use it and urged her to carry it always. But he didn't ask if she could afford it. At her local pharmacy, she was shocked to learn that it would cost \$600, and her health plan refused coverage. With only a few dollars in her checking account and her credit card nearly maxed out, she left empty-handed. During an office visit two weeks later, I prescribed two generic, inexpensive vials of epinephrine and showed her how to use a syringe.¹¹

These three stories reveal systemic, nationwide problems. The first highlights the dysfunction in our health plans, which routinely deny coverage—a problem we see repeated in stories two and three. The second highlights how massive hospital systems have created local monopolies, allowing them to determine when and how people receive care, as well as what to charge. The third highlights another form of monopoly—drugmakers' control over medications that should no longer have patent protection—plus the need to educate prescribers about questions to ask and alternatives to consider when writing prescriptions.

What unites these stories is their solution: legislation. Western Europe has proven that there are better ways to ensure that people get the care and medications they need. On this side of the Atlantic, the US Congress has an important role to play in making laws that govern healthcare delivery—a role it has too often shirked, allowing the American people's health to suffer for the sake of corporate profits. Corporate lobbying and campaign contributions to members of Congress¹² have no doubt helped double the cost of healthcare delivery in the United States compared to Europe. Before turning to legislative solutions, let's examine our monopolies—and learn a little more about the Western European alternatives.

The Destructive Power of Hospital Monopolies

Across the United States, we have about 5,000 acute care hospitals: roughly 3,000 nonprofit, 1,200 for-profit, and the rest academic medical centers or government hospitals.¹³ While more than half are designated nonprofit, don't be fooled; they run on similar business models as for-profit hospitals with extremely well-paid executives and an army of highly paid administrators.¹⁴ With exemptions from federal, state, and local taxes, they are supposed to offer public benefits like charity care. But research has found that “in 2018, nonprofit hospitals overall dedicated a smaller proportion of their expenses to charity care than did government-owned or for-profit hospitals,” and a study published in 2021 found that “nonprofit hospitals were more likely to sue patients for their medical bills than their for-profit counterparts.”¹⁵

It's like the very idea of healthcare has been turned upside down. What happened?

Both for-profit and nonprofit hospitals have formed pricing monopolies through mergers and acquisitions (which should violate federal antitrust laws). Although a handful of publicly owned district hospitals can be found in some states, the locally controlled community hospital has largely faded into the past.¹⁶ Throughout much of the United States, consolidation of hospitals reduces consumers' choices, leading to increased prices¹⁷ and stagnant wages for healthcare professionals.¹⁸ Among the largest for-profit and nonprofit health systems are Hospital Corporation of America (HCA) Healthcare, which controls 184 hospitals, Ascension with 139, CommonSpirit Health with 137, and Trinity Health with 92.¹⁹ Smaller but still of concern are regional systems like the University of Pittsburgh Medical Center. It has a virtual monopoly in a metro area of over two million people, with 40 hospitals and nearly 9,000 beds.²⁰ And apparently, it acts like it: it has been sued, unsuccessfully, by both the mayor and the state attorney general for not meeting its charity obligations.²¹

Today, hospitals without regional competition can arbitrarily set their fees for services,²² although contracts with some health plans may limit their fees, as



does Medicare. A recent report described a hospital that charged an extra \$722 for a nurse to administer a drug intravenously.²³ Yes, \$722 for less than a minute of work, when the nurse's time is already included in the hospital facility use or daily bed fee. For simple visits to a hospital ED, patients with common complaints such as chest or abdominal pain may receive hospital bills as high as \$30,000, even if no serious causes of the symptoms are uncovered.²⁴

How do hospitals create these bills? While no article could be long enough to detail all of the profit-making tricks, here are a few. Hospitals may charge for every item or procedure used in the care of a patient, including medications, IV tubing, IV fluids, an IV push of drugs, bandages, procedural trays, nebulized treatments for asthma, EKGs, splints, washing kits, and even warm blankets.²⁵ These extra fees are in addition to outpatient facility use fees or daily inpatient "bed rent," and can add up to thousands of dollars. In the past, many of these items were bundled together as a single charge and included in the hospital bed fee, as Medicare and some health plans now require.²⁶ Another trick is adding surcharges that result from special designations such as cardiac ICUs, pediatric ICUs, and trauma centers. For example, an extra charge may be added when an injured patient arrives by ambulance (trauma activation) and can range from a few thousand dollars to as high as \$50,000.²⁷ Similarly, the fee for a blood test may be much higher when ordered in the ED than in an outpatient area. It's obvious that all of these fees are bad for patients—who pay either directly or through higher health plan premiums and deductibles—but there are also less obvious but still significant negative consequences for patients and healthcare professionals.

In the 1980s and 1990s, a long list of independent practice physicians was available to serve most Americans, and those physicians competed with each other to be the best in the three As: affability, affordability, and availability. Where have they gone? Fee structures built into Medicare to win over the hospital industry made independent practices very difficult to sustain, while at the same time creating many ways for hospitals to increase profits (e.g., facility use fees).²⁸

Today, with those large profits, hospitals can hire physicians—often through affiliated medical groups—at attractive salaries and benefits. When I started my career, hospitals served doctors, providing support with staff, facilities, and hardware so that doctors could best care for their patients. Now, so many of my colleagues feel that doctors serve hospitals, who serve their CEOs, whose goal is money.²⁹

This Wall Street business model exploits healthcare workers along with their patients.³⁰ In some respects, physicians and mid-level clinicians have become the money generators for the healthcare industrial complex. Profits can be made from every order a physician enters into the computer, including laboratory tests,

imaging, procedures, supplies, and drugs. And the largest cut of these profits goes to the massive hospital systems that dominate US healthcare.

Community control has faded as each year more and more physicians, nurse practitioners, physician assistants, and nurses are being employed by Wall Street firms, either stockholder or private equity contract management groups (CMGs). This includes primary care providers, hospitalists, and hospital-based specialists in areas such as emergency medicine, anesthesia, and radiology. Corporations, including Walgreens, CVS, Amazon, and Optum, hire physicians and nurses and then contract with hospital entities for their services, making a hefty profit from increased fees to patients.³¹ Corporate employment of physicians and other clinicians results in loss of autonomy and independent thinking—the key elements of good patient care. It opens the door to requiring clinicians to follow protocols that result in increased profits, such as ordering unnecessary tests and prescription medications.

One of the most dangerous aspects of this corporate business model is that both for-profit and nonprofit health systems have increased retaliation against whistleblowers, including firing physicians, nurses, and other healthcare workers who complain about patient safety issues.³² For example, in 2020, the national news media provided extensive coverage of the firing of a Washington state ED physician who rang the alarm bells because he believed his hospital's COVID-19 response was inadequate.³³ Two corporate entities were involved: PeaceHealth St. Joseph Medical Center in Washington and the national CMG TeamHealth, which employs physicians to work in EDs throughout the United States. There are many other examples, including a colleague of mine who was fired for complaining about a patient safety issue in the ED and not playing "team ball"—in other words, not cooperating with corporate goals. Likewise, the media is filled with stories of nurses being fired for raising patient safety issues. Recently, NBC News reported about two nurses who were fired for filing written patient safety complaints; in one case, there was a next-day termination.³⁴

Short of firing, corporate monopoly medicine brings endless frustrations for healthcare professionals. Topping the list is computer software that now micromanages every aspect of care. Instead of focusing energy and attention on bedside patient care, physicians and nurses must spend valuable time clicking through prompts and entering data. A nurse recently told me about the problem of taking a finger stick glucose level. In the past, she would prick the skin, let a drop of blood stick to the glucose strip, and record the blood sugar on paper, all in about a minute. Now it takes at least five minutes of clicking through logins and a series of windows before and after seeing that drop of blood. "It's totally frustrating," she said, "and I am not given

This Wall Street business model exploits healthcare workers along with their patients.

We could receive outstanding healthcare in the United States for far less money if we regulated the healthcare industry.

any extra time to do this. Meanwhile, I have four or five other patients who are vomiting, screaming in pain, or needing to urinate who I ignore because I am evaluated on what's in the computer.”

Additional stressors include inflexible scheduling, long shifts, forced overtime, nurses caring for more patients than is safe, and skipped breaks. Especially troubling is that patients and their families are lashing out, and violence* against healthcare professionals is increasing.³⁵ The results of all these stressors are decreased effectiveness at work, burnout, moral injury,[†] and physical injury. But too many hospital CEOs have their heads in the sand, clueless about what life is like on the frontline of bedside healthcare.

The Astronomical Prices of Drug Monopolies

Forty years ago, most prescription drugs were very affordable. There was significant competition throughout the pharmaceutical industry, from manufacturing to sales. Along with reasonable prices, good customer service and quality products were important. But today, profit seems to be the only priority. Having successfully lobbied Congress, Big Pharma is able to maintain patents for decades—establishing a marketplace monopoly—and to set truly astronomical prices.³⁶

When a new drug is approved by the US Food and Drug Administration, laws passed by Congress can provide exclusive patent protection. No one else can make and sell that drug, usually for 20 years. Pharmaceutical corporations claim this is necessary because drug development and testing is expensive. However, in some cases development costs may be recouped in just a few years. And in other cases, development costs for the company are minimal, such as when the federal government supports drug research or the pharmaceutical company combines two or more drugs to make a “new” (patented) medication. Another common profit-making strategy is used near the end of the patent protection period; the pharmaceutical corporation makes minor changes to the drug, or only to its delivery system, and is granted many additional years of a patent-protected monopoly.

For example, a drug called Lupron was invented in 1973; it received a patent extension in 1989 because of a change made to the delivery system and was renamed Lupron Depot. Through continuous legal loopholes, it is still expensive; the wholesale price of the slow-release version of the drug is \$5,800. How do I know that's not a reasonable price? In some countries

where lawmakers don't allow price gouging, a three-month supply of Lupron Depot is available to physicians for \$260.³⁷ Another example is insulin, which was discovered about 100 years ago. A month's supply of insulin should sell for about \$25, but by making minor alterations to the drug in different ways, corporations have gained patent protection for the “new” insulin and have charged my patients as much as \$500 for a month's supply. Today, three companies maintain a monopoly on insulin, and the US Congress has only just begun counteracting that monopoly by capping the price for people on Medicare.³⁸ This is despite the fact that we spend six times more on insulin than people in Canada, Australia, or the United Kingdom.³⁹

Most profitable are a new class of drugs using monoclonal antibodies (often referred to as *biologics*).⁴⁰ Each time I open a copy of the *New England Journal of Medicine*, one of the United States' most respected peer-reviewed medical journals, I see multipage glossy ads for biologics as cures for issues ranging from arthritis to cancer. Often these new drugs cost \$60,000 a year or more. Humira, introduced in 2003, is one of the first examples; it now lists on GoodRx for nearly \$80,000 per year with a coupon.⁴¹ Humira can provide a new life for people with severe rheumatoid arthritis, but who can afford that price? Health plans have had their arms twisted to cover much of the cost, but out-of-pocket costs for patients remain high. In other countries, Humira sells for a fraction of the US price.⁴²

In addition to charging astronomical prices, pharmaceutical companies increase drug sales through direct ads to consumers. What is missing in these ads is the true retail price and the fact that companies make the most profit from very expensive drugs, those costing more than \$50,000 a year. In an effort to get physicians to prescribe drugs, some pharmaceutical companies have resorted to unlawful methods of influence. For instance, in *United States v. Biogen*, the Department of Justice charged Biogen with kickbacks to physicians, resulting in a \$900 million settlement in September 2022.⁴³

Western European Healthcare Costs Less and Delivers More

We could receive outstanding healthcare in the United States for far less money if we regulated the healthcare industry, as most Western European countries do.⁴⁴ I have collectively spent months as a visiting professor in Western European hospitals and clinics and have always been impressed with both the quality and low cost of care. Europeans have access to the same imaging technology, advanced surgeries, incredible cancer treatments, and new prescription drugs available to Americans. Most impressive are the minimal out-of-pocket costs to residents, which range from a few bucks to a few hundred dollars a year. Europeans were shocked when I told them it could take up to four months to get a new patient appointment in the United States with a primary care physician.

*For details, see “Ending the Scourge of Workplace Violence: Four Union Leaders Share Their Experiences and Strategies” on page 4.
†To learn more, see “Moral Injury: From Understanding to Action” in the Spring 2021 issue of *AFT Health Care*: aft.org/hc/spring2021/pittman.

With enough pressure, Congress could enact legislation with the power to protect patients and improve our collective health.

have Medicare negotiate drug prices, as enacted in the Inflation Reduction Act of 2022, got watered down.⁵⁵ The initial intent to negotiate prices for thousands of Medicare drugs ended up applying to only 10 drugs in 2023 and 15 drugs each in 2024 and 2025 as a result of lobbying (along with implied campaign contributions).⁵⁶

But I remain optimistic. Congress has acted against the evils of corporate monopolies in the past and can do it again. Examples include the 1890 Sherman Antitrust Act outlawing “conduct and attempts to monopolize a market” and the 1914 Clayton Antitrust Act, which outlawed “mergers and active acquisitions that lessen competition.”⁵⁷ Only over the past 40 years have independent physicians, hospitals, and pharmaceutical companies given way to the corporate monopolies. With enough pressure from healthcare

professionals and their patients (that is, almost all Americans), all US representatives and senators could stand up against the healthcare industrial complex and enact legislation with the power to protect patients and improve our collective health.

Success stories are limited but show that in some cases the “people’s lobby” can outsmart the corporate lobby. In December 2021, Congress passed the No Surprises Act, with the intent of putting an

end to outrageous ED bills as a result of seeking emergency care at an out-of-network hospital.⁵⁸ Congress acted because of tremendous public pressure, even though the healthcare industry lobbied extensively against it, including airing TV ads. Another success story occurred with passage of the Inflation Reduction Act of 2022. Despite the watering down, that legislation is already having a major impact: on March 1, 2023, Eli Lilly went beyond the legislative mandate, announcing a 70 percent reduction in the most common formulations of insulin and a maximum copay of \$35 per month for those with insurance. Before the end of March, the two other major insulin producers, Novo Nordisk and Sanofi, had also cut their prices.

Healthcare professionals should be leading the people’s lobby. We know that many of our patients are being over-tested and overcharged. We know that many patients we see in the ED wouldn’t be there if they had access to affordable primary, preventive care or if they could afford all of their medications without having to choose between medications, food, and rent. We know that far too little profit is being reinvested in our communities and far too much of it lines the pockets of executives and investors.

To save our patients and our professions, here are several steps we could take.

1. *Pressure Congress to regulate healthcare monopolies.* If you have a bad experience with healthcare or prescription drugs, either as a patient or a clinician, write letters about your experience. Explain what

happened to your union representative, human resources department, or boss. Follow up with a real paper letter, which can be more powerful than an email. Write to your lawmakers, including your federal and state representatives and senators, newspapers, local television stations, civic organizations, and anyone else you think might be helpful.

2. *Advocate for setting limits on what corporations can charge for medical care,* including hospital and physician fees, prescription drugs, and health plan premiums. Medicare already sets hospital and physician fees, and hospitals compete for Medicare patients. Regulating prices is the key element that results in Western European healthcare costing half of what it costs in the United States.
3. *Advocate for a consumer healthcare protection bureau.* The Consumer Financial Protection Bureau is charged with helping people who have been cheated by banks, finance companies, and lenders. We need a government agency to hold the healthcare industry accountable and help people who are cheated by healthcare corporations.
4. *Speak up.* If in your role as a healthcare worker you are forced to do something that favors profit over good patient care, report it to your union and the appropriate authorities. Anonymous reporting systems may be available. If you fear retaliation, seek help with union or patient advocate organizations. Be proactive on behalf of your patients, not the corporate entities that may employ you.
5. *Be politically active.* Vote. Attend town halls organized by your elected officials and candidates. Share your experiences as a healthcare professional as widely as possible—and ask everyone who listens to vote for putting patients over profits.

Congress has the ability to set the rules for the delivery of healthcare in the United States.* Over the past 40 years, too often these rules have favored corporations and corporate monopolies over the people who make up this country. Difficulties in accessing medical care, outrageous hospital prices, very expensive drugs, roadblocks created by health plans, and high out-of-pocket expenses have created hardships for too many people in the United States. At the same time, healthcare workers have been squeezed to do more in less time, making the job of caring for people more rushed and less rewarding. We cannot continue to be silent servants to corporate America. Together, we must ensure that patient care decisions are based on need, not driven by profit. Patients trust us to have their best interests first and foremost. Let’s not betray that trust. ✚

For the endnotes, see aft.org/hc/spring2023/derlet.

*For additional ways to improve care while controlling costs, see “COVID-19: From Public Health Crisis to Healthcare Evolution” in the Fall 2020 issue of *AFT Health Care*: aft.org/hc/fall2020/kitzhaber.



Solving the Staffing Crisis

The healthcare industry's relentless drive toward profit puts patients' health at risk and has pushed healthcare workers to the breaking point. We see the truth of this every day in AFT members' faces, and we know that something must be done. Here, we offer an excerpt of the AFT's Healthcare Staffing Shortage Task Force report that describes the challenges in detail and outlines a path forward. The full report—which includes lessons learned from the pandemic, more detailed research findings (with extensive endnotes), union legislative efforts, and strategic approaches to solving critical problems—is available at go.aft.org/ikt. To hear directly from task force members about addressing the healthcare staffing shortage, listen to the December 12, 2022, episode of the AFT's podcast, *Union Talk*: aft.org/latest-news/union-talk-podcast.

—EDITORS

Any conversation with a frontline healthcare worker quickly reveals deep frustration and anger with their employers and sheer mental, physical, and emotional exhaustion. The stories from AFT members are heartbreaking: a nurse in Connecticut assigned to 11 patients, a healthcare worker in Oregon who spends 20 minutes before each shift in tears trying to muster the emotional strength to go to work, the nurse in Montana who sees a colleague walking away from bedside care, the healthcare worker in New Jersey grieving the death of a colleague who contracted COVID-19 at the hospital. These are dark days for the healthcare workforce.

The COVID-19 pandemic revealed a healthcare system woefully unprepared for the crisis, allowing the world to see the chronic understaffing of our nation's healthcare facilities that existed well before the pandemic. Healthcare employers' decisions to put revenue ahead of patients and frontline caregivers left the workforce without appropriate personal protective equipment, exposed employees to increasing levels of workplace violence, stretched patient loads to unprecedented and unsafe levels, and left a workforce exhausted and, for far too many, in mental health dis-

stress. As a result, frontline caregivers are leaving their jobs in record numbers. America's hospitals have failed to fulfill their most basic responsibility: providing a safe place for patients to receive medical care.

As one of our nation's largest unions representing healthcare workers, the AFT and our affiliates have been forced to reckon with dangerously inadequate staffing in our nation's hospitals and healthcare facilities as well as colleagues who are planning to leave their jobs. Decades of understaffing have reached a crisis point, and it is a crisis of the healthcare industry's own making.

In response to the crisis of staff willing to endure the working conditions of our nation's healthcare facilities, delegates to the AFT's biennial national convention in July 2022 passed a pointed resolution, "Addressing Staffing Shortages in the Healthcare Workforce," adopting the recommendations made by the Healthcare Staffing Shortage Task Force and, among other things, specifically calling for

- passage of state and federal safe patient levels and securing staffing ratios in collective bargaining agreements;
- banning mandatory overtime;

By the AFT's Healthcare Staffing Shortage Task Force



- passage of federal and state workplace violence protection legislation, including the Workplace Violence Prevention for Health Care and Social Service Workers Act; and
- adequate pandemic preparedness protections in the law through means such as an Occupational Safety and Health Administration (OSHA) infectious disease standard and updates to the Centers for Medicare & Medicaid Services emergency preparedness rule.

The “Great Resignation” comes as the nation’s population ages and grows more diverse, requiring more workers in the health sector. However, in 2021, we see that employers in this sector are only able to hire at about the same rate as workers leave. Yet, we see the rate of job openings continue to increase because of this growing need as the population expands and ages, leaving our healthcare facilities with projected staff shortages.

It Is Time to Improve Diversity, Equity, and Inclusion in the Workforce Through Targeted Recruitment and Training

As our nation’s hospitals remain understaffed and the demand for healthcare professionals rises, there is an opportunity to make considerable progress toward greater workforce equity, which is a key component of truly centering health equity as the nation’s population continues to diversify. When the healthcare workforce reflects the populations it serves and operates with a deeper cultural sensitivity and understanding of patients’ life situations, patient outcomes improve. This, in turn, increases the comfort level of patients seeking care.

Today, minority healthcare workers are underrepresented, and as the complexity of the positions and the salaries increase, the diversity of the workforce decreases. For instance, while people identifying as Black or African American make up 13 percent of the US population, they make up only 7 percent of nurse practitioners, a higher-paying role requiring more formal education than other nursing roles. This clearly demonstrates a lack of racial equity in the nursing profession, but it also demonstrates an opportunity to “right the ship.”

To create a steady flow of new skilled workers to fill vacant positions, the healthcare pipeline and career pathways must be strengthened. To accomplish this, the sector must conduct targeted outreach, expand stackable credentials (professional credentials that can be lined up sequentially), provide affordable access to the required training programs, and, where possible, accelerate the training process. To maximize the impact of currently uncoordinated healthcare education and training programs nationwide that serve people at various levels of education and training, a nationally coordinated strategy organized around specific projected shortages is required.

One cannot, however, simply pipeline their way out of the current staffing crisis. Until the healthcare sector addresses the deplorable working conditions, dangerous patient levels, and inadequate compensation, it will be unable to attract and train new workers quickly enough to replace those who leave. New approaches must be implemented, and proven training models could be expanded. (Examine the full task force report online for seven examples of proven training models that could be expanded, from career and technical education in high schools to nursing residency fellowships.)

In 2021, there were 100,000 fewer RNs under the age of 44 than in 2020.

The AFT’s *Healthcare Staffing Shortage Task Force Report*, from which this article is drawn, demonstrates the union’s ongoing effort to improve our nation’s healthcare system and the working conditions our members endure. It was informed by months of work by the AFT’s Healthcare Program and Policy Council, roundtable discussions between clinicians and policy experts, surveys of healthcare members, and anecdotal discussions and workgroups composed of healthcare union leaders.

Section 1: The Recruitment and Retention Problem

“So many nurses are shorthanded. It’s critical to resupply as people leave the profession.”

—A healthcare worker in Connecticut

Almost universally, AFT leaders are hearing the same thing from frontline workers. Members working in already understaffed facilities are seeing their colleagues leave faster than they can be replaced.

These trends are not only anecdotal. In 2021, the US Department of Labor’s Bureau of Labor Statistics reported 55,000 fewer RNs employed than in 2020. This was the first decrease in total RN employment in more than five years.

In this same year, the median age of RNs increased for the first time in more than five years; this was driven by a reduction in total employment of RNs under the age of 44. In 2021, there were 100,000 fewer RNs under the age of 44 than in 2020. Looking at the rate of people quitting jobs in the healthcare and social assistance sector over time, we see just how historic this moment is. In 2021, the healthcare and social assistance sector saw its highest quit rate in the last decade.

In the wake of the COVID-19 pandemic, more and more healthcare workers have reported that they were considering leaving their jobs or their professions altogether. A healthcare worker in Connecticut links this directly to short staffing, saying, “You can only take care of so many people effectively. This is a recruitment/retention issue. Who’s going to want to go into work when it’s going to be horrible?” In a February 2022 poll, 23 percent of healthcare workers—nearly 1 in 4—said they were likely to leave the healthcare field soon.



OFNHP VIA TWITTER

Remove Barriers to Entry by Expanding Student Loan and Repayment Programs That Incentivize Joining the Healthcare Sector

A 2019 analysis of data from the US Department of Education found that the average graduate of an associate degree in nursing program held \$19,928 in student debt. For graduates with a bachelor of science in nursing, the average debt was \$23,711, and for graduates with a master of science in nursing, the average was \$47,321.

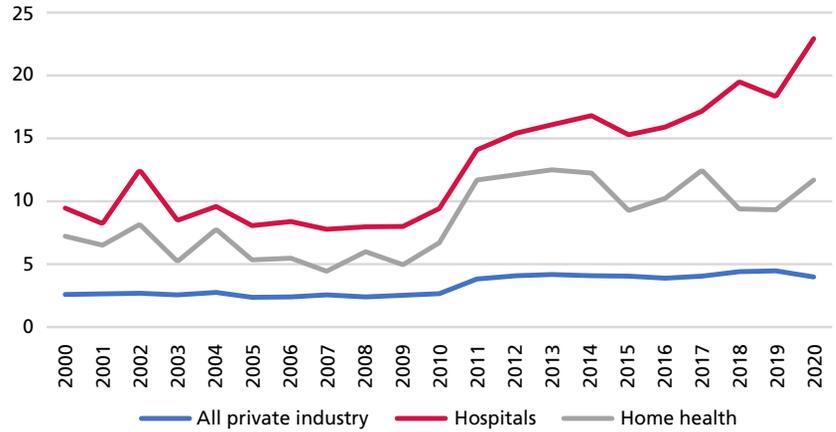
No effort to recruit talent into the healthcare workforce can be complete until the cost barriers for accessing and completing higher education and training programs are addressed.

While there are no publicly available data on debt burdens or education costs for other healthcare titles, one can make some educated guesses based on the average cost of the level of education required for certain roles. For example, the average cost of an associate degree is \$21,900 at a public institution and \$57,254 at a private institution. Many healthcare roles, including lab technicians, surgical technologists, radiologic technologists, and respiratory therapists, require an associate degree. Healthcare job titles that do not require a postsecondary degree are also not free of cost barriers because many require certification programs. For example, a program to become a licensed practical nurse can cost as much as \$15,000, and training to become a certified nurse assistant averages about \$2,000.

The AFT has been leading the effort to make Public Service Loan Forgiveness available for more people working in public service roles. Employees who work full time (30 hours or more a week for eight or more months of the year) for a nonprofit or government employer can qualify for full forgiveness of their federal student loan balance after 120 qualifying payments. This includes most hospital and public health workers. During the Trump administration, this program was woefully mismanaged, with workers' time credit not being applied correctly and their loan status wrongly placed into default. The AFT successfully sued the Trump administration. Through a yearlong waiver, borrowers who did not previously qualify or who were denied were able to get credit for past payments and get on track for full forgiveness. When properly managed and promoted, and when healthcare professionals and other workers are given the necessary information, the program can be a powerful tool for recruiting and retaining healthcare professionals.

AFT-affiliated unions have been working with state legislatures around the country on targeted strategies that increase the pipeline. This includes the Oregon Nurses Association winning passage of the Nursing Workforce Omnibus Bill (HB 4003) last year, which, among other provisions, creates a nurse internship license to augment the workforce and offers practical experiences for nursing students.

Workplace Violence Rates, 2000–2020



SOURCE: US BUREAU OF LABOR STATISTICS, SURVEY OF OCCUPATIONAL INJURY AND ILLNESS 2000–2020, TABLE R8

Section 2: Working Conditions Need to Be Improved to Recruit and Retain More Healthcare Workers

"I remember thinking during the first surge, 'If we just make it through this with none of our members dying, we will be lucky.' We made it until the third surge when we lost a beloved RN from the OR. We had over 75 percent of our members testing positive at one point during this pandemic. Many members were seriously ill, hospitalized, and some are still recovering with long COVID-19 symptoms. I watched my coworkers develop posttraumatic stress disorder in real time."

—Sheryl Mount, Health Professionals and Allied Employees, New Jersey

Although there is a growing body of evidence on the patient safety risks associated with poor staffing, much more research is needed on workers' injuries and illnesses. One of the few studies that looked at the relationship between occupational injuries and staffing found that shifts with fewer nursing care hours, lower RN skill mix, and a lower percentage of experienced staff had higher rates of needlestick injury. The California nurse-to-patient staffing ratio law offers an opportunity to evaluate the impact of staffing on healthcare workers' health and safety. One study found that registered nurses in California hospitals suffered 55.57 fewer illnesses and injuries per 10,000 RNs, a rate 31.6 percent lower than the rate in all other states. The reduction for licensed practical nurses was 38.2 percent.

Workplace Violence Makes Hospitals One of the Most Dangerous Places in America to Work, and Enforceable Standards Are Needed to Protect Workers

Violence to healthcare workers is a serious and growing problem exacerbated by inadequate staffing. Health-

The healthcare sector must address deplorable working conditions, dangerous patient levels, and inadequate compensation.



care and social services workers experience 76 percent of all reported workplace violence injuries in the American labor force, and the number of actual incidents of workplace violence is likely to be much higher. The rate of reported assaults grew by 144 percent in hospitals and 63 percent in home health agencies from 2000 through 2020. The rate of reported assaults increased by 95 percent in private sector psychiatric hospitals and substance use treatment facilities between 2006 and 2020. There were 87 workplace homicides from 2017 through 2019. Pandemic-related pressures on healthcare accelerated this trend—the rate of violence in hospitals increased by 25 percent in one year alone, from 2019 to 2020.

OSHA and the National Institute for Occupational Safety and Health (NIOSH) have both identified understaffing as a risk factor. Long wait times and inadequate attention can lead to escalating behavior in some patients and visitors. In some cases, workers are too busy to notice or respond. When there are too few workers available to safely restrain violent patients or when staff work in isolation, the risk of serious injury increases. More research is needed to investigate a causal relationship between understaffing and workplace violence.

OSHA, NIOSH, and researchers have emphasized the critical importance of workplace violence prevention programs that train frontline staff and managers to report all incidents of workplace violence and “near misses” in order to develop evidence-based prevention strategies. Unfortunately, healthcare workers often do not report incidents of workplace violence because they find themselves blamed for their assault. More work is needed to identify the staffing issues at the root of workplace violence.

When employers treat healthcare workers as disposable, patient care suffers.

Fatigue Is Making Healthcare Jobs Unsustainable, and Healthcare Workers Need More Recovery Time

Research on nurse fatigue has focused on the effects of shift work, including extended shifts and overtime, night shifts and rotating shifts, and insufficient recovery time between shifts. Chronic sleep deprivation has been linked to these factors. Chronic sleep deprivation causes fatigue; reduced cognitive function; increased risk of errors, such as needlestick injuries; unsafe driving; and patient safety errors in the short term. Chronic sleep deprivation can cause cardiac, gastrointestinal, and metabolic illnesses in the long run. Chronic lack of sleep has also been shown to foster proinflammatory activity and immunodeficiency, putting workers at higher risk for infection.

AFT local unions have been engaging in innovative bargaining to reduce fatigue among healthcare workers. The Ohio Nurses Association secured “double back” language in its contract with Lima Memorial Hospital, requiring a certain number of hours between shifts. The union also achieved a ban on mandatory overtime at the hospital. The Oregon Nurses Association won

double overtime pay for mandatory overtime at Oregon Health & Science University, which puts financial pressure on the hospital to hire more nurses. Meanwhile, the Washington State Nurses Association secured an additional RN float position to ensure adequate coverage, allowing all staff to take meal and rest breaks.

AFT affiliates have been working with their state legislatures to reduce mandatory overtime. The Ohio Nurses Association was successful in passing legislation in 2021 that establishes a legislative study committee on RN staffing issues to help legislators learn more about the issues and build support for better staffing.

Addressing the Mental Health Crisis of Healthcare Workers Requires Funding for New Support Programs

For many years, healthcare workers, particularly those at the bedside, have been stressed and have suffered the moral injury of repeatedly being expected to make choices that transgress their long-standing, deeply held commitment to healing. The scarcity of mental health care providers compounds the mental stress. Those who seek assistance are frequently unable to find providers or are placed on monthslong waiting lists.

A survey conducted in March 2021 by the Kaiser Family Foundation and the *Washington Post* asked healthcare workers whether they felt the worry or stress related to COVID-19 had a negative impact on their mental health. According to the survey, 61 percent said yes. Three out of 10 people polled either received or thought they needed mental health services because of the pandemic. At least 49 percent said the pandemic had negatively impacted their physical health, as well as their relationships with family members (42 percent) and coworkers (41 percent). Many people reported difficulty sleeping, frequent headaches, increased use of alcohol, or drug use, all of which were attributed to pandemic stress and worry. Another recent study found that more than 70 percent of healthcare workers have symptoms of anxiety and depression, 38 percent have symptoms of posttraumatic stress disorder, and 15 percent have had recent thoughts of suicide. The workforce urgently needs support.

Section 3: Safe Staffing Requirements Are Needed

California is the only state that mandates safe patient levels for multiple hospital departments by law. Massachusetts mandates ratios only for ICUs by law, and New Jersey mandates ratios for several departments through regulation of the hospital licensure process. A number of states also require that healthcare facilities have staffing committees that include nurses. This is based on the idea that every hospital is different, and each should have the flexibility to develop staffing matrices that best fit their departments. Unfortunately, because they are often poorly enforced and lack a clear

standard, staffing committees have not proven to be a successful strategy to achieve safe patient limits.

In contrast, safe staffing levels set by law in California have been shown to improve outcomes for patients and healthcare workers. Many experts argue that safe staffing levels are necessary because they provide hospital administrators and workers with a clear measurable standard. Setting the floor in law rather than collective bargaining agreements and staffing plans also allows for enforcement of these standards through state agencies rather than relying on hospitals to monitor their own compliance or on workers to file complaints after a plan has been violated.

AFT-affiliated unions around the country have been trying a variety of strategies at the bargaining table to reduce unsafe patient levels. For example, the Ohio Nurses Association at the Ohio State University Medical Center (OSUMC) won safe patient staffing levels for its workers, including a nurse-patient ratio in the medical-surgical unit of 1:4, while the nurse-patient ratio for the critical care unit in the emergency department is 1:2. The nurses at OSUMC are now empowered to challenge patient care assignments that are unsafe because they exceed the established ratio. While nurses occasionally flex up to accommodate additional patients, it is rare and is only done when the nurse can safely care for all their patients.

AFT-affiliated unions nationwide have also been working with their state legislatures to require increased staffing levels in their facilities and staffing committees. For instance, in New York, our unions won language in their 2019 state budget that requires the Department of Health to study how staffing enhancements and other initiatives can improve patient safety and care.

Outsized Use of Staffing Agencies: A Symptom of the Broken Labor Market That Needs Greater Oversight

With healthcare worker shortages and increasing patient levels during the COVID-19 pandemic, hospitals and health systems have begun turning more to healthcare staffing agencies. Though these agencies are not new to the healthcare landscape, rapidly escalating rates and accusations of price gouging have thrust them to the forefront of public debate over the cost of healthcare.

Traveling healthcare workers are a valuable addition to a hospital's care team in many situations, including bringing workers with specialized skill sets into rural and underserved areas. The problem arises when hospitals and health systems stop investing in recruiting and retaining staff nurses and health professionals and the use of temporary workers becomes a more expensive replacement rather than a supplement.

In a 2022 report, the American Hospital Association evaluated the cost of the pandemic for hospitals, including the increased money spent on temporary

workers through staffing agencies. In January 2019, travel nurses accounted for 3.9 percent of total hours worked by nurses in hospitals. In January 2022, they accounted for 23.4 percent. As hospitals have relied more heavily on staffing agency workers, labor costs have skyrocketed. Hospital labor expenses per patient at the end of 2021 were 36.9 percent higher than pre-pandemic levels.

The nurse labor market in our country has been broken. Hospitals have had to scramble to hire nurses in a time of public health emergency because they used lean staffing models prior to the pandemic. Every hospital competing for the same limited pool of nurses at the same time drove up wages. Coupled with years of deteriorating working conditions and lack of fair compensation, many nurses quit their staff nursing position to follow the money, taking traveler positions. Instead of complaining of the high rates charged by staffing agencies, hospitals should accept responsibility for creating a labor market in which dedicated staff are undervalued and underpaid; hospitals should reduce pay disparities and improve working conditions.

Before the pandemic, AFT-affiliated unions had been successfully bargaining language that limited their employers' use of travel nurses. The Washington State Nurses Association, for example, was successful in having the University of Washington Medical Center declare in their agreement that it "is the intent of the University of Washington Medical Center to minimize the employment of agency nurses." The Ohio Nurses Association successfully bargained with the Cuyahoga County Board of Health that any "substitute or temporary nurse will not be used to avoid filling any vacancies." The Oregon Nurses Association successfully got the Sacred Heart Medical Center in Eugene, Oregon, to jointly review the staffing pattern and use of per diem and other nurses in a unit and shift to determine whether additional regular positions/hours should be posted.



Unsafe Staffing Means Diminished Patient Outcomes

Every day, healthcare workers are forced to make impossible decisions due to unsafe staffing. Do they review the discharge instructions with a patient or respond to the flashing call button? Do they help a patient get to the bathroom safely or get another patient their medication on time? These are real decisions with real consequences for patient safety, and having to face them every day all but guarantees workers will suffer moral injury.

Research reflects the impact of unsafe staffing on patient outcomes. Each additional patient added to the average nurse's workload on a med-surg unit increased each patient's chance of 30-day mortality by 16 percent. In med-surg units, each additional patient per nurse was associated with a 5 percent lower likelihood of surviving in-hospital cardiac arrest. In contrast, patients were 63 percent less likely to be readmitted within 30 days in hospitals where staffing in pediatric units was in line with the staffing limits (4:1) set in California state law. Two-thirds of California staff nurses said the ratio law makes them more likely to stay at their jobs, and 74 percent said it has improved the quality of care in the state.

The Unique Challenge of Rural Healthcare

Rural communities tend to have sicker, older, and poorer residents than the country as a whole. Since 2010, more than 120 rural hospitals have closed, 39 since 2018. An additional 453 rural facilities can be considered vulnerable to closure based on performance levels. Rather than closing, rural hospitals acquired by larger systems often have their services hollowed out as they become feeder facilities for larger hospitals located farther away. In Ohio, for example, a number of rural labor and delivery departments have closed, forcing expectant parents to travel greater distances to give birth.

The community impact of rural hospital closures has been profound. As Mark Holmes of the University of North Carolina found, “Rural hospitals are often an anchor institution, providing not only needed healthcare, but also a significant portion of jobs and billions of revenues in purchasing goods and services from other businesses. As a major employer in rural areas, hospitals and their closures have tremendous impacts on the economies of already vulnerable communities.”



Section 4: Compensation of Healthcare Workers Needs to Be Increased

The healthcare industry as a whole was worth a staggering \$8.45 trillion in 2018 and accounted for more than 19.7 percent of total US gross domestic product in 2020. The compensation package for people at the top, including hospital executives, reflects this. However, the reality for the people who provide the direct care, provide food for patients, keep the facilities clean and hygienic, and otherwise support the operation of our nation’s healthcare facilities is far different, and they are increasingly discovering that their wages aren’t worth their working conditions.

While hospital CEOs earn an average of \$600,000 annually, the true compensation differential at specific facilities can be much greater. For example, in 2018, the CEO of Kaiser Permanente, a large nonprofit healthcare system, made nearly \$18 million. In 2017, the top 10 highest-paid nonprofit health system executives earned \$7 million or more. Even the bottom 25 percent of nonprofit hospital CEOs enjoyed annual compensation of about \$185,000.

In contrast, other healthcare professionals make significantly less, ranging from \$125,690 for pharmacists to \$38,190 for medical assistants. The gap is only wider for those hospital employees whose jobs do not require specialized degrees, such as janitorial and kitchen staff and medical-records personnel. To successfully recruit and retain staff, the healthcare industry must fix its compensation gap.

Section 5: Corporate Trends

Driven by an insatiable desire for income, hospitals and health systems have systematically undervalued and underinvested in the healthcare workforce. While executives enjoy multimillion-dollar compensation packages, healthcare workers have been forced to do more with less. Lean staffing models that rely upon on-call, mandatory overtime and travel nurses to flex staffing at peak census levels have

resulted in dangerous patient loads, which stretched many healthcare workers beyond their limits long before the pandemic.

Following the adage “never let a good crisis go to waste,” the healthcare industry has seized upon the COVID-19 pandemic to advance new cost-saving strategies. One little-noticed provision of the CARES (Coronavirus Aid, Relief, and Economic Security) Act gave the Centers for Medicare & Medicaid Services the authority to waive the requirement that hospitals provide 24-hour nursing services. While this currently applies to only a limited total number of patients, the geographic footprint of these waivers is quite big; 206 hospitals run by 92 systems spanning 34 states have received temporary waivers to run what they call “hospital in the home” and “hospital without walls” programs. These models may foretell the future of care delivery, as evidenced by the 2021 announcement by Kaiser Permanente and the Mayo Clinic of a \$100 million investment and joint partnership with at-home acute care company Medically Home. Removing a patient from the hospital setting maximizes profit in the hospital industry by eliminating the need for ancillary services, such as food and environmental services, and 24-hour nursing services.

There is also increased pressure, often driven by the healthcare industry, on scope of practice—essentially, who is allowed to do what. In some instances, expanding scope of practice for a given discipline makes sense, such as allowing a highly trained advanced practice registered nurse to work independently and provide much-needed clinician care in rural America. However, expanding the scope of practice for less-skilled healthcare practitioners only to save money for the employer can impair the quality of treatment provided to patients. These decisions should be driven by increasing access to high-quality healthcare and not from cost considerations as the healthcare industry tries to find new ways to increase revenue.

Rather than trying to solve the staffing crisis, the healthcare industry is looking for ways to deliver cheaper care. To put it bluntly, the industry is sacrificing patient care to save money. Instead of degrading the standard of care, we would all be better served by appropriately staffed healthcare facilities.

Consolidation has been a growing trend in the healthcare sector throughout the 21st century, and the pandemic has only widened the economic gap between the large, prestigious healthcare networks and the remaining community-based hospitals and critical access hospitals, many of which are in rural America. Small, independent hospitals are now financially strapped and ripe for acquisition by larger, prominent systems, which have evolved into regional, multimarket systems. While advocates of consolidation often claim that it will ultimately improve the

quality of care, there is no evidence to that effect. There is evidence, however, that consolidation imposes downward pressure on worker pay. Mergers that significantly reduce the number of hospitals in a local labor market have been found to lower wage growth for nurses and other skilled workers. As a result, healthcare positions in those hospitals become less attractive and harder to fill.

Section 6: Worker Voice and Trust

“It gives me hope that nurses haven’t given up yet. Having a union, at least we have a voice.”

—A healthcare worker in New Jersey

As frontline care providers, nurses and health professionals have invaluable insight into how each decision made by hospital administration impacts patient care. This expertise coupled with the trusted position healthcare workers hold in their communities should make it obvious to healthcare employers that healthcare workers are their greatest asset. Yet, too often health systems treat healthcare workers only as an expense to be controlled. When employers treat healthcare workers like disposable parts and not dedicated professionals, it is no surprise that workers experience burnout, hospitals experience turnover, and ultimately, patient care suffers.

A 2019 meta-analysis of the association between nurse work environments and outcomes found that in hospitals with better nurse work environments, the odds of an adverse event or death were 8 percent lower. It is not surprising then that research has also linked nurse involvement in meaningful shared governance with patient satisfaction. The percentage of patients reporting they would definitely recommend the hospital was 14 points higher in hospitals where nurses were categorized as “most engaged” in shared governance based on an assessment of three measures in the Practice Environment Scale of the Nursing Work Index, according to a 2016 study. The same study found that nurses in hospitals where staff were most engaged in shared governance were 44 percent less likely to report that the overall quality of care was fair or poor and 48 percent less likely to report a lack of confidence that hospital management will resolve problems related to patient care.

The best way to ensure a specific employer’s shared governance is to make it part of a collective bargaining process that holds management accountable for including the perspective of direct care providers. The most successful model is the national partnership between the Kaiser Permanente systems and the AFT’s Oregon Federation of Nurses and Health Professionals and its other bargaining partners. Kaiser’s shared governance is far from a panacea for all that ails the healthcare system, but it has proven to shape management decisions in a positive way, albeit not with complete employee satisfaction.

A collective bargaining agreement (CBA) is the single most potent tool to ensure that healthcare professionals have a protected voice at their facility. CBAs create an accountable system where real discussion between labor and management takes place, giving workers more protection to speak up about difficulties. AFT-affiliated unions, like the Oregon Nurses Association, have successfully bargained for meaningful hospital committees. This includes at Providence St. Vincent Medical Center, where the union successfully bargained for clinical unit self-scheduling, and at Oregon Health & Science University, where the union successfully bargained for unit-based nursing practices committees.

The staffing crisis in our nation’s healthcare facilities is not some mysterious, intractable problem that we lack the tools to fix. Rather, given all that the nation’s healthcare workforce endured through the pandemic and before, it is completely understandable—and with a commitment from healthcare employers to put patients and their workforce above maximizing revenue, it is correctable. The task force’s report includes a menu of strategies that can be used to improve our nation’s healthcare facilities and concrete examples of where they have been successfully used. It is intended to help frame the national discussion about the staffing crisis and to provide a road map to fixing the chronic problem. **+**

Our nation’s staffing crisis is correctable—if healthcare employers put patients and their workforce above maximizing revenue.



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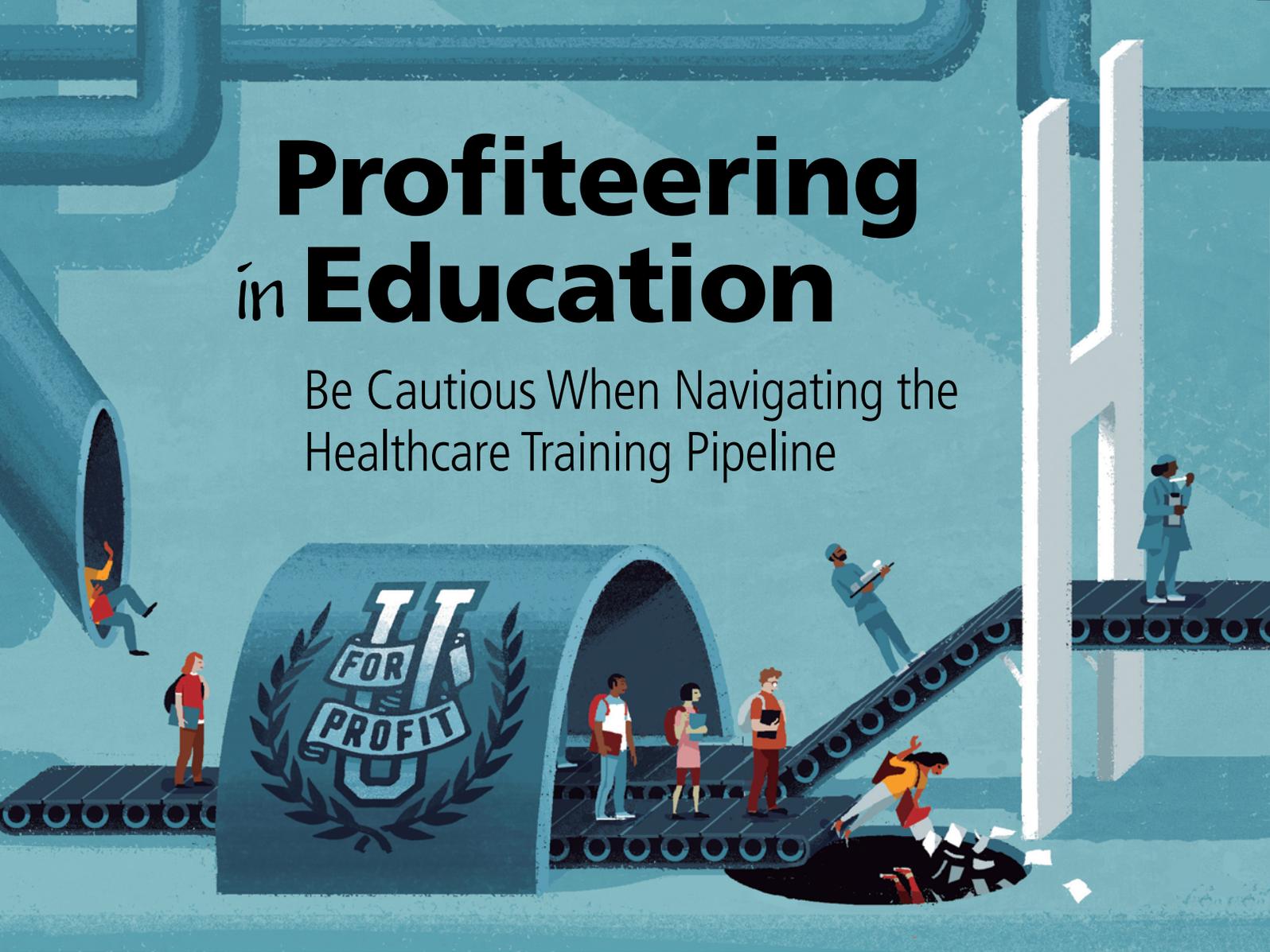
Examples of Strategic Approaches

- Enact federal and state laws that mandate safe staffing levels and staffing ratios that include the whole care team and incorporate requirements into governmental regulations, such as the Centers for Medicare & Medicaid Services Conditions of Participation.
- Include safe staffing levels in collective bargaining agreements.
- Ban mandatory overtime through federal and state legislation, regulation, and collective bargaining agreements.
- The US Health and Human Services Department’s Health Resources and Services Administration should convene an emergency task force to develop a national healthcare workforce strategy. The task force should include the US Department of Education, the US Department of Labor, and both industry and labor representatives. The AFT is uniquely positioned to provide strategic input because our membership includes healthcare workers, career and technical education program teachers, and nursing program and other healthcare professional program faculty.
- Partner with organizations and mental health experts devoting resources and activities aimed at developing clear demands for improving healthcare workplaces, ensuring mental health needs of the workforce are addressed, and developing resources and education programming that provide meaningful support to healthcare professionals.

For many more recommendations for addressing the staffing crisis in workplaces and at state and federal levels, read the task force’s full report at go.aft.org/ikt.

Profiteering in Education

Be Cautious When Navigating the Healthcare Training Pipeline



By **Stephanie Hall** and
Anna Bernstein

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In September 2022, over 1,600 students at Stratford University, a for-profit institution, received notice that their school would be closing, leaving them unsure of options to complete their training in a variety of fields, including nursing and health sciences.¹ Stratford's accreditation status had been in limbo, and during that time, the US Department of Education restricted the school's ability to enroll new long-term students. The school's access to federal student aid was also in jeopardy. Because Stratford was fully reliant on student tuition from a steady flow of new recruits, the bulk of which came from federal student aid dollars, Stratford owners decided it was better to cut their losses and run than to wind down operations in an orderly manner.

As a result of Stratford's precipitous closure, hundreds of nursing students were left stranded, many already multiple thousands of dollars in debt with no details about how to transfer their credits or how to continue their training elsewhere. After intense public pressure, about 40 nursing students who

were extremely close to graduating were offered a pathway to finish. But many more, including those with only a handful of courses left, are now stranded. Kathleen Estrada, for example, had just six courses left, but because few of her credits will transfer, she faced an extra year and tens of thousands of dollars at another institution. Instead of pursuing her dream to become a nurse, she has switched to a psychology program.²

Stratford students have been left holding the bag, through no fault of their own. Worse, they have been doubly victimized by an underregulated for-profit college industry and a broken healthcare training pipeline. This country faces an urgent need to address a worsening shortage of healthcare workers—and this requires addressing issues within the educational pipeline. We need to ensure that there are adequate training programs and funding for prospective nurses and allied health workers to prevent them from graduating overwhelmed by debt. But equally important is protecting future healthcare

workers from predatory and subpar programs that take advantage of students—an issue plaguing the healthcare education ecosystem and threatening our entire healthcare system as a result.

Context: An Unregulated Pipeline

Before the emergence of COVID-19, the strain on the US healthcare workforce—and the critical role of nurses and other professionals—was often overlooked. The pandemic pushed these concerns to the forefront, highlighting the threat of a worsening health workforce shortage. It is estimated that by 2030, the number of registered nurses alone that will be needed will reach 3.6 million, and this 28 percent increase in demand is not projected to be met.³ Although accelerated by untenable working conditions during the pandemic, this crisis is caused in part by a generational shift; many baby boomers—who make up a substantial portion of the health workforce—are retired or near retiring⁴ just as the nation’s aging population is expected to require an increased capacity for care.

The US Department of Health and Human Services Bureau of Health Workforce projects shortages of registered nurses, licensed practical nurses, nurse practitioners, nurse anesthetists, and nurse midwives.⁵ Washington, Georgia, and California are predicted to be the hardest hit by shortages, though the distribution of supply and demand of healthcare workers varies dramatically between states. It also varies between urban, suburban, and rural areas, with supply far more adequate (even too great) in urban areas than in rural ones.⁶ For example, a 2017 Bureau of Health Workforce analysis of supply and demand for healthcare workers in rural areas found a 69 percent deficit of surgeons in rural regions. In reality, the overall supply of surgeons matches the demand, but those surgeons are concentrated in urban areas.⁷

The majority of today’s registered nurses worked in roles like nurse assistant or licensed practical nurse before pursuing their RN.⁸ Over the past 50 years, there have been substantial increases in the proportion of nurses who hold bachelor’s degrees and in the number of nurses pursuing graduate-level training.⁹ A major impact of increasing credentialism in nursing (and allied health fields) is increasing student debt held by the workforce. Debt taken on by nursing students incentivizes them to remain in clinical positions rather than to take on lower-paid roles in nurse training and education. Nearly 70 percent of nursing graduate students surveyed in 2016 financed their education with federal student loans.¹⁰ Nursing students faced a median debt between \$40,000 and \$54,999 after graduating—so it’s unsurprising that half of those surveyed named repayment of loans as their biggest concern upon completing their programs.

Barriers to education and the burden of nursing education loans inherently impact women disproportionately: only 9.4 percent of registered nurses and 8.1 percent of licensed practical nurses and vocational nurses are male.¹¹ Despite making up the majority of the workforce (90 percent of registered nurses), women in the field earn less than men, with female RNs making \$7,300 less annually than their male counterparts¹² (though some of that gap may be due to male RNs working in facilities that pay more, doing more overtime, and taking more premium-pay shifts¹³). The gender wage gap in nursing persists regardless of level of education, certification, age, or experience. Mirroring the pay inequities across other industries, the wage gap facing Black and Latina women is particularly egregious; these wage gaps are closing so slowly that they are on pace to remain for 350 and 432 years for Black and Latina nurses, respectively.¹⁴

On top of disparities in pay, women in nursing are experiencing the strains on family care that have become even more extreme since the start of the pandemic. In the United States, women provide the vast majority of unpaid care—and most do so while holding full- or part-time jobs. With so many women leaving the workforce due to childcare or eldercare responsibilities,¹⁵ on-site childcare centers have been put forth as part of the solution to the nursing shortage in particular.¹⁶

Building a Better Pipeline

To address this crisis, it is necessary to turn upstream to educational and training programs because this shortage is closely tied to challenges in the nursing education pipeline, including a lack of instructors and preceptors (experienced clinicians who supervise nursing students’ clinical rotations).¹⁷ Without attractive salaries for education positions, advanced degree nurses are incentivized to stay in clinical tracks, where pay is higher. In interviews conducted to inform a report by the Center for American Progress, low salaries* were identified as the driving factor in the nursing educator shortage.¹⁸

Without sufficient educators, clinical sites, or preceptors, potential nurses are being turned away from programs despite the growing need for nurses. From 2011 to 2020, schools turned away roughly 47,000 to 68,000 qualified applicants annually.¹⁹ Even more concerning, the types of nursing degree programs that are seeing declines in enrollment are the same programs that train students for

Unmet demand for training plus weak quality assurance allows predatory schools to take advantage of students.

*To read about how low salaries disincentivize prospective nurse educators—and how union activism can help—see “Our Healthcare System Is Crashing” in the Fall 2022 issue of *AFT Health Care*: aft.org/hc/fall2022/dayton.

future careers in nursing education, research, and administration.²⁰

This unmet demand for training is coupled with a weak infrastructure of program quality assurance.²¹ This dangerous combination allows unscrupulous for-profit colleges and education companies to take advantage of students. Predatory schools may appear to meet demand and churn out graduates at a breakneck pace, but they leave many worse off than when they started: in debt with no degree and no job prospects. If this pipeline issue goes unresolved, the nursing shortage will only deepen in the coming years, ultimately putting the US healthcare system in an even more precarious position.



Seeking Training? Proceed with Caution

Given the underregulated training pipeline, nurses, allied health workers, and prospects should be cautious when reviewing their education and professional development options. The largest programs for nurses and allied healthcare workers are found in all types of colleges: public (any institution controlled by a state or local government), private nonprofit (typically controlled by a governing board that, by design, does not gain financially from the school's operation), and private for-profit (schools that are privately owned or publicly traded in which management answers to owners and investors).

In the past, a college's business model was a reliable indicator of how cautious a prospective student should be. Predatory practices like high-pressure or deceptive student recruitment were more often found in the for-profit college sector.²² Today, the lines between college control and business practices are blurred. One reason for this is that the US Department of Education previously relied on the Internal Revenue Service's (IRS) determination of which organizations were legitimate nonprofits. Under this process, the IRS in turn relied on the word of college executives and managers in their self-attestations,

rather than conducting independent reviews. With lax oversight of college integrity, a number of for-profit colleges—some with dubious track records—converted to nonprofits to take advantage of the benefits that are conferred to nonprofit organizations.²³ Many of these are operating as nonprofits in name only; they can be considered covert for-profit colleges. The US Department of Education is beginning to increase its oversight and no longer relies on IRS determinations, but many schools that converted to nonprofit status in recent years are in fact set up to enrich former owners and other insiders.

While these business structures wouldn't normally be of concern to a prospective student, they often go hand in hand with predatory practices that affect students' academic and financial well-being. In 2020, the Government Accountability Office found that one-third of college conversions from for-profit to nonprofit involved transactions that personally financially benefited former owners and other related individuals. The transactions that result in covert for-profits are known as insider conversions; they tend to have worse financial performance, and many such schools engage in deceptive marketing practices.²⁴

Where you attend school matters for the experience you will have, for how employers perceive your qualifications, and for your own financial outcomes.²⁵ For example, registered nurses with bachelor's degrees from public colleges or universities hold an average federal student loan balance of \$27,301, while graduates of for-profit colleges have an average student debt load of \$34,118.²⁶

In the allied health field, graduates from associate degree and undergraduate certificate programs take on substantial debt considering the amount of time required to complete those courses of study. At public institutions, like local community colleges or state universities and their regional branches, allied health students take on an average of \$13,311 in federal student debt. At private nonprofit institutions, they take on \$16,601, and at private for-profit schools, they take on an average of \$22,682 in federal student loans.²⁷ (Students' debt load could be higher from prior programs or courses; these figures represent only the federal debt taken on by graduates in their allied health programs.²⁸) Graduates feel the effects of their debt when bills come due. The average allied health graduate has a \$203 per month payment due on their federal student loans, but that average masks disparities. For graduates of public colleges, the figure is just \$150. Nonprofit college grads pay closer to the average, at \$200, and for-profit grads owe a whopping \$270 per month.

American consumers generally enjoy a level of comfort knowing there are standards when it comes to product safety, whether it be from the automobile, food, or toy industry. Unfortunately, that reality is not directly applicable to the higher education

marketplace. Higher education consumers are at an extreme disadvantage when weighing their options. The most prominent seal of approval a prospect may see is a college's accreditation status listed on its homepage. Unfortunately, accreditor reliability has declined along with nonprofit integrity; the two issues are deeply intertwined. Not only have signifiers of quality and business practices eroded, but the digital infrastructure that leads a prospective student from searching to enrolling in courses is also rigged in the favor of the college industry.²⁹

For-Profit Problems in Nonprofit Schools

Given the intricacies of accreditation and higher education policy, the downstream impact of nefarious institutions can be difficult to grasp, and it often goes unacknowledged in conversations about healthcare workers in particular. To better understand how for-profit and covert for-profit institutions are harming students and impacting the health workforce, we can examine the practices of one especially bad actor: Ultimate Medical Academy.

Ultimate Medical Academy (UMA) is a private career college specializing in allied health training that opened in Clearwater, Florida, in the mid-1990s.

It offers programs for people seeking careers as medical and dental assistants, medical office assistants, pharmacy technicians, and related positions. In 2005, the school was acquired by an investment management group that was focused on “unlocking value and improving educational quality by bringing world-class management and staff to its client companies.”³⁰ The investment firm did just that by transforming the tiny career college into a large online enterprise with 10,000 students.

UMA's enrollment peaked in 2018 at over 15,000 students, almost all of whom were studying online. UMA's student body is 96 percent women, and the vast majority are over the age of 22. Over half of UMA students identify as a racial or ethnic minority, and in recent years, more than 75 percent of UMA students qualified for a Pell Grant, meaning they demonstrated exceptional financial need.³¹

In 2015, UMA's investment firm cashed out by selling the school to a Denver-based nonprofit called Clinical and Patient Educators Association (CPEA). Publicly available documents indicate this was an insider transaction. According to public records,

Predatory schools leave many students in debt with no degree and no job prospects.

Help Students Get the Facts Before Enrolling

The healthcare workforce in this country must be bolstered—and prospective healthcare students must be protected in this effort. The prevalence of providers like Ultimate Medical Academy and the failure of regulators and other watchdog groups means workers, students, and prospective students must watch out for red flags that indicate they may be considering a school with little to no value proposition. Here are key strategies to help you evaluate training or professional development opportunities in the healthcare field:

✦ Search a school's track record.

The US Department of Education's College Affordability and Transparency Center has a collection of tools like the College Scorecard (collegescorecard.ed.gov) and College Navigator (nces.ed.gov/collegenavigator) with important information, including the average cost charged to students, the median amount of student debt taken on, the size of monthly payments, how many students are struggling to repay their loans, and the median earnings of graduates. The College Scorecard also includes information on how students in

specific programs fare. Also useful are the College Affordability and Transparency List (collegecost.ed.gov/affordability), which gives total program costs of specific career and vocational programs across the country, and 90/10 Information (collegecost.ed.gov/ninety-ten), a list of schools that receive more than 90 percent of revenue from federal financial aid.

✦ Learn how student tuition is spent.

A school's operating budget indicates its intentions, and a lot can be learned about a school's intentions and on-the-ground operations based on how it spends the tuition dollars collected from students. Schools that spend very little student tuition on instruction could be diverting those funds toward advertising and recruiting new students or to lining the pockets of owners and shareholders. Conversely, some public institutions charge less in tuition than they spend on instruction; these colleges offer the best bang for the tuition buck, thanks to public subsidies. Prospective students can consult instructional spending levels of schools on

The Century Foundation's website (go.aft.org/ubx).

✦ See if a program is under review or investigation.

Attending a school that is not in compliance with the US Department of Education is risky, but identifying those schools on your own is challenging. The Century Foundation developed the PEPS Bot (go.aft.org/etc) to help. It draws on data from the US Department of Education's Postsecondary Education Participants System (PEPS) database and can be used to determine the status of a school's Program Participation Agreement (PPA), the contract agreement with the US Department of Education to receive federal funding. The tool also shows changes in school ownership and identifies schools operating under an expired PPA but still receiving federal aid—which can indicate the school is having issues meeting the department's eligibility requirements.¹

—S. H. and A. B.

For the endnote, see aft.org/hc/spring2023/hall_bernstein.

We must move beyond viewing prospective clinicians as education consumers and treat them as an integral part of the common good.

CPEA, UMA, and the private investment firm all included executives with personal stakes and connections to each other. UMA's chief executive officer at the time of the transaction simultaneously served on the board of directors at CPEA. CPEA's then-chairman and president also held a substantial ownership stake in UMA. In other words, for the initial years it claimed nonprofit status, UMA was in fact still under the control of its former owners, who stood to gain from its sale and conversion.³²

The school continues to operate with a questionable business structure, a fact recognized by the US Department of Education, which has yet to fully certify the school for participation in federal student aid programs. Instead, the school is considered provisionally certified and must submit itself to cash and financial monitoring by the department. Further, UMA has a revolving door of for-profit college executives, owners, and investors, including key executives from disgraced Trump University.³³

UMA is owned and operated by a nonprofit organization but has the revenue and expenditure profile of a for-profit college. For example, the school derives the vast majority of its revenue from federal sources, including student loan dollars and military student benefits. There are limits to how much of a for-profit college's revenue can come from federal sources, so the incentive for schools like UMA to be designated as nonprofit is high. According to industry analysts, UMA has not engaged in fundraising or set up any long-term investment funds—common fiscal strategies of legitimate nonprofit colleges.³⁴ Additionally, UMA spends just 17 cents on instruction for every tuition dollar it collects from students.³⁵

A 2017–2019 US Department of Education review of UMA found the school in violation of federal aid disbursement rules for running a diploma mill for prospective students who wished to enroll but had not graduated from high school. UMA did so by forming a relationship with a for-profit online education company called ed2go. For a fee, prospective students were sent work to complete that the school said would satisfy high school diploma requirements (sometimes completing said work in less than one day); their diplomas were then sent to UMA, which the department claimed held the document until students enrolled in UMA.³⁶

Business structure aside, UMA's impact on students is also of concern. UMA employees have alleged they are encouraged by management to engage in high-pressure sales tactics to recruit students. The average annual cost of attendance in UMA's largest program (medical administrative/executive assistant and medical secretary) is \$18,214. And average earnings of UMA's allied healthcare graduates who took

out federal student loans to attend are just \$22,862 three years after graduation.³⁷ In fact, just 30 percent of UMA graduates earn more than the typical high school graduate six years after attending. Nearly three-fourths of UMA graduates who borrowed to attend are either not repaying their loans or have defaulted.³⁸ According to data acquired via a public information request, at least 460 UMA students have filed for what is known as borrower defense to loan repayment with the Department of Education, which means those borrowers allege they were misled or were subjected to illegal practices in the process of enrolling in the school.³⁹ While the public does not have access to the content or status of those applications, the number of claims puts UMA on par with campuses of some of the most notorious predatory colleges in the country.⁴⁰

Although it is problematic to deny access to students who lacked previous opportunities—like the opportunity to complete secondary education and pursue a career in healthcare—a lack of viable options along with little to no regulation means hazards can be set up anywhere, and they are easy for students to fall into. UMA has served as a cash generator for executives, and it happens to have a side hustle of providing allied health training to a relative handful of students at its Clearwater campus.⁴¹

Unfortunately, career colleges like UMA are the standard, not the exception. Some of the largest producers of nurses and allied health workers are colleges with the same profile as UMA: they converted from for-profit to nonprofit status without changing their governance or business practices to match. These schools include Keiser University, Herzing University, Remington College, Altierus Career College, and Purdue University Global (plus recently closed Independence University).⁴² For-profit career colleges are also still in operation, as are for-profit education companies that operate in the background of many public universities' online nursing programs. Prospective students seeking online nursing education opportunities should be aware that many online programs offered by public colleges and universities are in fact managed by for-profit education companies called online program managers (OPMs).⁴³ OPMs get paid based on their success in procuring new students for their clients (i.e., colleges), which means the admissions and enrollment process will seem more like a pressurized sales pitch than it otherwise would be.

Until the federal government and states increase the availability of training opportunities at public colleges, scam-ridden programs will continue to pull in students looking for career opportunities, the harms of which disproportionately impact women, Black and Latinx communities, and those in healthcare and education deserts.⁴⁴ College quality assurance systems have largely failed, and prospective students aiming to enter any industry have reason

to be cautious—but when it comes to the healthcare field, these flawed systems have ripple effects that affect medical patients downstream. We must move beyond viewing prospective college students—especially prospective health clinicians—as education consumers and treat them as the integral part of the common good that they are.

Systemic Fixes to Protect the Healthcare Workforce

Fortunately, there are policy levers to address nursing and healthcare worker shortages, and some steps are already being taken at the federal level. Most recently, the US Department of Health and Human Services announced an investment of \$13 million through the Health Resources and Services Administration to strengthen nursing education and training with two grant programs. Grants awarded through the Clinical Faculty and Preceptor Academies Program will address pipeline issues by creating academies to train clinical nursing faculty and preceptors. Funding awarded through the Registered Nurse Training Program, meanwhile, will enhance nursing education to better prepare nursing students for the provision of culturally sensitive, high-quality care in underserved areas.⁴⁵ Although these investments are a step in the right direction, greater funding is needed to comprehensively address the workforce shortage.

Congress has other opportunities to bolster the nursing workforce, in part through investing further in existing programs like Title VIII of the Public Health Service Act, the Nursing Workforce Development programs. This funding is critical for loan repayment and scholarship programs for nursing students. Crucially, this funding also provides loans for nursing faculty development and grants for improving outcomes and increasing diversity in nurse education. Progress was made when funding for Title VIII was included in the CARES Act⁴⁶ and in the appropriations package for 2022, which increased funding for the Title VIII programs over the previous year to \$280 million.⁴⁷ More funding is needed to address this crisis, however, as evidenced by the ongoing shortage and debt faced by nursing graduates; a coalition of nursing professionals has asked for \$530 million for the Title VIII program to meet the demand.⁴⁸

Even as the pandemic receives less attention (and less funding), we must continue to prioritize the health workforce, and educational programs in particular. Other health crises continue to worsen, including a maternal health crisis that disproportionately impacts Black and Indigenous women and birthing people.* Congress should move swiftly to

pass the Perinatal Workforce Act,⁴⁹ part of the Black Maternal Health Momnibus Act,⁵⁰ to expand and diversify the maternal health workforce. Funding for the perinatal workforce, which unfortunately stalled in Congress early in 2022, would have provided funding to train nearly 170,000 new maternal health professionals.⁵¹

The US Department of Education indicated it plans to release in 2023 what could be the most impactful regulation for protecting nursing and allied health students and other career education students from expensive training programs that do not pay off. The so-called gainful employment rule ensures students do not go into an unmanageable amount of debt relative to their earnings.⁵² Unfortunately, the earliest the rule will go into effect is 2024, meaning thousands of prospective students stand to fall deeper into needless debt in the meantime.



While the public waits for new accountability rules that will address predatory career education programs, the US Department of Education could use a tool it already has at its disposal: its own contracts with colleges that participate in federal student aid programs. These contracts, or agreements, put colleges on the hook for following the department's laws and regulations in exchange for access to federal student aid funds. Most colleges sign agreements with the department that last for years at a time. However, some of the worst providers in the career education space are only provisionally certified by the department, meaning the agency proactively approves their approval for federal funding monthly, despite documented abuses.⁵³ It is time for the US Department of Education to enforce these contracts and make sure colleges are delivering on their obligations. +

*To learn about the maternal health crisis, see "The Importance of Respectful Maternity Care for Women of Color" in the Spring 2021 issue of *AFT Health Care*: aft.org/hc/spring2021/taylor.

For the endnotes, see aft.org/hc/spring2023/hall_bernstein.

Why Medicine Needs the Arts



While much of this issue focuses on addressing crises in healthcare caused by corporatization and a single-minded focus on the bottom line, Jill Sonke offers us something different: a glimpse of one of many ways healthcare could work and feel better if hospitals prioritized patient well-being over revenue. For a compelling introduction to Sonke's work, watch her TEDxUF talk at go.aft.org/lq7q.

—EDITORS

By **Jill Sonke**

Jill Sonke, PhD, is the research director in the Center for Arts in Medicine at the University of Florida, the director of national research and impact for the One Nation/One Project initiative, and a codirector of the EpiArts Lab. She has written dozens of articles on the benefits of the arts and serves as a consulting editor for the *Health Promotion Practice* journal.

When I was a kid, I had a hard time falling asleep at night. In my wakefulness, I would sneak down the stairs to the bookshelf where the family encyclopedias lived.

I read over and over the sections about the brain, reproduction, and digestion. And when I did sleep, I dreamed of being a doctor. I couldn't wait to turn 14, which was when I could volunteer in a hospital. By the time that day came, I had my application submitted and my requisite white shoes in hand; I was thrilled to begin the next week. I changed bedsheets and bedpans, helped patients eat, and spent hours reading and talking with them. I absolutely loved being in the hospital and being a small part of the care team.

I was also a competitive gymnast during that part of my life. One day when I was in my junior year of

high school, a dancer came into the gym to help with our floor exercise routines. As she guided us, I found myself absorbed and lost in movement in a way I had never experienced. I felt a kind of energy and elation I had never felt. Although I didn't know the words or what they meant, I was experiencing both *transcendence* (a shift in my state of consciousness) and *self-transcendence* (an expansion of my conceptual boundaries). I knew I wanted to have that experience every day for the rest of my life. This was both my first transcendent experience and my first life epiphany.

That summer, I auditioned for a spot as a dance major at Interlochen Arts Academy, a magnificent performing arts boarding school in northern Michigan. Miraculously, I got in with a scholarship based purely on potential. So, my trajectory toward medicine took a hard turn toward the arts. Or so it seemed. In the end, these two paths actually led to the same place. As I look back now, I can see experiences in my life that both foreshadowed and shaped what would become my understanding of how the arts and medicine are connected and why medicine needs the arts.

One of them happened at Interlochen. I woke up one winter morning when I heard my roommate, a vocal major, scream. She had woken early to study and

made a cup of tea using our contraband hot pot. She sat on the floor with the hot pot on a shelf above her. When the shelf suddenly broke, she received second- and third-degree burns and began what turned into weeks of excruciating treatment in the hospital.

A few months earlier, I had given her a Joni Mitchell cassette tape. While she was in the hospital and going through very painful dressing changes and debridement procedures, she would play the tape, volume turned up loud, and sing at the top of her lungs. As she later described it to me, she transcended and survived her pain by singing. As an artist, that made perfect sense to me.

But I didn't really think about transcendence or self-transcendence until years later, in 1994, when I became a dancer in residence with the University of Florida Health Shands Arts in Medicine program. As a member of the hospital staff, I worked on the bone marrow transplant and pediatrics units, dancing with patients. Nurses and doctors wrote referrals for me to see their patients when they felt that the patients could benefit from movement or creative engagement.

Early on, when I described my work to people and they noted what a great distraction it must be for patients, that comment felt demeaning, as if they didn't recognize the depth of experience and transformation I was witnessing among patients who embraced the arts.

Although I wanted each patient to experience the joy of transcendence and the expansion of self-transcendence, I saw that patients benefited significantly from arts engagement even if they were merely distracted for a while. As human beings, we have limited cognitive capacity: we can only pay attention to so much at one time. While we think we are great multitaskers, we actually aren't, and this can work to our advantage. When we experience pain or anxiety, focusing on something else—like a creative activity—can occupy our attention and reduce our perception and experience of pain.¹ Over time, I came to realize that distraction can be a powerful mechanism and gift.

I also saw, through working with patients and delving into research, that arts engagement can make real changes in our brains and bodies. When we engage with the arts—either actively or receptively—we can experience a range of physiological and hormonal responses. Among those responses are heightened flows of hormones, including

- endorphins, our body's natural inborn painkillers, especially when we are actively involved, such as by singing or dancing;²
- dopamine, which elicits a feeling of joy when we anticipate or experience a reward, such as what comes from artistic expression, discovery, and achievement;³
- serotonin, an emotional regulator and inborn antidepressant, which heightens our sense of self-esteem;⁴ and
- oxytocin, which is our bonding hormone.⁵

In addition, both music and dance/movement have been shown to reduce elevated levels of cortisol in the presence of stress.⁶ These mechanisms are clear in the literature, but I know them through my experiences with patients.

Bertis: My First Teacher

One of the very first patients I worked with as an artist in residence was a six-year-old girl named Bertis. Bertis has sickle cell disease, which means she deals with episodes of extraordinary pain. She was reluctant to dance at first, but as soon as she stepped in, she fell in love with dancing and began to use it to manage her pain in the most masterful way. She was one of my greatest teachers. She taught me about flow state, relaxation response, and self-transcendence. Together, these three concepts became the theoretical and practical foundation of my work, and they also underpin the now-burgeoning field of arts in health.

In the first several years in which we worked together, Bertis danced to induce joy, pleasure, and fun as a counterbalance to her pain. We would play movement games in which we leapt out of her hospital room window, rowed clouds to the beach, and swam underwater with dolphins. By shifting her cognitive awareness in movement rich with imagery of her own making, she could distract herself from and reduce her perception of pain. She also wanted to learn about dance. In her small room, we did lessons in ballet, modern dance, and improvisation. Then as she got older, her pain got worse.

One day, when Bertis was 14, I got a call from her doctor saying that she had been admitted with a really bad pain crisis. When I walked into her room, she was alone and sobbing, rocking in a fetal position on her bed. She didn't look up when I entered, so as I always did, I leaned over her and said softly, "Hi Bertis, it's Jill. Do you want to dance?"

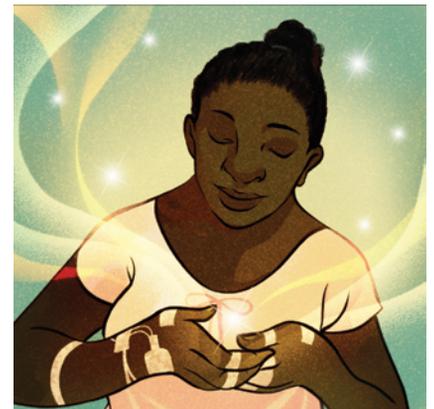
This would seem like an absolutely ridiculous question to anyone looking in, but it made perfect sense to Bertis, and she said yes. She struggled but managed to sit up. I turned on her favorite music and led her in gently moving her arms. Before long, she was in a state of deep concentration, with her eyes closed, and had taken the lead in the dance. I followed, and after about an hour of beautiful fluid movement, she was transformed. That day, a photographer was with me documenting my work. She asked Bertis, "What happens to your pain when you dance?"

Bertis replied, "Oh, it's still there, but I don't care because I feel so good."

Flow State

Later that week, Bertis's doctor came into the room while we were dancing. Bertis didn't notice, so he sat

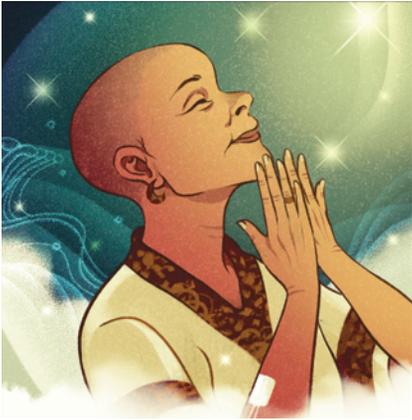
Bertis danced to induce joy, pleasure, and fun as a counterbalance to her pain.



quietly and watched for almost 30 minutes. When he left, he put a big note at the front of her medical chart: “Dancing works better than meds—call Arts in Medicine.” After that, I got a call every time Bertis was admitted to the hospital; at her request, her pain meds were reduced by half before my visit, and she could maintain that lower dosage into the wee hours of the next morning.

Bertis taught her entire care team about how creative engagement can help with pain management and well-being, and she taught me more about creative processes than I had ever learned in my dance training. Bertis is extremely adept at doing what all

artists strive to do—to get into that special creative space, the flow state, from which we can make truly authentic art. And she does it with amazing efficiency, perhaps motivated by her pain. Bertis is a master of flow state—that state of consciousness in which our awareness is highly focused on the present moment and on the activity at hand.⁷ Flow state is a merging of action and awareness and often results in a sense of euphoria as well as a suspended awareness of time, or the sense that “time flies.” It’s the transcendent state, the high, that I experienced myself when I danced for the first time in the gym decades ago.



Relaxation Response

When we engage in the flow state, we can also elicit a relaxation response, which is the antithesis of the stress response (fight or flight). It has been shown to reduce pain, anxiety, and the use of medication.⁸ Relaxation response is a hypothalamic response that decreases nervous system activity and increases parasympathetic activity.⁹ Essentially, it is an innate capability that can be summoned to reduce stress and enhance the body’s immune response. Just as stress has been linked to immune suppression, the relaxation response has been linked to enhanced immune response.¹⁰

Music has been ubiquitous throughout time and cultures as a means for counterbalancing the stresses of life and eliciting a relaxation response. I see this phenomenon in action every day in the city in which I live. As I move through the streets, a majority of people—myself included—are wearing headphones or earbuds. Many of us “dose” ourselves with music throughout the day to relax and to shift our state of being. While most of us are simply looking to boost our energy and lift our spirits, a vast array of research demonstrates the benefits of music for pain management.¹¹

Numerous studies of the use of music during burn dressing changes and debridement procedures have validated the experience that my roommate described to me all those years ago. They have documented reductions in pain, anxiety, heart rate, and muscle tension, and found that music enhances relaxation and the

patient’s experience.¹² While music can’t replace pain medication in such scenarios, it can reduce anxiety, the perception of pain, and the amount of medication needed, thus reducing side effects and risks, including the risk of pain medication addiction.¹³ And, for those suffering from substance use disorder, a recent integrative review found that music has been shown to reduce pain, reduce the amount of pain medication taken, improve substance use disorder treatment readiness and motivation, and reduce substance craving.¹⁴

Self-Transcendence

Many years ago, I had a visit with a patient on the bone marrow transplant unit. She told me about her home near the beach and her love of the ocean. When she said that she wanted to do some movement, I offered her a phrase of movement in which we stretched our arms out across the horizon as if we were on the beach, reached down and scooped up some water, and then tossed it over our heads to let it shower back down over us. She was repeating the phrase with her eyes closed when she took in a breath and said, “Now I know I’m going to be all right. The seashells all just turned to jewels.”

This patient had a self-transcendent moment. That image held deep meaning for her. And it meant even more to her than the statistics and prognoses she was given because it had come from within herself. In that moment, some of her fear turned to confidence. She had used her own inner resources, namely her creativity, to find confidence and a representative image to hold onto. The jewels on the beach became a symbol and affirmation of her survival and helped to fuel her confidence through her transplant and recovery.

Self-transcendence is a shift or expansion of our conceptual boundaries, a moment in which we see ourselves or the world around us differently. Self-transcendent moments are often described as insight or epiphany, or as “aha” moments. Viktor Frankl,¹⁵ a psychiatrist and Holocaust survivor, and Abraham Maslow,¹⁶ the psychologist who established humans’ hierarchy of needs, began writing about this concept in the 1960s. They understood that self-transcendence enhances our sense of well-being and wholeness. Well-being, in fact, can be described as a sense of wholeness.

Medical researchers have found direct correlations between self-transcendence and well-being.¹⁷ In healthcare-based studies, they have demonstrated relationships between vulnerability, self-transcendence, and well-being. Specifically, they found that when we are vulnerable, like when we are in the hospital or dealing with illness, we are more susceptible to self-transcendence, and when we self-transcend, our well-being is enhanced.¹⁸ These can be little moments, but they can make a big difference, and these moments can happen when we engage in the arts.

Frankl considered self-transcendence “the essence of existence” for humans because we live “by ideals and values.”¹⁹ Maslow placed self-transcendence at

the top of his hierarchy of needs, above self-actualization, recognizing that transcendent experiences help a person develop a sense of identity that transcends or extends beyond the personal self; “this may involve service to others, devotion to an ideal (e.g., truth, art) or a cause (e.g., social justice, environmentalism, the pursuit of science, a religious faith), and/or a desire to be united with what is perceived as transcendent or divine.”²⁰ Human beings across cultures have recognized the arts as a means for self-transcendence and have engaged them in healing practices for millennia. Today, artists and arts programs in hospitals provide patients with opportunities to self-transcend within some of the most critical moments of their lives.

becoming a Patient Myself

Nearly a decade ago, and 20 years into my career as an artist, researcher, and educator in the field of arts in health, I found myself in the role of patient. I had to have two eye surgeries on the same day—one was a deconstruction and the other a reconstruction. I was most anxious about the hours I would have to pass between the surgeries. So, I reached out to my colleague who was the director of the arts in medicine program at the Mayo Clinic, where the surgeries were taking place, and asked if a musician could visit me between the surgeries. She said yes, and to my surprise, I felt both relief and panic. I was glad to know I would have a live music performance to distract and relax me, but a huge question immediately weighed heavily on me: *What if I don't like it?*

I had invested the past two decades of my life in the belief that the arts and artists belong in hospitals and that medicine needs the arts to serve patients holistically. What if I felt differently as a patient? I had developed and taught thousands of students in degree programs in which people invested their trust, time, and money. I had helped drive the development of a field in which half of American hospitals invested in the arts.²¹ If I didn't like it, would I have to find a new career?

The day came, and two musicians gently entered my room as I rested after the first surgery. One of them asked if I had any requests. I didn't have the focus to answer the question and asked them to play whatever they liked. They played three songs. These weren't songs I might have chosen on my own, but as I listened, they transformed that moment of anxiety and pain into a moment of beauty and bliss. Tears flowed, not because I was afraid or in pain, but because I was wonderfully overwhelmed by the beauty of the music and the gift of presence, connection, and caring that the artists brought. I felt deeply cared for and safer in an institution that was concerned enough about their patients to have artists available to attend to my spiritual well-being. All of that made a huge difference. When I think back on my whole experience, that moment rises to the top instead of the difficult moments. I felt well, whole, and joyful, rather than broken and afraid.

That is why medicine needs the arts. Art can't replace medicine. Art doesn't cure diseases, and artists who work in this field are not healers or therapists.* But artists are important members of our interprofessional healthcare teams.²² They can attend to some of the needs of patients in ways that caregivers—as much as they would like to—simply don't have time for. And, as I describe in “How the Arts Can Support Clinical Staff” on page 40, artists are essential partners in the realization of a healthy and holistic system of care, for patients, for caregivers, and for the system itself.

Today, as we continue to contend with the COVID-19 pandemic, our healthcare systems are radically overburdened and understaffed. Care providers have suffered deep moral injury as a result of the pandemic, and they need more tools to support their own health, well-being, and professional longevity.[†] Our healthcare systems must embrace new approaches, resources, and partners to accomplish the changes that are necessary for healing from the pandemic and for building and sustaining systems of care. The arts have been shown to support the health and well-being of hospital staff by improving working conditions, levels of concentration, efficiency, and enthusiasm, and also by reducing anxiety and stress.²³ Thankfully, the arts and artists are available resources in every community.

By 2007, there were arts programs in approximately half of the hospitals in the United States.²⁴ These programs use the arts to provide more holistic care, and their artists work from the deep knowing that engaging in art helps us in so many ways. It is transcendent. It is joyful. It connects us to others. It can provide distraction from pain and anxiety. And all those things are simple but profound gifts in healthcare.

I still live for the transcendence I discovered in the art of dance and for the meaning I first felt when I volunteered in a hospital. All of that is amplified when I see the arts helping to make medicine, including the patients it serves and the extraordinary people who provide care, more whole. Even Plato recognized that we need more than medicine to heal when he wrote, “For this ... is the great error of our day in the treatment of the human body, that physicians separate the soul from the body.”²⁵ Medicine can do extraordinary things today, and with the arts, it can do more. +

For the endnotes, see aft.org/hc/spring2023/sonke.

*However, there is a whole field of creative arts therapies that arts in health professionals work alongside.

†To learn more about moral injury, see “Moral Injury: From Understanding to Action” in the Spring 2021 issue of *AFT Health Care*: aft.org/hc/spring2021/pittman.

Art doesn't cure diseases. But artists are essential partners in a healthy, holistic system of care.

How the Arts Can Support Clinical Staff

Caregiving is a high calling and an essential role in every society, and caregivers come to their work to do good, to help people. In my work over the past 30 years, I have asked hundreds of nurses, medical students,

and other care providers to describe the moment when they knew they wanted to be a caregiver. Most describe intimate, generous, and meaningful moments of caring for a grandparent or of being cared for by a professional or family caregiver. The moments are soft, unrushed, deeply present, and loving. While most of these caregivers can describe specific instances of realizing their vision in their professional work, they also describe how the circumstances in which they work make these moments rare.

Today, the challenges that clinical staff face have accumulated to levels that are increasingly difficult to endure, as evidenced by higher levels of staff turnover and increasingly dire shortages.¹ Typical stresses in the healthcare environment have been compounded by the COVID-19 pandemic and by increased violence against care providers.² Higher patient-staff ratios due to staff shortages mean that care providers have less time to spend with their patients, fewer resources to offer them, and fewer opportunities to provide care in the ways they envisioned themselves doing so.³

For several years, I supervised musicians working on a research project in an emergency and trauma unit at our very busy tertiary care hospital. I received a note one day from a trauma nurse who wrote to share an experience. The unit had a patient whose life the trauma team couldn't save. As they ceased their efforts and the patient's family members began to arrive, the team felt an agonizing sense of failure. Just then, the nurse saw two musicians in

residence walking down the hallway. With the family's permission, the team invited the musicians into the room to play. The nurse described the beauty of the moment, how the music provided calm and helped connect the patient, family members, and care team. She shared that it had profoundly transformed the situation from a failure to a success for the care team because they were able to do something to care for everyone involved. They felt that, although they had not been able to cure, they had been able to bring a measure of healing to the moment and to the family.

Enhancing Patient-Centered Care

There is no single solution to the profound challenges our healthcare systems and providers are facing today. Amid greater complexity and hardship in the healthcare environment, caregivers must draw on more than scientific knowledge to serve patients effectively and to be well themselves. While the arts are not a panacea, the arts and artists are available resources that can help humanize and bring beauty and meaning to both the environment and practices of care. Artists are invaluable members of the interprofessional care team who can enhance the provision of patient-centered care. They can improve quality of care by providing holistic dimensions of caring, including creative, cognitive, and social engagement.⁴ In these ways, artists can help extend the care provided by clinicians and help make those moments of satisfying caring more common than rare.

We know that engagement in the arts and humanities can cultivate caregivers' creativity, curiosity, empathy, critical thinking, communication, and social advocacy—all of which can bolster clinical skills.⁵ Medical school curricula are increasingly drawing on the arts and humanities, along with arts methods, to build these and other skills in students.⁶

Enhancing Caregiver Well-Being

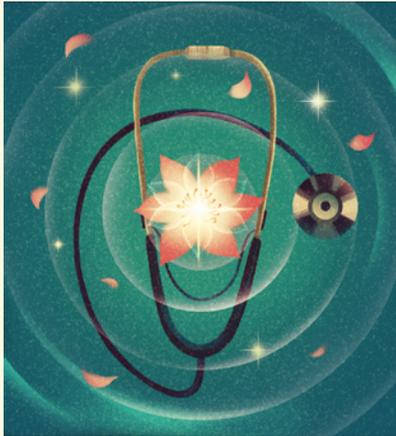
Perhaps more importantly today, the arts can also contribute signifi-

cantly to caregiver well-being and retention. Engagement in creative activities at work can increase staff well-being by reducing stress and fatigue and by positively impacting general health, mental well-being, creativity, and a sense of community at work, as one study of nurses engaged in silk painting at work found.⁷ A higher frequency of cultural activities in the workplace has also been positively associated with well-being at work, and studies have found that when given a choice, nurses are inclined to choose or retain employment in a modern hospital that offers the arts.⁸

The practice of medicine is an art. It requires creativity and presence as well as the unique skills and perspectives that each individual caregiver brings to bear. And arts engagement is a health behavior. People—including caregivers—who engage in the arts (such as going to a museum or concert) just once a month or more are less likely to be depressed or lonely and less likely to die early than those who engage in the arts less than once a quarter.⁹ As of 2007, there were arts programs (ranging from music to crafts to writing poetry) in about half of the hospitals in the United States, which means that many caregivers have access to the arts for their patients and for themselves.¹⁰ These programs exist to help reduce suffering and to improve clinical outcomes. For example, music therapy reduced procedure times, staffing needs, and sedation in children undergoing tomography scans and echocardiograms;¹¹ it also reduced medication, home health aide visits, and nursing home stays among patients with dementia.¹² Arts programs also cultivate joy, connection, and meaning, which can be amazing gifts for patients and caregivers alike. They bring greater holism to the practice of medicine and can help caregivers experience the kind of deep and meaningful caring that they came to their roles to provide.

—J. S.

For the endnotes, see aft.org/hc/spring2023/sonke_sb.



Art programs cultivate joy, connection, and meaning for patients and caregivers alike.

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*The OSHA survey specifically looked at intentional injuries caused by another person, categorized by occupation.

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