



HEALTH CARE

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From Code Red to Caring

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A Better Life for Us, Our Patients, and Our Communities

RANDI WEINGARTEN, AFT PRESIDENT

EVERY PERSON in America deserves the freedom to thrive, fueled by opportunity, justice, and a voice in our democracy. That is what the AFT fights for. Whether we work in healthcare, public service, or education, we strive for a better life for all. That's what binds us together.

This is about values, but also about solutions that make those values real. That's why the AFT offers up real solutions—and fights for them: bargaining living wages, helping wipe out student debt, and fighting for adequate staffing through our Code Red campaigns so patients get the care they deserve.

With Code Red, we're fighting the love fest corporations have with profits—like those in the healthcare industry who put their profits over patients' needs. Financialization and consolidation are sweeping the healthcare sector. Staffing is being reduced and workplace violence is increasing. Private equity's intrusion into the healthcare sector intensifies hospitals' cuts to services and staffing, often while plundering hospitals' assets.

Code Red engages our members and community allies in the fight for high-quality care. We have created campaigns across the country. And we're winning. The Oregon Nurses Association and Oregon Federation of Nurses and Health Professionals partnered to win a historic staffing law that requires that all job classifications in acute care settings have staffing dialogues with management and set staffing ratios. The law has robust penalties for noncompliance.

It's the best healthcare staffing law in the nation.

AFT Connecticut achieved a major staffing victory with a law

ensuring bedside nurses can refuse unsafe assignments. They also have staffing committees that approve staffing plans, and where the nurses have the majority vote. Likewise, the Washington State Nurses Association won safe staffing legislation that tightens regulatory control over staffing conditions and gives nurses new power to ensure safe staffing levels.

These laws are transformative. They will help with patient safety and staff retention. But more must be done. We're working to recruit youth for the four million open healthcare jobs our country will have by 2031. Creating pathways from high school to jobs of today and tomorrow. On page 20, you'll read about a high school in a hospital in Ohio. Through a partnership with Bloomberg Philanthropies, our union is helping spread that model of experiential learning across the country—starting with the Northwell School of Health Sciences in Queens, New York, where students will gain real-world experience in a wide range of healthcare jobs.

These real solutions translate to better care for patients and a stronger voice for you in your profession. This is our unwavering North Star.

Even as we fight back against the staffing crisis, we also must fight forward for a better future. That is why we engage in politics, as a means to secure the future we need. So let's look at what the Biden administration has actually done: it got us through COVID-19, created 14 million new jobs, and is bringing inflation down. The US economy is growing faster than any other large economy. And this administration is committed to quality healthcare for all—along with protecting repro-

ductive rights and health professionals' autonomy. It has already increased the number of people with health insurance to the highest level in our history, championed legislation to reduce burn-out and address the mental health crisis among healthcare professionals, helped rural hospitals stay open, and empowered Medicare to reduce prescription drug costs.

We can see who has our backs, who cares about healthcare and healthcare workers. The Biden administration is fighting for us and our patients—and is pledging to do more. And we need to see more at the bedside. That starts with partners, and a partner in the White House to fight private equity overtaking healthcare, to stop hospital closures, and to invest in safe staffing.

Healthcare is a huge issue for voters, so your voice is crucial. A recent Gallup poll shows that voters trust healthcare professionals more than workers in other professions. But in this environment, with so much disinformation and distrust, we need to get out the facts and ultimately get out the vote. We know from our member outreach that AFT members prefer President Biden to Donald Trump by strong margins, but the only poll that really matters is Election Day.

Thank you for everything you do day in and day out. Together we will realize the freedom of everyone to thrive. +



We're fighting for adequate staffing so patients get the care they deserve.

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Our Mission

The AFT 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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From Code Red to Caring



In year two of the AFT's multiyear Code Red initiative, affiliates across the country are fighting back against a corporatized health-care system that jeopardizes patient care and worker well-being for the sake of profit. Code Red campaigns have led to groundbreaking staffing laws and greater focus on training and support systems that will bolster recruitment and retention. These victories are the result of AFT members' fierce commitment to the fight—and are inspiring first steps toward the transformation we need.

The feature articles in this issue point toward several key elements in creating a healthcare system that prioritizes patients and workers. We start by hearing from four AFT affiliates about their ongoing Code Red campaigns, including two that are hard at work implementing and enforcing the staffing laws they won in 2023. On pages 4 through 7, read how affiliates are supporting new healthcare workers, protecting essential services and care, and using staffing committees to ensure safe staffing levels.

Then, we examine some of the structural issues that have brought healthcare workers to this crisis point. "Caring for the Caregivers" on page 8 provides a framework for what causes moral injury and what we must do to address and prevent it. In "Building a Morally Centered Healthcare Organization" on page 10, a researcher imagines a healthcare workplace that truly values staff and actively seeks to prevent moral injury, offering an exemplar for unions and frontline staff to focus their advocacy. On page 16, in "Help-

ing Healthcare Workers Heal," a journalist describes the grief and trauma health professionals experience and outlines the systemic changes needed to restore humanity to an increasingly inhumane healthcare system. Finally, in "Creating a Healthy Community" on page 20, a retired educator describes a high school partially located in a hospital that is helping young people become healthcare professionals in their community. Together, these articles go to the heart of our union: fighting for a better life for all.

—EDITORS

Maximize Your Staffing Committee's Effectiveness

The AFT has developed a training series to help union health professionals advocate for safe staffing on their workplaces' staffing committees. Each of the series' three one-hour modules focuses on a different aspect of committee work, with AFT affiliate leaders from across the country delivering presentations drawn from their on-the-ground experiences. Members can work through the series at their own pace, receiving 3.0 contact hours for completion. For more information, visit go.aft.org/n0i.

Making a Difference for Nurses in Connecticut

By John Brady

John Brady, RN, is the vice president of AFT Connecticut, an executive board member of the Connecticut AFL-CIO, and the former president of the Backus Federation of Nurses. He retired from Backus Hospital after 16 years as an emergency department nurse.

Connecticut's staffing legislation went into effect October 1, 2023, and we've been making great progress on our Code Red campaign goals.* We have established stronger staffing committees in all eight acute care hospitals that we represent. We're training committee members on how to participate in meetings and what the committees and staffing plans should look like under the new law. We're also educating our members more broadly about the legislation. We created a Safe Patient Limits toolkit (visit aftct.org/safe-patient-limits-toolkit) with webinars and additional resources, and we're working with the AFT on a national webinar series on staffing committees, including how to use the committees for internal organizing.

We've also been working to ensure that hospitals abide by the legislation. The first staffing plans under the new law were submitted to the state on January 1. At five of

Hospitals that violate the law by not meeting their approved staffing numbers 80 percent of the time will face penalties beginning this October, but they must adhere to the other parts of the law—like posting the committee-approved staffing plan—now. So, we filed complaints against these three hospitals with the Connecticut Department of Public Health (DPH), the agency enforcing the legislation. Our staffing committee labor co-chair submitted the committee-approved plans to DPH, and it is investigating.

We know that DPH will want us to work this out with management at each hospital. However, these managers are trying to manipulate their way into the ratios that they mistakenly believe are good for their bottom lines. In meetings, they say things like, "This will cause backups in the emergency waiting room; how would you feel if that was *your* family?" This is not a capacity issue. Proper staffing ratios improve safety, patient outcomes, and nurse recruitment and retention—and research shows they *are* good for the bottom line.† Unless we force hospitals to staff at levels at which nurses feel safe and able to give patients the care they deserve, nurses will continue to be pushed out of the profession. Our members have pushed back, and we have the majority vote, so we hope DPH will back us up. If it doesn't, we have enough friends in the legislature and in the governor's office to address that.

This year, we are also working on workplace violence, another issue that ties into recruitment and retention. There was a horrible incident in October 2023, when a visiting nurse was murdered during a home visit. There have been other situations where the home care assignment was in a dangerous neighborhood. We're lobbying for greater safety measures for our members that include and go beyond adequate staffing. We need a way to assess potential risks and flag those in patient charts. We also want wider access to the hands-on de-escalation training that tends to be only available for staff in the emergency or psychiatric departments. It should be required for anyone who interacts with patients, whether in clinical or support capacities.

We're working with a coalition that includes the Connecticut Nurses Association, other unions in the state, and interested legislators to strengthen Connecticut's existing staff safety legislation. Additionally, Joe Courtney, one of our congressmen, has been working on an Occupational Safety and Health Administration standard for workplace violence for years. We are cautiously optimistic that we may get that standard this year.

This Code Red campaign has been an incredible internal organizing tool. Our staffing committees have really owned our new legislation, and we're going to keep communication channels open so that we know what's going on at the different hospitals and can learn from each other. Many Connecticut hospitals are still not unionized. My hope is that through this campaign they see what can happen when people are empowered to use their collective voice—and that they'll join us so they can make a difference in their hospitals too.



COURTESY OF AFT CONNECTICUT

our hospitals, the administration submitted the plans that our committees developed, voted on, and approved. At the other three hospitals, the administration refused to submit the committee-approved plans to the state. Instead, perhaps thinking they could get away with subverting the law, they submitted separate plans that had not been approved by the committees. In one of these, Backus Hospital, the meeting minutes that are available to everyone clearly show that the plan passed by the committee is not what the hospital submitted.

*For an introduction to Connecticut's Code Red campaign and new staffing legislation, see "Winning Landmark Legislation for Connecticut Nurses" in the Fall 2023 issue of *AFT Health Care*: aft.org/hc/fall2023/brady.

†To learn more, see "Patient Outcomes and Cost Savings Associated with Hospital Safe Nurse Staffing Legislation" by Karen Lasater et al. in *BMJ Open*: pubmed.ncbi.nlm.nih.gov/34880022.

Empowering Nurses in Oregon

By Tamie Cline

Tamie Cline, RN, is the president of the Oregon Nurses Association (ONA) and a bargaining unit leader at Good Shepherd Medical Center in Hermiston, Oregon. She has served on the ONA Professional Nursing Care Committee since 2020 and has been a delegate to the AFT's convention since 2018. She is currently an IV therapy and wound care nurse in the Good Shepherd Treatment Center.

Since the passing of Oregon's staffing legislation in July 2023, we've been working to ensure its successful implementation.* The nurse-to-patient ratios take effect June 1, the new non-RN staffing committees must be formed by December 2024, and then June 2025 will bring civil monetary penalties for hospitals that violate the law. While passing this legislation was not easy, the real work lies in seeing it implemented and ensuring our members are empowered to report staffing violations.

Administrators at some smaller hospitals are already complying with the ratios set under the new legislation. But many larger hospitals aren't. Our state regulatory agency is already receiving complaints about employers that are understaffing (such that nurses are still missing their meal and rest breaks), assigning nurses to areas they're not properly trained for, and canceling staffing committee meetings. In one hospital that had better staffing ratios than what's mandated in the new law, administration used the law as an excuse to increase nurses' workload—even though the law specifically forbids it.

This new legislation won't work if our members don't know about it and don't fight to enforce it. Administrators will continue trying to skirt the law or exploit loopholes. So we are educating members about their rights under the law and about the role of staffing committees. It can be challenging to get the word out to our many members, so we're using several channels to communicate. We are holding membership forums and will be offering on-demand courses on our website through OCEAN (Oregon Continuing Education Activities for Nurses; visit oregonrn.org/page/onlinece). We're hosting monthly conference calls with the staffing committee chairs and reaching out to them individually to ensure they are engaged and have the resources they need. And once a month, I'll be including a personal message in our weekly member newsletter to ensure we keep spreading the word.

We are also focusing on where our power lies in this law: drafting comprehensive staffing plans that ensure a good working environment for staff and high-quality care for patients. We have a team of nurse practice consultants who are meeting regularly with staffing committee co-chairs and advising on what staffing plan changes to consider—and how to prevent changes to existing plans. They're telling our members to stand strong and to not



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accept ratios that are outside the intent of the law. The law says that if they cannot come to an agreement with the employer, they go to mediation. And a mediator will uphold the law.

We also want to empower members to file complaints when employers violate the law. Many nurses are not filing complaints because they're so used to complaints going nowhere and because the complaint process is very cumbersome. Nurses are too overworked to write out complaints during their shift, and the last thing they want to do is spend 20 minutes doing it when it's time to clock out. To address this, we are also involved in the regulatory agency's rulemaking process, helping interpret the law, closing loopholes so employers cannot manipulate staffing plans, and refining the complaint process. And we're encouraging members not to wait until the law goes into effect to write complaints. Filing complaints when violations occur now can help ensure that hospitals' violations will automatically bring a monetary fine beginning next year.

Pushing back on hospitals and refusing to be overworked goes against nursing culture. We are conditioned to believe that we must step up and take on extra work. We believe we must put our own health and safety in danger to fix problems created by administrators—who are making greater profits each year by cutting costs on the backs of the workforce. So as we're educating our members, we are also retraining our way of thinking. I think we're going to see a huge difference as hospitals learn they can no longer bully and manipulate our nurses because we're fighting to protect ourselves as well as our communities.

*For an introduction to Oregon's Code Red campaign and new staffing legislation, see "Historic Staffing Win for Oregon Health Professionals" in the Fall 2023 issue of *AFT Health Care*: aft.org/hc/fall2023/cline_burley.

Fighting for Healthcare Access in Central Brooklyn



AFT

By Frederick E. Kowal and Carolyn Kube

Frederick E. Kowal, PhD, is the president of United University Professions (UUP), an AFT vice president, and a professor of political science and Native American studies at the State University of New York at Cobleskill. Carolyn Kube, MS, MT (ASCP), is UUP's statewide vice president for professionals and was a medical technologist for 32 years at Stony Brook University Hospital.

The focal point for our Code Red campaign is the State University of New York (SUNY) Downstate Medical Center, which is a public medical school and hospital in central Brooklyn. One of three SUNY teaching hospitals, it's located in a community that is predominantly African American, with large Caribbean and Latinx immigrant populations. This community is under-resourced and has many economic and healthcare challenges.

Downstate is one of seven very financially stressed healthcare institutions in the area. Since 2011, it has faced multiple financial challenges and threats of closure—most notably by former governor Andrew Cuomo, who tried to forcibly close the institution by cutting off all state funding. With the incredible support of AFT President Randi Weingarten, we were able to fight off the worst of those challenges. But now, SUNY has determined it no longer wants to be “in the hospital business.” Working with our current governor, Kathy Hochul, SUNY plans to close the hospital to build affordable housing, maintaining the medical school but parceling out hospital services to other institutions, including Kings County Hospital Center across the street.

This proposal has disastrous implications. It will result in the greatest harm to patients in central Brooklyn, who are least able to pay for healthcare and have high incidences of severe chronic conditions such as diabetes and hypertension.¹ This community also has a severe maternal morbidity rate, higher than anywhere else in the state.² The quality of patient care at all seven central Brooklyn hospitals has already suffered because of the financial challenges of the last several years. Patients who can afford healthcare routinely go elsewhere, often to Manhattan. Patients

without means may not seek care at all. Wait times at Kings County are already so long that patients have left, their IV lines and poles still attached, to seek care at Downstate's ER. Without Downstate, what will these patients do?

This proposal also harms our Downstate members. By SUNY's own calculation, it will impact 10 to 20 percent of members and send 2,400 employees to a single wing of Kings County, which is in even worse financial shape. Where will that leave our members?

And closing Downstate while keeping the medical school open will greatly harm the medical school and the quality of future healthcare for the community. Area hospitals are so desperate for funds that they're accepting money from offshore medical schools to place their residents—meaning fewer slots available for local residents and interns who need to continue their training. SUNY Downstate's medical school has one of the largest, most diverse graduating classes in the state, with physicians who overwhelmingly choose to serve equally diverse communities in New York. New York should be investing in the hospital, not making it harder for future doctors to complete their education.

So, our immediate priority is stopping the closure. We began with getting our story out to the public with a very clear message: Brooklyn needs Downstate. We're posting testimonials from Downstate doctors, nurses, and administrators on our website with our campaign message and press releases. We're launching a visibility campaign with television, radio, and social media spots, and providing posters, stickers, and T-shirts to be worn in solidarity. We're asking members to write letters to the governor and using rallies, silent protests, and pickets to keep momentum going. We've already garnered strong support in the New York state legislature to stop this destructive plan.

We are strengthening our community coalition, reaching out to clergy members and other community leaders and groups. We're talking with people directly about how this plan will impact them and their families. And we're working with other unions, including New York State United Teachers, the Public Employees Federation, the New York State Nurses Association, and two AFSCME locals, to increase awareness and support.

Long term, we are aggressively advocating for a reimagined Downstate through a community- and stakeholder-driven process that is inclusive every step of the way. The result will be a world-class academic medical center that addresses the longstanding health disparities in Brooklyn. Downstate would then make a real difference to the maternal mortality crisis and the rates of chronic disease in this community and serve as a groundbreaking national example. To best serve the community, we are calling for a planning process that centers the central Brooklyn community and those engaged in the lifesaving work at Downstate.

This is a very passionate and personal issue—and a moral cause—for us. We remain hopeful that the governor's office, the legislature, and all other stakeholders will join us in the important work of planning a sustainable future for Downstate that provides the access and care this community deserves.

For the endnotes, see aft.org/hc/spring2024/kowal_kube.

Standing Up for Alaska's Nurses

By Donna Phillips and Stacey Sever

Donna Phillips is the labor council chair of the Alaska Nurses Association and an AFT vice president; she was an intensive care unit nurse for 44 years, with 29 years advocating for union nurses and Alaskans at Providence Alaska Medical Center. Stacey Sever is a former emergency room and flight nurse with Providence Health & Services and the health and safety committee chair of the Alaska Nurses Association.

In Alaska, our staffing and retention problems can be exacerbated by the remoteness of our facilities. For example, we have only one long-term acute care hospital in Alaska—and in Providence Alaska Medical Center alone, we have dozens of patients who don't meet inpatient or skilled nursing home criteria but have nowhere else to go. Administration said they wanted to put those long-term patients on one wing of the med-surg floor with a nine-to-one patient-to-nurse ratio. Naturally, our nurses revolted. Union members went to town halls to speak their minds and wore bright red badges in protest. Within two weeks, the hospital backed down, and they haven't revisited it since.

We're continuing to use our power to check hospitals' greed, including by incorporating staffing ratios into our contract campaigns—but we don't expect that healthcare employers in Alaska are going to commit to safe staffing ratios without legislation. Our staffing committees function more like scheduling committees, and employers like Providence try to change staffing plans at will. That's why staffing legislation is the primary focus of our Code Red campaign.

We're preparing for a long campaign, starting with research. We are working with AFT staff to develop a white paper on the need for safe staffing ratios in Alaska hospitals, and we're asking our nurses to complete a brief staffing survey so we have data on current workplace conditions. We plan to use both as foundations of our campaign as we hold lobby days and lay the groundwork for legislation.

We also know that there's more we can do to help Alaska nurses sooner.

One major staffing issue has to do with preparation. There's a shortage of instructors because nurses with five years' experience can make more at the bedside than a nurse with a PhD does teaching. Students who get coveted spots in nursing programs graduate with thousands of dollars of debt; some facilities give a sign-on bonus or other incentives, but if nurses leave before a specified time, they often have to return part of that bonus. Unfortunately, there's no way to know in advance that the job will be a good fit or that new nurses will get the support they need.

We have programs that attempt to address some of these issues, but sometimes they create additional problems. For example, the residency program at Providence Alaska Medical Center brings in three cohorts of about 40 recently graduated RNs each. The staff nurses do their best to train the new nurses, but they don't get a lesser assignment so that they have time for the work of precepting. We're also finding that because of short staffing, these new nurses are asked to start taking assignments before they've completed their residency.

If the facilities that desperately need the next generation of nurses took on more financial responsibility for preparing them, that would be a huge help. There's pressure to change licensure requirements and decrease the quality of care we provide because these facilities don't have enough staff—but where are they when it comes to cultivating that staff?

We're working with a legislator on a bill that would establish nurse apprenticeships so that students would get paid while they're learning nursing hands-on from experienced nurses, much like the trades do. Apprentices would gain experience as they help turn and walk patients and do other time-consuming tasks RNs are asked to do, and they would benefit from spending a lot more time in the hospital before graduation. You can read about what happens when someone goes into pulmonary edema or has any change in condition that requires quick intervention—but seeing it is completely different. If you have that first experience before your residency or first job, you have a huge advantage (and so do your patients).

We're also educating members and our community about the importance of the political process. If we want to pass legislation, we need to get people elected who will support it, from the governor down to the local level. We're writing about it in *Alaska Nurse* and other publications and talking about it at our conferences. We also went door knocking to get out the vote for the mayoral and school board races in Anchorage. Nurses need to understand how important it is to know their elected officials and tell them what's happening at work.

We're committed to winning protections for Alaska healthcare workers and patients. We prefer collaborating with administrators, but we're fighting to make the most of those opportunities. +



COURTESY OF ALASKA NURSES ASSOCIATION

Caring for the Caregivers

Addressing Burnout and Moral Injury



The COVID-19 pandemic placed incredible strain on the health and public safety workforce. The nature of their work meant that they faced high risk of exposure while being called on to meet tremendous healthcare and service demands. Even before the pandemic, mental health, burnout, and moral injury were rising issues for this workforce. But during COVID-19, more than 50 percent of health workers reported burnout, and 40 percent reported anxiety or depression. Though the critical period of the COVID-19 pandemic may be waning, burnout and moral injury among health and public safety workers persist.

The Workplace Change Collaborative (WCC) recently released the National Framework for Addressing Burnout and Moral Injury in the Health and Public Safety Workforce, which explores the drivers and processes of burnout and moral injury and identifies practical strategies and tools to improve worker and learner well-being in health and public safety settings. The framework emphasizes organization- and system-level changes in recognition that threats to personal and professional well-being originate in or are compounded by upstream drivers.

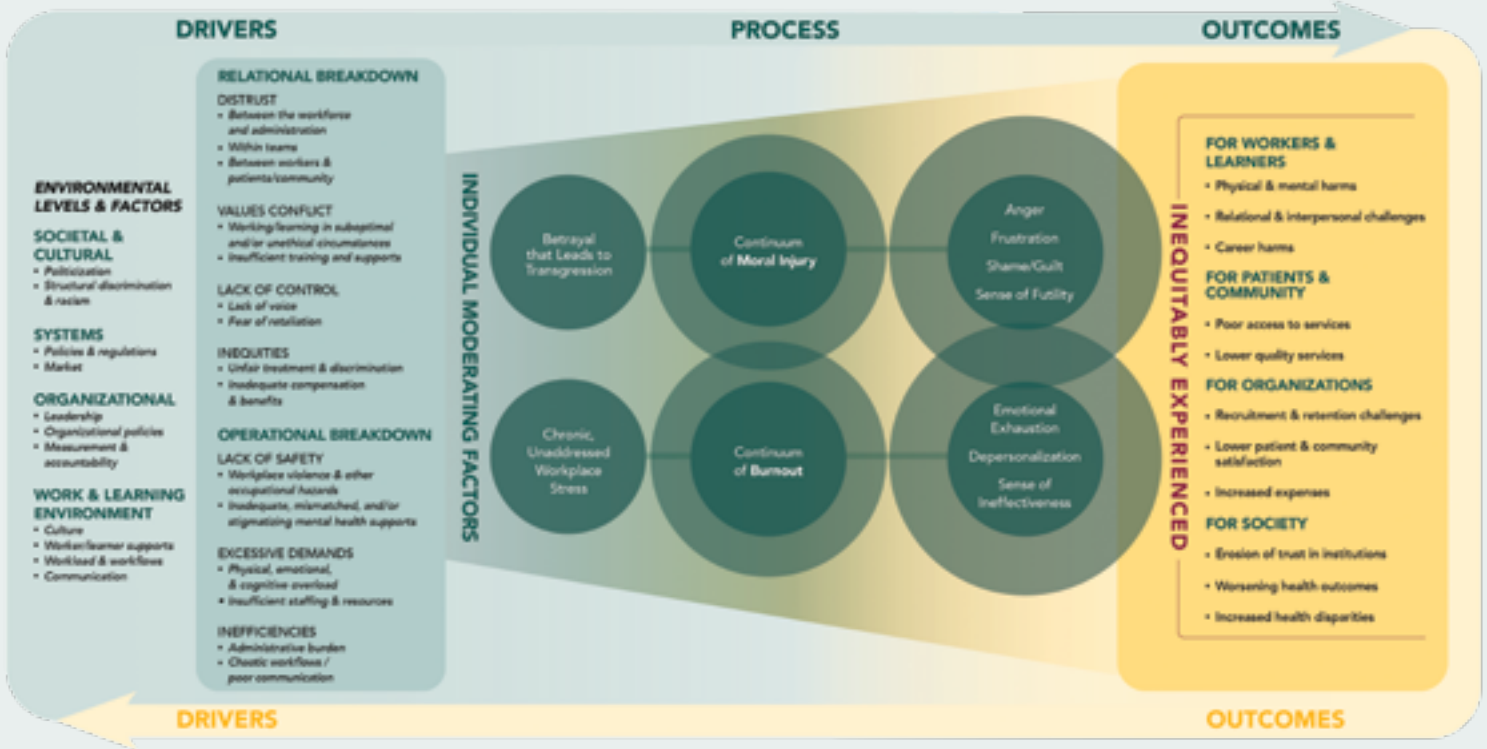
To explore an interactive version of the framework, go to wpchange.org. For actionable strategies for a wide range of stakeholders, see wpchange.org/actionable-strategies. If you'd like details on how we developed this framework, see our report at go.aft.org/x5v. Here, we share graphics that summarize the key factors that drive burnout and moral injury and how to improve the well-being of the health and public safety workforce.

As a healthcare professional, you have likely experienced the complex and intersecting factors that produce burnout and moral injury firsthand. Overarching environmental factors—from politicization and racism to unmanageable workloads—contribute to relational and operational breakdown. Relational breakdown refers to the distrust, conflicting values, lack of control, and inequities experienced in work and learning environments. Operational breakdown is seen in a lack of physical and mental health safety, excessive work demands, and inefficiencies. Often, interventions have focused on operational breakdown; however, burnout and moral injury will not be fully addressed without repairing distrust and other relational challenges. We hope this framework helps you, your union, and your employer rebuild relationships and trust, solve operational problems, and restore workers' well-being. +

By the Workplace Change Collaborative

The Workplace Change Collaborative is a partnership between the Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University, the Institute for Healthcare Improvement, Moral Injury of Healthcare, and AFT Healthcare.

Burnout and Moral Injury in the Health and Public Safety Workforce



Addressing Moral Injury & Burnout in the Health & Public Safety Workforce





Building a Morally Centered Healthcare Organization

The concept of moral injury* in healthcare gained attention six years ago, with a viral article in *STAT* that has been downloaded 300,000 times and is still one of the publication's most read articles ever.¹ The coronavirus pandemic intensified interest in the concept, and some investigators began quantifying the experience,² while others looked at potential sources and drivers of the distress.³ I am a psychiatrist who worked for the Department of Defense and as an executive for an international nonprofit before turning to address clinician distress full time. Along with Simon Talbot, an academic plastic surgeon with a subspecialty in hand surgery, I have been working for nearly a decade to address clinician distress. During that time, we have searched for an organization that minimizes the risk of moral injury to hold up as an example, to no avail.

We have followed up on every lead from either leadership or clinicians that promised a positive work environment. We have talked with facilities across the country, from small clinics to independent hospitals to large academic medical centers representing both for-profit and not-for-profit institutions. One organization we visited is representative of the pattern we repeatedly encountered: the health system draws people from 100 miles around with its great outcomes and happy patients, and we hoped to learn its secrets for maintaining excellence and, presumably, a healthy workforce. But we barely had time to introduce ourselves before the president slapped the conference table and said, "We're so glad you're here. We're in big trouble."

A few organizations manage well in isolated areas, or for short periods, but none have stood out as providing excellent patient care in a way that is sustainable for clinicians over several years. In virtually

every case, as Dr. Danielle Ofri, an internal medicine physician at Bellevue Hospital in New York City and an expert on doctor-patient relationships, has written, under the strain of profit-driven corporate healthcare, adequate patient care has come to depend on the "one resource that seems endless—and free—... the professional ethic of medical staff members."⁴ In too many places, clinicians are sacrificing their own well-being to uphold the oaths they made to patients.

Dr. Don Berwick, the founder of the Institute for Healthcare Improvement and a career-long change agent in healthcare, wrote in June 2020, "When the fabric of communities upon which health depends is torn, then healers are called to mend it."⁵ While the article was published shortly following the most intense period of the COVID-19 pandemic, Dr. Berwick's piece was not pandemic-centered. He spoke extensively about the sociopolitical environment in which communities exist and healthcare is delivered, arguing that health workers must insist, in whatever ways are available to them—voting, writing opinion pieces, working with community agencies, and others—on fundamental shifts in our collective commitment to moral change.

The foundation of professionalism in medicine, nursing, and other health professions is the covenant each individual makes with society to provide services that society is unable to provide for itself, in exchange for certain privileges: a comfortable living, respect, and the right to define and enforce appropriate practice. These privileges are rooted in the presumed integrity of the individuals entering the professions—in trust. Global risks to integrity, then, put professionals and their professions at risk. As such, it behooves individual clinicians to hold their organizations responsible for creating work environments in which their integrity is not threatened, either directly—by being asked to put the best interest of the organization ahead of the best interest of the patient, for example—or by association with an organization that does not uphold its own mission, vision, and values.

By Wendy Dean

Wendy Dean, MD, is a psychiatrist and cofounder of Moral Injury of Healthcare. She has published widely on clinician distress and its impact on patient care and is the author, with Simon Talbot, of *If I Betray These Words: Moral Injury in Medicine and Why It's So Hard for Clinicians to Put Patients First*. The primary study referenced in this article was a collaboration with Deborah Morris, PhD, and her team at St. Andrew's Healthcare in Northamptonshire, England, for which the author is deeply grateful. No outside funding supported the work.

*AFT Health Care has published several articles on moral injury documenting the challenges healthcare workers face and how to address them; see aft.org/hc/subject-index#moral-injury.

In too many places, clinicians are sacrificing their own well-being to uphold the oaths they made to patients.

Patients present to health systems with a mental picture of what they imagine their care will be like based on the marketing materials they have seen, their interactions with medical staff, and perhaps the institution's reputation among friends and family. Some of those expectations are conscious and reasonable; others are less so. When encounters fail to meet their expectations, patient responses may range from resignation to rage to abandonment of care, with potentially significant impacts on their health outcomes, well-being, and relationships with future health professionals.⁶

Clinicians, too, come to health systems with expectations for their experience of working for the organization. Those expectations come from mission, vision, and values statements and other public documents; job posting language; human resources interactions; and triangulating interviews and conversations with current and former staff. When a health employer's culture fails to meet a clinician's expectations for what their work will be like and the care they can provide, clinicians, like patients, have a range of responses. They may feel angry, ashamed, embarrassed, or even betrayed by the marketing slogans that some organizations admit are "puffery," not meant to be truthful.⁷

Workers usually explore other employment options when they realize their situation is not as originally promised, but too many find their exit is blocked. Employment contracts with restrictive covenants, also known as noncompete clauses, bind nearly one in five workers in the United States and prevent employees from working for a competitor in the same market.⁸ An astounding 57 percent of healthcare employers use noncompete agreements.⁹ Many also use training repayment agreement provisions (TRAPs) to reimburse companies for training costs when an employee leaves soon after receiving said training.¹⁰ Nearly one-third of nurses are subject to TRAPs sometime during their careers.¹¹ Yet others face sign-on bonus repayment for early termination of a contract. These contract mechanisms are meant to retain employees through contractual or financial leverage, rather than through enticements such as raising wages or improving working conditions.¹² When such leverage compounds an employer's failure to meet expectations, the risk of betrayal and consequent moral injury is high.

Recent surveys have highlighted increased levels of burnout between 2018 and 2022, which correlated with distrust in management, lack of supervisor help, not enough time to complete work, and a workplace that did not support productivity.¹³ There have been striking findings about moral injury, too. In 2020, 45 percent of workers responding to the Moral Injury Events Scale agreed with the statement "I feel betrayed by leaders who I once trusted,"¹⁴ and 41 percent of those responding to the Moral Injury Symptom

Scale for Healthcare Professionals met criteria for moral injury.¹⁵ Despite increased attention to health workforce mental health and well-being during the pandemic, symptoms are not receding as intended. Moreover, since 2007, when the Cleveland Clinic first created a chief wellness officer position, dozens of large hospitals have followed suit, with the trend accelerating over the last five years. The American Medical Association even recommends creating the position as a first step in addressing staff distress. Unfortunately, none of these measures is having the hoped-for level of impact.

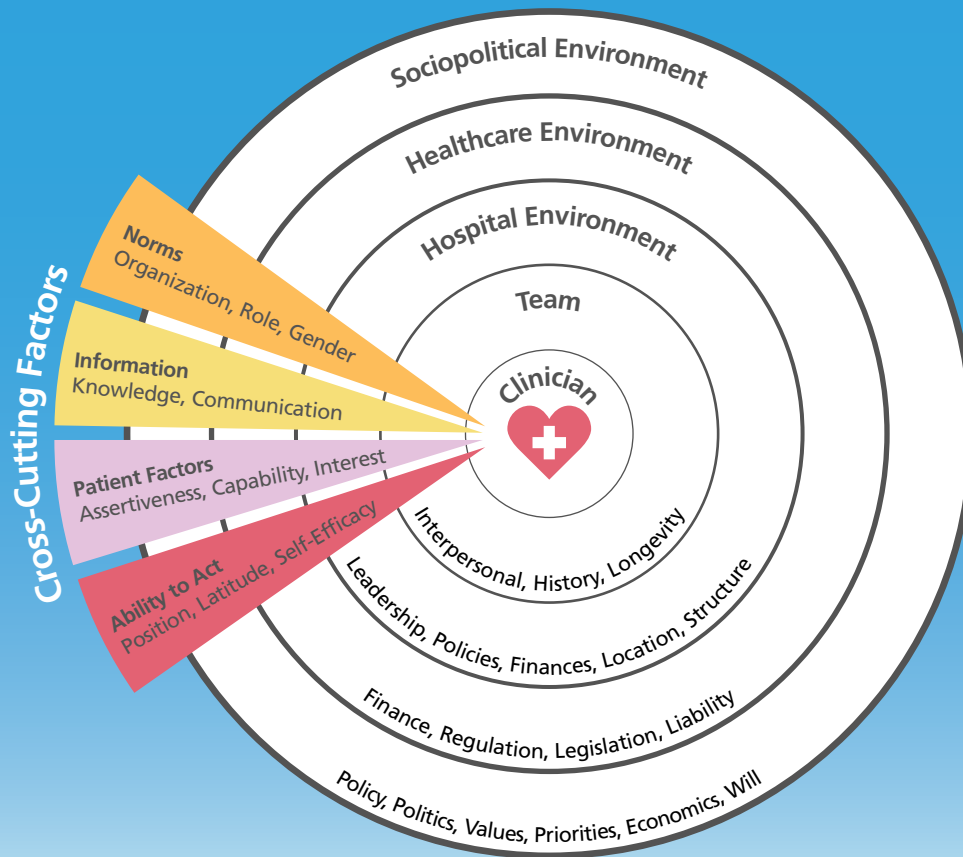
In the spring of 2023, with researchers in the United Kingdom, our organization, Moral Injury of Healthcare, set out to develop an international consensus among those who specialize in moral injury. We wanted to know what characteristics a non-morally injurious, or *morally centered*, organization would exhibit. We wanted to describe a North Star toward which leaders can navigate, and for which unions and frontline staff can advocate.

More than 50 individuals with suitable expertise in moral injury, from either an academic or a clinical perspective, were identified through professional networks, literature searches, and advertising on LinkedIn. Invitees came from around the world and from a cross-section of fields—healthcare, first responder communities (including law enforcement), and the military. Only a handful of invitees declined the invitation. Some participants had done research in moral injury for decades, and others had never done research but were part of wellness teams in hospitals or clinics. Over three months, we presented iterative questionnaires focusing on how to describe morally centered organizations, and then delineating the characteristics of such institutions. Some descriptions were based on organizations known to be performing well in some areas, and others were descriptions of envisioned ideals. There was strong consensus about the findings described below, despite participants representing diverse perspectives.¹⁶

Ecological models are well known in health literature, representing the multiple levels of influence impinging on health behaviors and outcomes. Moral "health," similarly, is influenced by factors at many levels (as shown in the figure on page 13): an individual's background and upbringing, interpersonal factors among team members, the hospital environment and leadership, the environment of healthcare writ large, and the general sociopolitical environment in which care is rendered. Viewing the findings through the lens of an ecological model, from sociopolitical to hospital environments, provides a logical progression, with one caveat: this is a discussion of the characteristics of a morally centered *organization*, and as such, it will not include characteristics of individual sufferers to be addressed, nor solutions focused on individuals.



Moral Injury Ecological Model



A morally healthy organization approaches potentially transgressive situations with courage.

A Moral Core

Mitigating moral injury begins by aligning outward representations of corporate culture with manifest corporate conduct. In other words, the words on the walls must match what happens in the halls. A culture predominated by a values-based framework, which balances compliance-centric rules with an internalized set of shared professional values, encourages intuitive decisions that are “right” for serving patients’ best interests. Organizations with cultures that inspire people to excel at patient care, and operational environments that facilitate their doing so, are places where clinicians thrive.

These organizations recognize practitioners as knowledge-worker professionals. Professionals, by definition, have a unique fund of knowledge, based upon which they provide services to society that society cannot provide for itself. These practitioner-professionals are trained to make complex judgments, with integrity, under conditions of technical and ethical uncertainty. Their judgments then lead them to take highly skilled action. Nurses, physicians, and other health practitioners are hired specifically for their unique knowledge and skills (and those with such

unique skill sets can be identified by the extensive credentialing process meant to prove their claims). Because no one else—other than a similarly or more highly trained professional—is qualified to intervene in their decisions, healthcare professionals must be free to act on their training and ethical principles, without confounding demands, such as admission quotas, documentation requirements, and length-of-stay constraints.¹⁷

In a healthy environment, professionals exercise their education and training as they deem appropriate and are responsible for decisions in their areas of expertise. Practitioners control a health system’s decisions that impact patient care and clinical workflow, for example. Administrators value clinical input and work to facilitate optimal care delivery that is sustainable for practitioners. This, of course, requires careful selection of clinical and nonclinical team members, for those who are mature, self-aware, and introspective; have values aligned with the organization; and demonstrate high integrity. The organization anticipates that the potential for moral challenges is ever-present in healthcare workplaces. However, while some moral challenges

Clinicians thrive when excellent patient care is part of the organizational culture.



are unavoidable, as in critical or crisis care situations, avoidable moral challenges, like administrative encroachment on clinical decision-making, are minimized.

Facing the risks of moral injury and engaging in honest, courageous conversations about threats to our moral foundations requires leaders who are, first and foremost, trustworthy. They are sufficiently skilled for their roles, exhibit high integrity, and deliver on promises. They are humble, vulnerable, authentic, and engaged, and they select other team members, clinical and nonclinical, who are the same, while reinforcing these characteristics. Such leaders model morally congruent practices and provide opportunities for everyone to acknowledge and reflect on conflicts in their values and practices.

But providing opportunities to reflect on potential moral transgressions is ineffective without training and education related to recognizing and navigating unavoidable moral challenges. Mentorship in these regards is essential, as is support for staff who are exposed to moral risks, which is where a values-based framework of corporate culture proves critical. Rather than compliance-based frameworks that seek to prevent or to root out (and usually punish) *misconduct*, values-based frameworks seek to shape and enable *professional*

conduct. To that end, disciplinary processes are fair, open, visible, honest, consistent, equitable, and just. The organization provides support and *repair*-focused strategies for those who have transgressed.

A morally healthy organization approaches potentially transgressive situations with courage and curiosity rather than avoidance, blame, or shunning. Challenges from within the organization to sources of moral transgression are welcome, if uncomfortable. And the organization, situated in a complex sociopolitical ecosystem, has an obligation to speak out in defense of its workforce against potential regulatory or legislative sources of moral injury, valuing moral justness more than simple adherence to regulation and legislation.

The Moral Imperative of High Resource Utilization

The outermost circle in the ecological model of moral injury is the sociopolitical environment of policy, politics, values, priorities, economics, and will. Healthcare organizations and systems must acknowledge the influence they exert on the communities they serve, and whose resources sustain them. Healthcare consumes 17.3 percent of the US gross domestic product, or slightly more than one-sixth of the economy,¹⁸ which is more than five times

US defense spending.¹⁹ Even the smallest healthcare megaproviders, in 2017, had revenue greater than Fox News, CNBC, and MSNBC combined.²⁰ In 2020, health firms spent a total of \$713.6 million on lobbying. Pharmaceutical and health product manufacturers spent the most (\$308.4 million), followed by providers like health systems, hospitals, and clinics (\$286.9 million), insurers (\$80.6 million), and others (\$37.7 million).²¹ The economic power of the healthcare sector is staggering. As Dr. Berwick wrote, “The cycle is vicious: unchecked greed concentrates wealth, wealth concentrates political power, and political power blocks constraints on greed.”²² Healthcare spending remains high (with a low return on investment when the United States is compared with other wealthy countries²³), and far too little is spent on factors that have a strong impact on communities’ health and well-being: housing and food insecurity, social services, public safety, education, job training, and criminal justice reform. It is unconscionable that these huge healthcare institutions, which capture so much of our economy as to crowd out other needy sectors, should remain silent and sidelined on issues of moral consequence for their patients and their workforces.

Bargaining Morality

Although it will be challenging to make morally centered organizations the norm in healthcare—and pressure to change will need to come from many sources, including communities and legislators—unions have a major role to play in advancing moral practices. How does one translate these research findings into negotiations at the bargaining table? The following points may be useful to consider or adapt.

1. The organization must conduct audits of key performance metrics related to staff experience such as turnover, retention and exit interviews, absenteeism, and job satisfaction. Whether or not the organization conducts such audits, the union should also conduct retention and exit interviews and gather information on job satisfaction.
 - Provide yearly updates to action plans addressing the findings, in collaboration with workforce representatives.
2. The organization must invest in measuring not only burnout, but moral injury.²⁴ The results must be shared with the workforce in a timely way. With or without the organization’s support, the union can also measure burnout and moral injury, sharing its findings with staff and management.
 - Risk and management strategies for moral injury must be communicated freely with the

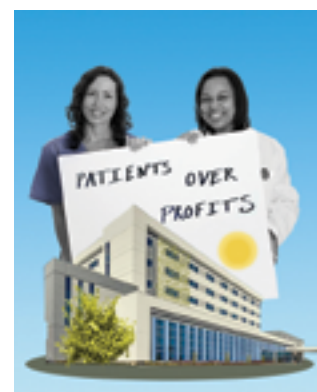
workforce and must be informed by input from practicing clinicians.

3. Related to moral injury is physical and psychological safety. The organization must measure and commit to researching the physical and psychological safety of the workforce, also sharing results in a timely way. Again, the union can do this with or without the organization’s help.
 - As an extension of psychological safety, and to ensure whistleblowers have recourse in the event of retaliation, a disinterested third party should be engaged to inquire about whistleblower experiences when speaking up.
4. The organization must ensure adequate mechanisms are in place to empower workers at all levels to discuss moral and ethical dilemmas in the workplace.
 - The union may want to establish a committee to determine what mechanisms make the workforce comfortable with such discussions, then bring its recommendations to management.
5. Processes for developing solutions to prevent avoidable risks of moral injury and mitigate unavoidable risks must have meaningful engagement from all levels of the workforce (e.g., through labor-management partnerships or other similar mechanisms). Such solutions development must be appropriately resourced to support strategy development, implementation, and sustainment.

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Health worker distress was a crisis before the coronavirus pandemic, and it has only intensified since. None of the myriad interventions to help individual workers address their experiences have made a substantial impact on workers’ mental health and well-being, despite health systems collectively pouring millions of dollars into them. It is time for two new approaches: first, to expand the definition of clinician distress to include the relational ruptures of moral injury, and secondly, to begin holding health systems responsible for the environments they create. Again, quoting Dr. Berwick, “The source of what the philosopher Immanuel Kant called ‘the moral law within’ may be mysterious, but its role in the social order is not. In any nation short of dictatorship some form of moral compact, implicit or explicit, should be the basis of a just society.”²⁵ And the basis of the institutions where we are promised to heal. +

For the endnotes, see aft.org/hc/spring2024/dean.



Unions play a major role in holding health systems responsible for the environments they create.

Helping Healthcare Workers Heal

Reckoning with Grief in the Workplace



By Rachel Jones

Rachel Jones, MS, is a staff writer for SevenPonds, a website focusing on an array of issues related to end of life. A former correspondent for the Associated Press, her work has appeared in *Time* magazine, *The Lancet*, *Scientific American*, and many other publications. This article was excerpted from *Grief on the Front Lines: Reckoning with Trauma, Grief, and Humanity in Modern Medicine* by Rachel Jones, published by North Atlantic Books, copyright © 2022. Reprinted by permission of publisher.

Every year, tens of thousands of aspiring doctors, nurses, and other healthcare professionals immerse themselves in US educational and training programs, eagerly preparing for their roles as healers. In Pennsylvania in the 1980s, Rosalind Kaplan was one of them. And, like many others, she was sometimes shocked by the emotional impact of the traumas she encountered—gunshot wounds, stabbings, failed resuscitations. She vividly recalls one night as a resident on the hematology/oncology service when an elderly, extremely weak patient receiving chemotherapy experienced a massive gastrointestinal bleed; she had to perform CPR on him as he was bleeding out in the radiology suite. “He died alone, on a cold metal table, and I started imagining what that would be like,” she said. When she began telling the attending physician what had happened, she started to cry.¹

Although little research has been done on the impact of grief or trauma among healthcare professionals, a 2017 study of a small group of Canadian oncologists found that they experienced difficulty with the deaths of their patients, particularly those they considered young, long-term, or unexpected.²

The bedrock for this study came from a previous study, which found that oncologists demonstrated sadness, crying, and loss of sleep, along with feelings of powerlessness, self-doubt, guilt, and failure.³

Leeat Granek, a critical health psychologist and associate professor at York University in Toronto who coauthored both of the studies, was inspired to initiate the research after her mother died of metastatic breast cancer. “I knew I was feeling something,” said Granek, whose mother had received treatment from her healthcare team for nearly 20 years. “And I found myself wondering, what’s going on for them?” Granek found that in addition to regular feelings of grief, oncologists reported that they often felt responsible. “There’s kind of this intellectual understanding that yes, you did everything that you could,” Granek said. “But emotionally the feeling is, I’m supposed to cure this patient and they died. And I feel like a terrible failure that they didn’t make it.” Granek said it’s essential for healthcare systems to begin normalizing and validating feelings of grief and loss among practitioners. “Acknowledgment would remove the stigma from the individual person and recognize that it’s part of the work that people do,” Granek said.

Learning to Acknowledge Grief and Trauma

Sherry Lynn Jones, a former paramedic and ER nurse with a PhD in education, came to a similar conclusion regarding trauma. “We have expectations as paramedics that we’re going to go out there and ... make a difference,” said Jones, who started out as an EMS volunteer in her small Michigan town in the late 1980s, serving community members she often knew personally. “We’re not trained in how to handle it when things go wrong.”

Early on in her career, Jones began working with the International Critical Incident Stress Foundation, doing stress management interventions with people in emergency services. “Because we also gave them information about preparedness and education, they did not respond so badly after that,” Jones said. “You can inform and educate, and people know that these things are going to happen.” But such education isn’t common. As Jones pursued her interest in nursing education, her dissertation research⁴ confirmed that there is a significant lack of formal training related to grief, trauma, and resilience.

“Most of Us Never Talk About It”

Chris Poole, who after 10 years as an acute care nurse maintains an aura of unflappable calm, works on the medical-surgical floor at the University of California, San Francisco (UCSF). Poole considers himself highly fortunate to work at a California hospital, where state law not only limits nurse-patient ratios but also mandates a break nurse, so that staff can actually take time to sit down. Still, he experiences difficult emotions around some patients, such as the 50-year-old woman with inoperable, metastasized cancer with her children in tow. “It can bring tears to your eyes, and these patients can stay with you,” said Poole. “It’s probably not the healthiest thing, but there’s a lot [of emotion] there under the surface.”

Poole will sometimes discuss particularly difficult cases with his mother, who was also a nurse, but acknowledges that other means of processing would be helpful. While there are some support groups available to nurses at UCSF, Poole said that because he lives about 40 minutes away in Berkeley, he wouldn’t attend on his days off. “I’m sure it would be good to get together with other nurses and talk, because we all experience this,” he said. “But most of us never talk about it.”

In her research, Granek found that this was common. “Everybody’s feeling the same way, and saying the same things, but they’re not talking to each other,” Granek said. A 2017 study of oncologists in both Israel and Canada revealed that the top desire for these specialty physicians coping with terminal patient illnesses was simply the validation of their grief and other related emotions. In addition, they also expressed interest in lectures, seminars, trainings, group debriefings, and most importantly the opportunity to take time off.⁵ “There’s a huge variation in terms of what people found helpful in coping with these emotions,” Granek said, who advises that institutions provide a

range of interventions and make these offerings opt-out rather than opt-in to normalize their necessity.

Disenfranchised Grief

Doctors, nurses, paramedics, and others who work closely with illness and death have to find their own ways to navigate and process occupational grief while remaining as available as possible to the needs of their patients. And depending on their individual makeup, their work and home environments, their support systems, and other factors, this exposure can, over time, profoundly affect their mental and emotional well-being.

The fact that patient deaths affect clinicians differently is something that Alexandra Jabr, a paramedic educator in the Los Angeles area with a master’s in mental health specializing in grief and bereavement, has often witnessed in the field. Jabr spent about 15 years as an active paramedic and now teaches aspiring paramedics in community colleges and counsels fire departments on occupational resilience, behavioral health, and death communication. “The way I respond to a child dying is different from the way a parent is going to respond,” Jabr said. Instead, Jabr found herself reacting strongly to a young couple who’d suffered a car accident in which the husband died at the scene and his wife waited for hours on the side of the road. “It was heartbreaking because we were the same age,” Jabr said. “It was just the association that changed for me, and I never quite forgot that.”

When such emotions are not dealt with and processed, they can accumulate—with devastating consequences. When asked how first responders process grief, Jabr said, “I don’t think they do.” She often discusses *disenfranchised grief*—grief that’s not openly acknowledged, socially validated, or publicly mourned—with the firefighters and paramedics she educates, and she found that one man was “just blown away” when the concept explained why he’d felt sad or upset over patient deaths—emotions he’d previously dismissed, telling himself he hadn’t known the person.

Kenneth Doka, a leading researcher in the field of grief and loss who coined the term *disenfranchised grief* in 1985, said that healthcare workers experiencing patient deaths would fall into the category of *disenfranchised grief* where a relationship isn’t recognized.⁶ Noting that some institutions are better than others at recognizing and acknowledging the grief experienced by clinicians, Doka added that healthcare workers can also disenfranchise themselves for various reasons, such as the belief that becoming attached conflicts with their professional role. To better support their staff and prevent burnout, occupational stress, and turnover, healthcare organizations

It’s essential that healthcare systems normalize and validate feelings of grief and loss among practitioners.



“need to provide support, education, and sometimes ritual” to process patient deaths, he said.

Don Dizon, the director of women’s cancers at Lifespan Cancer Institute and director of medical oncology at Rhode Island Hospital, said that writing about grief-laden experiences on his blog and on social media has been a “godsend” to processing his emotions. While he posts more for himself than for others, Dizon

also benefits from colleagues who resonate with and respond to his words. “You realize that the experience, even though it’s painful, is one that other people have also experienced,” he said. “And then that sense of isolation goes away.” For similar reasons, Dizon enjoys participating in Schwartz Rounds at his hospital, a program created by the Schwartz Center for Compassionate Healthcare that offers healthcare workers—including security guards, phlebotomists, and any other professionals who might interact with a patient—regularly scheduled times to discuss the social and emotional aspects of a patient’s case with

others in the field.* Dizon always finds himself disappointed by the low physician turnout. “It’s a missed opportunity,” he said. “So many of us suffer silently, and I think trying to go beyond that is still a challenge.”

Shared Humanity

Children mangled by car accidents, young mothers succumbing to cancer, unexpected deaths in the operating room: the list of traumas experienced by medical professionals is long and varied. Many healthcare workers find themselves deeply affected by their patients’ tragic circumstances and shoulder an increasingly heavy burden of unresolved grief. But some are beginning to embrace innovative ways of coping. Perhaps surprisingly, many of these efforts involve finding greater connection with patients who are dying, as well as seeking support from therapists, chaplains, and the larger faith community. By recognizing and honoring the humanity of those they serve, many healthcare professionals find that they are able



*The center launched Schwartz Rounds to provide healthcare workers with a forum to discuss the social and emotional issues of patient care, and they’re now offered at hundreds of hospitals and other healthcare organizations around the world. Those who participate report improved teamwork and communication, lower rates of stress and isolation, and greater feelings of compassion toward patients.

The Grief of Systemic Injustice

Some clinicians feel that their responsibilities—and the difficult conversations required of them—extend far beyond their medical role, particularly when socioeconomic factors play a part in their patients’ ongoing decline. While more than a third of graduating medical students intend to care primarily for underserved populations,¹ those who do so often say their grief is compounded by their inability to address the impact of widespread health disparities on patients. Particularly for underrepresented minority clinicians who’ve chosen to serve their communities, grief over patients’ chronic and terminal illnesses is inextricably linked to much larger issues of racial inequality, economic disparities, and social injustice.

As the daughter and granddaughter of Mexican migrant farmworkers in Oregon, Eva Galvez was inspired to become a doctor by witnessing the health challenges in her community and watching her grandmother struggle with poorly controlled diabetes, partly due to linguistic and cultural barriers. Now, Galvez—who’s been working for some 10 years as a family physician at the Virginia

Garcia Memorial Health Center, a community health provider that serves a largely Latino population west of Portland—revels in the opportunity to serve patients that remind her of her own family in a setting that “feels like home.”

Still, Galvez struggles with the challenges confronting her patients. “The skills I learned in medicine aren’t necessarily the things that I can use if people are having difficulty with immigration or housing, or suffering from trauma,” said Galvez, who would like to see more medical school training on managing social determinants of health. “They’re problems that we may be able to fix, but it’s going to take more than just doctors and it’s going to take years.” Galvez was particularly struck by the situation of Latinos when the COVID-19 pandemic hit. Her clinic was on the front lines, providing testing at centers, drive-thrus, and mobile clinics. When it became clear that Latinos—many of whom are essential workers—were 20 times more likely than other patients to have the virus,² Galvez became even more of an advocate, pushing for more testing, improved

mitigation measures, and more culturally appropriate educational tools for migrant farmworkers. Many were living in cramped conditions, afraid to speak up for fear of losing their jobs but also out of fear of deportation. The pandemic shone a light on health challenges that had long been in place. “COVID is a disparity,” Galvez said. “But what about diabetes and renal disease? Those have been there all along.”

Over the years, Galvez has developed methods of creating space for herself—stepping back from the news, and from work, so she can let go. She spends time with her husband and two children, connects with girlfriends, and goes for early morning walks or runs during which she says a prayer of gratitude. “There’s even guilt sometimes in that because I can step away, and my patients can’t,” she said. “But I also think that if I don’t give myself that space, then I’m not going to be there for anybody.”

—R. J.

For the endnotes, see aft.org/hc/spring2024/jones.

to mitigate their distress about the suffering and death they're forced to witness daily.

Roughly a decade ago, Jonathan Bartels was working as a trauma nurse in the University of Virginia Health System when he was inspired by a chaplain who asked everyone to stop after a patient's death and said a prayer. While Bartels didn't relate to the religious nature of her prayer, he was struck by the power of the concept and translated it into "the Medical Pause," which uses secular language to call for a moment of silence.⁷ "You can have someone who's Christian next to someone who's Hindu next to someone who's Buddhist, and someone who's atheist or agnostic, all honoring that patient but doing it in silence," he said. "But all with the same mission—which is really to take a moment to recognize this last rite of passage. To reinstate ritual ... back into a system that has driven ritual out through its scientific pursuits."

Bartels said that he witnessed an immediate difference when experiencing the trauma of code blues and other patient deaths. "I didn't just separate, I was able to close the gap from one act to another, and I was able to put [the trauma] down," he said. "And then my peers were able to put it down. But it's not—and I say this often—it's not a panacea, it's not a cure-all. This is the first step in many, many steps of what is really being called for to take care of ourselves."

As Bartels found, ritual doesn't need to be elaborate to be effective. "The biggest difference was the way people left that room," Bartels said. While clinicians will typically toss their gloves on the floor, along with the equipment and blood, and walk out, the Pause allowed them to reconnect and leave with a sense of reverence. "This really changed things because we could stop to honor that person, and not walk away disappointed," he said.

Such moments are powerful. Pulmonary critical care and palliative care-trained physician Jessica Zitter vividly recalls the first time she witnessed an ER resident implement a moment of silence following a patient's death. It was only a few years ago—something the resident had been taught in her training. "I was blown away," Zitter said. "I was so touched and moved, and I thought, why haven't we done this before? This is exactly what we need to do when a person's life passes through your hands." Since then, Zitter has continued the practice. "This is very big stuff, and it should be meaningful," she said. "The second we stop seeing it as meaningful and human and poignant and sad and connecting, that's when we start to lose our humanity."

Moving Toward Systemic Change

Healthcare is just one of the numerous US systems—along with social services and housing, among others—that the COVID-19 pandemic revealed to be severely lacking in humanity. But healthcare workers have been dealing with the fallout of a detached and uncaring system for decades. The widespread lack

of support for grief and trauma extends well beyond patient deaths and medical trauma to unrealistic work hours and schedules, escalating workplace violence, bullying, and other forms of mismanagement and abuse.

Integrating grief and trauma for healthcare workers must begin in training and continue as an essential component throughout their careers—including varied offerings such as Schwartz Rounds, International Critical Incident Stress Foundation interventions, debriefings, coaching, and confidential and nonpunitive access to mental health services. No matter how much healthcare organizations might wish otherwise, there is no single solution—no silver bullet, no magic wand. Self-care trainings can be helpful, but they should be provided on paid workdays and acknowledge time constraints and other issues. Most importantly, such approaches simply cannot replace the need for widespread governmental, systemic, and institutional reform; improved staff support; and more reasonable work schedules, implemented with direct feedback from healthcare workers at all levels. More often than not, staff recognition is reduced to a pizza party or a coffee mug—minimal gestures that fail to recognize or address the traumatizing and grief-inducing circumstances they confront on a daily basis. Such token measures won't be enough.

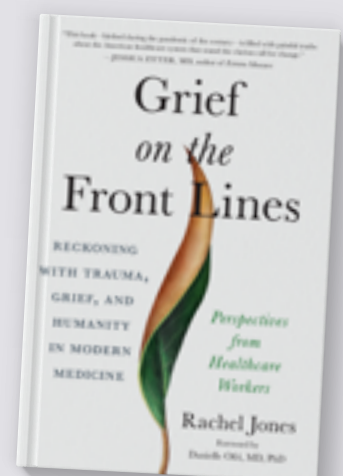
The pandemic established a unique window into the challenges and sufferings of US healthcare workers at all levels of a malfunctioning system. Having absorbed this view, perhaps we can make the adjustments necessary to better support one another, to move toward a future that is more sustainable, more just. Not only for healthcare workers, but for all of us who will inevitably fall ill, suffer, and die—hopefully, with the best assistance possible at our bedsides. ✦

For the endnotes, see aft.org/hc/spring2024/jones.

As a staff writer for SevenPonds.com, a small but determined end-of-life website, I had the opportunity to interview healthcare workers for an article about the traumatic nature of code blues in hospitals. It seemed that the more doctors, nurses, and others were able to acknowledge their grief and face the reality of death and dying, the more they were able to connect with their patients, the less stress they experienced, and the more resilience they exhibited. This despite challenging work environments, minimal resources to support them, and limited literature dealing with death, trauma, and grief in healthcare—though this has shifted somewhat since the COVID-19 pandemic. I wrote *Grief on the Front Lines* in an attempt to help fill that void, while bringing all of us to a deeper understanding of our shared humanity and mortality.

—R. J.

Healthcare workers can mitigate distress over patient suffering by finding ways to honor their shared humanity.



Creating a Healthy Community

How a Hospital and High School Partnership Is Launching Healthcare Careers



By Pamela Hummer

Pamela Hummer is the editor of *Critique*, the Cleveland Teachers Union newspaper, and the monthly newsletter of the Northeast Ohio AFT retirees' chapter. A retired early childhood teacher and former union representative, she volunteers weekly in several Cleveland preschool and kindergarten classrooms.

On a busy Wednesday morning, several high school teachers are expertly directing a lively group of students gathered around their lockers to the correct places to begin the school day. But even though the hall has lockers and classrooms and school posters, this is not a school building; it is the MetroHealth Main Campus Medical Center, and the high school students are wearing white hospital coats and genuine hospital ID badges.

This is the Cleveland Metropolitan School District's Lincoln-West School of Science and Health (LWSH). Its partnership with Cleveland's MetroHealth main hospital is a unique model for experiential learning and career preparation.

In this high school housed in a hospital, students study a biomedical curriculum with a STEM (science, technology, engineering, and mathematics) focus, in

addition to more traditional high school courses. They learn firsthand about the variety of careers available in a hospital system and work one-on-one with a mentor who is a healthcare professional. They receive training in advanced healthcare programs such as Stop the Bleed, the American College of Surgeons program that teaches how to stop bleeding in a severely injured person, and Code Red, which is training for an emergency that includes CPR, AED (automated external defibrillator), and first aid certification. Students have access to internships and networking opportunities in the hospital system, which can lead to jobs in the system. Juniors and seniors also have an opportunity to earn state tested nurse aide (STNA) credentialing in an accelerated three-week program in the spring.

"This school—a high school embedded in a hospital—is the only program of its kind in the country," explained Shari Obrenski, president of the Cleveland

PHOTOS BY SUZANNAH HOOVER

Teachers Union. “The former CEO of Cleveland’s MetroHealth hospital system, Dr. Akram Boutros, had a vision about what a hospital system should be to a community. And it’s far more than just taking care of the physical health of the people. He really was taking a look at the determinants of health and asking, ‘How can our hospital impact those determinants of health?’ And one of the determinants was around education and how the hospital system could be part of that.”

Preparing for Careers in Healthcare

In grades 9–10, students attend regular classes in the Lincoln-West school building, and they also attend regular MetroHealth experiences—presentations, trainings, and activities—at both the school and hospital locations. In December, for example, 10th-graders attended a presentation on nutritional disparities and their relationship to community health. It included information about nutritional resources available in the community, a discussion with a dietitian, a cooking demonstration, and an explanation of the healthy plate model.

In grades 11–12, students take all their classes at the hospital. They have regular high school classes on Monday, Tuesday, Thursday, and Friday. The LWSH wing at the hospital campus has classrooms for core and elective subjects such as English, math, history, psychology, chemistry, Spanish, and various biomedical sciences, with teachers assigned full-time to the site.

Juniors are assigned to mentors based on their interests and meet at least once a month. They also attend lectures and presentations by different healthcare professionals, learn about a wide array of career possibilities in the hospital system, and participate in a variety of healthcare experiences. Seniors are engaged in internships on Wednesday mornings. On a drab Wednesday in January, MetroHealth secondary education specialist Salethia McPherson energetically delivered morning announcements to the quiet group of seniors, including opportunities for afterschool activities that could be included on their college applications and important details about applying for the spring STNA certification program. Her comments incorporated an encouraging “pep talk” and some specific instructions before sending the seniors to meet their internship supervisors throughout the hospital.

On Wednesday afternoons, seniors participate in a capstone study experience. This is a regular course in every senior’s weekly schedule, in which they journal about their internship experiences from the morning, recording their observations and assessments. As a culminating activity, students use this information to study problems or situations they observed at the hospital and devise possible solutions. One recent capstone study was about improving the emergency department patient experience. Students discovered

that the ED was short-staffed on weekends, one of the busiest times. The students proposed possible solutions, such as compensation incentives for those who work on weekends and expanding and enhancing the ED area to better accommodate patients.

For its healthcare-related courses, the school uses a curriculum developed by Project Lead the Way that combines the study of biology with principles of biomedicine. Students engage in case studies with a series of labs, dissections, and other procedures to determine diseases. They learn how to measure blood pressure and what the normal levels for blood pressure and cholesterol are. They study human anatomy and physiology along with medical interventions and biomedical innovations.

Students also get training from emergency department doctors, ultrasound technicians, and other healthcare professionals. They get hands-on experiences in various departments in the hospital system and see firsthand not only different medical careers, but jobs in other areas such as human resources, finance, business, nutrition and culinary services, and information technology. And side by side with teachers, the hospital’s medical professionals provide in-depth explorations that go beyond books and classrooms. For example, when teachers were instructing on the topic of health disparities, including environmental disparities in the community, MetroHealth provided information about lead poisoning, with real-life examples. In another instance, students were engaged in a dissection of cow eyes, and a physician from the hospital’s ophthalmology department provided a deeper experience for students.

Lincoln-West students study a biomedical curriculum, learn about health careers, and train in advanced healthcare programs.





Students are mentored by health professionals and participate in a variety of healthcare experiences.

“We are building a school-to-workforce pipeline,” said LWSH’s principal, Juliet King. “We are getting students engaged in STEM, and this model is changing the game in so many ways. We hope this inspires others to see education in a different way.”

The Lincoln-West School of Science and Health opened in the fall of 2016, and the first senior class graduated in 2019. Although LWSH is highly regarded and students are thriving, there is one major challenge: space. In grades 11–12, due to space limitations at the hospital, only 50 students can be accepted in each grade. “We are very hopeful now, with the opening of the new MetroHealth Glick Center and additional available space, that more students can continue in the program in grades 11–12,” said Obrenski. “In 9th and 10th grades, we have about 100 students in each grade. But in 11th and 12th grades, the hospital can currently only take 100 students total, 50 in each grade, so the program is losing up to 100 students in grades 11–12. We need to fix that and make sure that we can accommodate all of them—not half of them—in this valuable program.” The need to accommodate more students is especially pressing because of the success LWSH is having. Its graduation rate of 85 percent¹ is 10 points higher than the district’s graduation rate.²

One of those graduates is Khandah Abdullah, the 2023 valedictorian; she now attends Cleveland State University majoring in biology. “I was interested in

studying medicine but had limited knowledge about the high school, even though my brother graduated from Lincoln-West two years earlier,” she said. “I didn’t realize how unique the program was and what great opportunities it provided.”

She was planning a career in nursing when she entered the school in the fall of 2019. In her junior year, her mentor was a nurse. “I learned a lot from that experience and from my senior-year internship about the reality of a nurse’s schedule, duties, and expectations.”

Abdullah participated in the white coat ceremony in fall of 2022 and obtained her STNA credentials in the school’s accelerated three-week program in the spring. With her experience and training at MetroHealth, she is now qualified to work as a patient care nursing assistant (PCNA).

“I wouldn’t be able to work at this level, a PCNA, without the experiences I had through the Lincoln-West/MetroHealth program,” she said. “Other college students I meet are surprised because they are just starting to learn those skills now. I learned them in high school.”

The exposure to real career experiences was valuable in other ways, too. She learned what it takes to run a big hospital. “There’s a lot more than doctors and nurses. There are so many specialties and other career opportunities, and they aren’t all in direct patient care. We learned about many different jobs in a hospital system. This program helped me find my passion.”

Creating Opportunities

MetroHealth is a unique partner in that it is a community hospital, and addressing the social determinants of health—such as affordable quality housing and education, nutritious food, public transportation, and well-paying jobs—is one of its key goals. Cleveland has some of the best healthcare institutions in the world, but its population also has some of the worst health outcomes. Across two communities just two miles apart, there is a 23-year difference in residents’ average life expectancy.³ This is in large part because the social determinants of health have a huge impact on health and well-being—often far greater than healthcare⁴—and Cleveland is the second-poorest large city in the United States.⁵

Although the LWSH program has open enrollment for students throughout the district, most of its students live in the MetroHealth hospital area. The hospital is located just west of Cleveland’s downtown, in a racially mixed area with a significant Hispanic and Latinx population. While English is the most prevalent language, Spanish is second, with 21 percent of residents speaking it at home. The median annual household income in the area is \$32,000.⁶

“The partnership between Lincoln-West and MetroHealth began with a very different vision

than many specialty schools that accept only certain qualified students,” explained Obrenski. In this school, the original vision was to enroll kids from the nearby community, if they chose to attend, and genuinely involve them in all of the work of the hospital, exposing them to all of the different jobs associated with the hospital, teaching them about health factors, and improving health and economic outcomes for them and their families. The vision has only grown from there.

Students are finding many personal connections to their learning. For example, when AFT President Randi Weingarten visited LWSH, students were engaged in a Stop the Bleed training. They were told that there are many different types of traumatic bleeding that they might encounter and were asked what type they wanted to focus on. Every student chose gunshot wounds because that’s what they too often deal with in their community. They have all been impacted by gun violence in some way, and now they have the knowledge and skill to increase a victim’s odds of survival.

Another example is an LWSH student who learned to identify stroke symptoms. When he recognized that his grandmother was having a stroke, he called an ambulance immediately. His grandmother received timely treatment for the stroke in the ambulance on the way to the hospital, and it greatly improved her outcome. “There are lots of stories like that,” added

Obrenski. “Students are working in the hospital, both as interns and in the summer, and graduates of the school are now employed in the hospital. Students and their families and communities are benefiting from their healthcare knowledge and employment opportunities.”

The community-focused aspect of MetroHealth is central to the partnership’s success. People of color face the effects of racism every day, and societal and economic inequities are apparent in their poorer health outcomes.⁷ Adding to the problem, mistrust of the medical field is more common among Black and Latinx people than white people, often as a result of discrimination.⁸ By enrolling and then employing students from the community, the partnership is helping to address some of the inequities and rebuild trust.

“We are trying to create pipelines out of poverty,” said McPherson. “It starts with students from the community having meaningful, hands-on experiences in the healthcare field. That leads to building valuable skills that can be applied to a job or career that can economically sustain a household and that creates better, healthier communities. That’s the golden ticket, that’s the pipeline, and it starts with kids from within the community.”

For the endnotes, see aft.org/hc/spring2024/hummer.



Beyond Mandates

Crafting Effective Vaccination Strategies for Healthcare Workers



By Alex Dubov and
Lisa R. Roberts

Alex (Oleksandr) Dubov, PhD, MDiv, is an associate professor of behavioral health and bioethics at Loma Linda University. He has worked at Emory University Hospital as a palliative care counselor and at Florida Hospital Celebration Health (now AdventHealth Celebration) as a certified healthcare ethics consultant. Lisa R. Roberts, DrPH, MSN, RN, FNP-BC, CHES, FAANP, FAAN, is a professor and director of research at Loma Linda University's School of Nursing. Her research focuses on nursing interventions and public health programs to address the needs of vulnerable populations.

Met Maria, an experienced nurse and union leader. Her journey through the COVID-19 pandemic has given her a firsthand account of its toll on healthcare workers. As healthcare administrators across her state, including at Maria's own hospital, began to talk of issuing mandates for employees to get vaccinated or face job loss in 2021, Maria found herself at the forefront of opposition. Her stance was not against vaccination. She believes vaccination is the most effective protection against COVID-19 and that everyone who can safely do so should be vaccinated. For this reason, she and her fellow union leaders have actively encouraged their members to get vaccinated. But she knew a hospital mandate that would strip healthcare workers of their voice and autonomy was not the answer.

Criticism of Maria emerged in social media and the press, suggesting that she was on the wrong side of the vaccine issue. However, those critics failed to understand the nuances of her stance. As a representative of all of her union members, including some who were hesitant about vaccination,

Maria's opposition to vaccine mandates was also a strategic move to protect against a sudden loss of valuable staff during an ongoing shortage crisis. She called for negotiation because she knew that the best pathway to effective safety measures was by fostering trust and consensus among workers, ensuring that any vaccine policies implemented at the hospital resonated with the needs and concerns of all her members.

Maria's goal was to find and implement policies that would encourage maximum voluntary vaccine uptake to keep her members—and their patients and communities—safe. And in Maria's world, that journey was about balancing the urgent need for protection against COVID-19 with the delicacy of workplace dynamics and individual choices.

Exploring Vaccination Mandates: Ethics, Legality, and Effectiveness

In July 2021, Dr. Zeke Emanuel, a physician and vice provost for global initiatives at the University of Pennsylvania, and Dr. David Skorton, president of the Association of American Medical Colleges, organized a statement signed by over 80 medical societies and

organizations.¹ The statement called for mandatory vaccination for all healthcare workers, citing multiple reasons healthcare employers should mandate vaccination. Here, we share and expand on their rationales before turning to the more complex question of how to increase vaccination acceptance.

First, vaccination mandates are ethical. Healthcare professionals have a duty to protect others, especially when vaccination, a low-risk method to do so, is available. Beyond this general duty, they also have a unique ethical and professional responsibility to promote the health of patients and communities. Vaccination aligns with this duty and protects vulnerable individuals they encounter daily. Also, the COVID-19 vaccination requirement builds on established practices, as many healthcare facilities already mandate vaccinations against diseases such as hepatitis B.

Second, vaccination mandates are legal. The US Supreme Court has upheld the states' authority to enforce vaccine mandates twice: in 1905 for adult smallpox vaccinations and in 1922 for school-based vaccinations. Additionally, a 1944 US Supreme Court ruling emphasized that parents don't have the right to expose their children to contagious diseases.² And, according to the US Equal Employment Opportunity Commission, employers are legally authorized to mandate vaccines.³

Third, mandates are effective in increasing vaccination rates. The influenza vaccination coverage is consistently at its highest (94 percent) among health workers where vaccination is mandatory (with limited exceptions, such as an allergy, medications, or medical conditions that make vaccination risky).⁴ Similarly, studies show the effectiveness of COVID-19 vaccine mandates. One study across 13 states found that mandates for K-12 schools, congregate settings, and long-term care facility workers resulted in more than 634,000 first-dose vaccinations over two months, totaling 11.5 percent of first-dose vaccinations.⁵ Another study in 38 states showed that COVID-19 vaccine mandates in nursing homes increased staff vaccination rates by an average of 6.9 percentage points, with a 14.3 percent increase in Republican-leaning counties.⁶

As the pandemic's acute phase subsides, the future of vaccination requirements remains uncertain despite the ongoing evolution of the COVID-19 virus. In May 2023, the US government officially lifted federal COVID-19 vaccination requirements. Soon after, the Biden administration ended the COVID-19 public health emergency declaration.⁷ However, these decisions were influenced more by social and political considerations than scientific reasoning. With the gradual rescinding of vaccine mandates at the federal and state levels, healthcare institutions face an important policy question: Is there still an ethical and scientific rationale for maintaining some form of



COVID-19 vaccination requirements, or should they be abandoned entirely?

The Case for Continued COVID-19 Vaccination Requirements

As we move from the debate about *whether* vaccination mandates should be implemented to the more nuanced discussion of *how* they should be implemented, it is essential to note the significance of such measures. Encouraging both healthcare workers and the public to receive, and continue receiving, the latest COVID-19 vaccine is crucial for several reasons. Despite the official announcement of the pandemic's end in May 2023, there has been a significant increase in severe cases and hospitalizations. Between July 1 and December 30, 2023, hospitalization rates surged by 8.5 percent nationwide, along with a rise in COVID-related deaths from 542 to 2,189 per week.⁸ Holiday gatherings fueled this surge, with wastewater data (an admittedly rough estimate) indicating that the United States was in its second-largest wave of COVID infections in early January 2024.⁹ Amid nurse shortages, hospital administrators worry about healthcare workers contracting COVID-19. This concern arises from the fact that the majority of patients age 65 and older recently hospitalized for COVID-19 received the primary vaccine series but not the bivalent booster.¹⁰ In addition, according to data from the Centers for Disease Control and Prevention (CDC), while almost all healthcare workers received the primary vaccine series, only 17 percent of those working in acute care hospitals were up-to-date with the COVID-19 booster vaccine in June 2023.¹¹

Study after study shows the benefits of COVID vaccination. Research suggests that during the first two years of their rollout, COVID-19 vaccines in the United States saved more than 3 million lives and prevented

Union leaders have to balance the need for protection from infectious disease with workplace dynamics and individual choices.

Vaccination aligns with healthcare workers' duty to promote health and protect vulnerable individuals.

over 18 million hospitalizations. On the other hand, vaccine hesitancy led to the loss of about 234,000 lives between June 2021 (when vaccines became widely available) and March 2022.¹² The vaccine has been shown to be highly effective and safe, with nearly 700 million doses administered to over 80 percent of the population.¹³ It significantly reduces the risk of long COVID and helps with recovery from its symptoms. One study indicated that the vaccine's effectiveness against long COVID increases from 21 percent after one dose to 73 percent after three or more doses.¹⁴ Additionally, COVID-19 vaccination effectively lowers the risk of heart attacks and strokes that are associated with COVID-19 infection,¹⁵ providing a compelling case for widespread immunization.

Although vaccination is undoubtedly beneficial, polls indicate that only half of US adults planned to receive the latest COVID-19 vaccine (recommended by the CDC in September 2023).¹⁶ Recent polls show that political affiliation significantly influences people's willingness to vaccinate. The majority of Democratic voters, 79 percent, said they were likely or certain to get immunized with the new vaccine. In contrast, only 39 percent of Republican voters planned to receive the vaccine,¹⁷ which aligns with the anti-public health measures stance of some high-profile Republicans. For example, Governor Ron DeSantis's administration publicly discourages Florida residents from receiving the latest booster.¹⁸

The Role of Vaccine Hesitancy in the Mandate Discourse

Division over the benefits of repeated vaccination extends to healthcare workers—and their vaccine hesitancy can impact patients' willingness to get immunized. To understand the factors influencing vaccine hesitancy among healthcare workers, we worked with a team of researchers to conduct several large studies of healthcare workers in Southern California.¹⁹ Our goal was to uncover the varied reasons for vaccine hesitancy, paving the way for targeted interventions and impactful education campaigns. It is essential to address vaccine hesitancy among healthcare workers, given the high level of trust²⁰ the public has in them to provide accurate information about vaccination benefits and risks.

One of our main findings was that placing healthcare workers into dichotomous groups such as anti-vaccine vs. pro-vaccine is inadequate in accurately tailoring vaccine uptake interventions.²¹ Healthcare workers choose not to get vaccinated for various reasons, such as personal beliefs, cultural influences, misconceptions about vaccine safety, and variations in perceived personal risk. Therefore, the decision-making process involved in vaccine uptake is much more nuanced than a simple binary view suggests. This finding aligns with broader research on vaccine hesitancy. Numerous studies²² have attempted to define the concept of

vaccine hesitancy, but existing definitions often hint at different ideas. Some describe vaccine hesitancy as a cognitive state, emotion, attitude, or belief. Others focus on vaccination behavior, involving acceptance, refusal, or delay of immunizations. Additionally, certain definitions describe vaccine hesitancy as a decision-making process. The range of available definitions reflects diverse attitudes among healthcare workers. This diversity highlights the importance of conducting research to understand factors driving vaccine hesitancy within an organization before implementing interventions to enhance vaccine uptake.

Our studies of vaccine hesitancy highlight its dynamic nature, which is influenced by context and evolves over time. Factors like emerging virus variants, political polarization, and local outbreaks shape hesitancy, with public perceptions changing as situations unfold. For example, during the early stages of our research,²³ we found that some nurses hesitated to get vaccinated due to concerns about the COVID-19 vaccine's potential impact on fertility and pregnancy. Some nursing groups on social media (which were initially created to support burned out staff) unintentionally spread misinformation and amplified vaccine hesitancy among nurses.²⁴ However, with increasing evidence of vaccine safety and the implementation of interventions that target group-level resistance, nurses' attitudes toward vaccines have improved significantly, resulting in higher vaccination rates. Similarly, vaccine hesitancy among healthcare workers of color, which seemed like it could be related to a lack of trust in vaccines, was often, in fact, due to access issues to vaccines or reliable information.²⁵ For instance, finding reliable information about vaccines in Spanish was challenging at the pandemic's beginning. Additionally, Latinx healthcare workers, who disproportionately work in lower-paying roles with fewer protections, such as paid sick leave,²⁶ faced difficulties in taking time off work for vaccination or dealing with any side effects. Moreover, the process of signing up for vaccines, which relied on emails, unique identifiers, and web access, presented obstacles for nonclinical frontline staff.

Beyond Mandates: Tailoring Vaccination Campaigns for Vaccine-Hesitant Groups

With the prospect of a vaccine mandate looming at Maria's hospital, she reviewed the research on effective ways to increase voluntary vaccine uptake among healthcare workers. There were promising employer interventions to make voluntary vaccination easier—including offering paid time off and childcare support and providing convenient vaccination stations. But Maria was also intrigued by the research on communication campaigns, which can increase awareness of the importance of vaccination while addressing misinformation for those who are hesitant or undecided about vaccination.

Maria learned that successful vaccination campaigns rely on tailored messages. However, instead of tailoring messages by demographic characteristics (e.g., age), campaigns need to address specific beliefs prevailing in various groups of hesitant healthcare workers.

In our research, we identified four groups with varying levels of uncertainty regarding the COVID-19 vaccine.²⁷ The smallest and most hesitant group, which we labeled *misinformed*, staunchly opposed vaccination. This group was slightly older, leaned Republican, and was influenced by vaccine-related myths, questioning the reality of the COVID-19 pandemic and doubting vaccine effectiveness. They significantly underestimated the risks of the virus and mortality, influenced by politically biased news media. Establishing trust in this group may require approaches using direct peer communication. For instance, the “Nurses Who Vaccinate” campaign effectively used healthcare workers as “vaccine ambassadors” to dispel misinformation.^{*28}

Group 2, which we labeled *uninformed*, had lower levels of education and a higher proportion of Latinx members who worked in allied health roles. Unlike the misinformed, they were less influenced by misinformation but faced difficulty accessing reliable vaccine information. They were twice as likely to use messaging apps like WhatsApp and Telegram, often relying on them as a source of COVID-19 information.²⁹ The Latinx community was disproportionately affected by COVID-19 due to their overrepresentation in frontline jobs. Effective communication strategies are needed to take this reality into account. The involvement of trained community healthcare workers, called *promotores*, may significantly improve vaccine attitudes within this group. In one study, *promotores* successfully used social media to spread culturally relevant, accurate vaccine information.³⁰ Effective messaging for this group aligns with their cultural values, such as emphasizing the limits of natural immunity, connecting vaccination to family responsibility, and presenting vaccination as a tool to push through difficult times.³¹

Group 3, which we labeled *undecided*, was the closest on the hesitancy scale to accepting the COVID-19 vaccine. The group was primarily composed of white nurses and respiratory therapists working in ICUs. They recognized the personal risk of virus exposure and the severity of COVID-19. It’s worth noting that members of this group were mostly Republicans, which implies that their reluctance to vaccinate could be linked to their political identity. Several communication strategies can be implemented to encourage vaccination in this group. For example, highlighting the nonpartisan nature of vaccination decisions and



emphasizing endorsements of the COVID-19 vaccine by political figures can have a positive impact.³² Additionally, wearable tokens like badge stickers and pins can be employed to increase the visibility of vaccination status.³³ Highlighting shared values and framing vaccination as a means to protect families or fight poverty by enabling people to return to work can also be effective.³⁴

Finally, Group 4, which we labeled *unconcerned*, comprised healthcare workers who were willing to recommend vaccination to others but hadn’t themselves been vaccinated yet. Members of this group were younger, educated, racially diverse, and primarily Democrats. While they had accurate knowledge about the vaccine’s effectiveness, they tended to underestimate the personal risks associated with COVID-19, causing them to postpone vaccination. Nudging techniques can encourage members of this group to get vaccinated. Techniques such as asking them to write down the date and time of their scheduled vaccination or emailing a pre-booked vaccination appointment that can be modified if needed are effective.³⁵ Email or text reminders that give them a sense of ownership over the vaccination decision, such as “claim your dose,” are also effective.³⁶ Furthermore, providing incentives, like bonuses, pay raises, tuition reimbursements, student loan forgiveness, or lottery prizes, may be particularly effective in motivating this group to get vaccinated.³⁷

Healthcare workers’ vaccine hesitancy can impact patients’ willingness to get vaccinated.

The fact that at this point in the pandemic, many healthcare workers haven’t kept up with subsequent COVID-19 shots following the first series suggests that they are not influenced by hesitancy; instead, a sense of exhaustion may influence their decision about getting further immunizations.³⁸ This vaccination fatigue is marked by burnout, decreased motiva-

*For a model of direct peer conversations that can help dispel vaccine misinformation, see “Become a Vaccine Champion” in the Spring 2022 issue of *AFT Health Care*: aft.org/hc/spring2022/koslap-petraco.



When you understand the factors driving vaccine hesitancy, you can design campaigns to increase uptake.

tion and enthusiasm for ongoing vaccination efforts, and a sense of futility about vaccination campaigns.

Several factors may contribute to vaccination fatigue. Witnessing the steady toll of the pandemic on patients can lead to emotional fatigue and doubts about the effectiveness of vaccination efforts. Increased workloads and dealing with COVID-19 cases alongside routine responsibilities can also decrease enthusiasm for vaccination efforts. The continuous influx of information and evolving guidelines about COVID-19 may overwhelm healthcare workers, further contributing to fatigue. To address vaccination fatigue, healthcare institutions need to reduce administrative burdens and logistical challenges associated with vaccination. This can be achieved by offering time off after receiving boosters, for example. Additionally, strategies designed to address staff burnout—such as meditation, mindfulness-based programs, and improved communication and teamwork³⁹—may also prove effective in combating vaccine fatigue.⁴⁰

Harnessing Behavioral Economics Strategies

In addition to tailoring vaccine messages for different groups of hesitant healthcare workers, health administrators—and union leaders—can explore strategies based on behavioral economics principles known as nudges. Nudges offer alternatives to mandatory vaccinations by subtly influencing people's behavior without restricting options or significantly changing incentives. Nudges change behavior using *choice architecture*—that is, by organizing the context in which people make decisions. The idea behind choice architecture is that people often make less-than-ideal decisions not because they lack information but because they are affected by predictable irrational biases and cognitive errors. Examining how these biases affect people's decisions about vaccination can help us develop nudges to enhance vaccine acceptance among healthcare professionals.⁴¹

- **Omission bias:** People may prefer doing nothing (omission), even if it poses a greater risk than taking a potentially less harmful action. In various studies, when weighing the benefits and risks of vaccination, people tended to accept a higher risk of catching a disease rather than experiencing vaccine side effects.⁴² Interestingly, they were more willing to endure prolonged symptoms if caused by an infection than if they occurred due to a reaction to a vaccine.⁴³
- **Ambiguity aversion:** Individuals may prefer a known risk (avoiding treatment) over an unknown risk (a confusing treatment). This bias influences vaccination decisions when safety information appears unclear or constantly changes.⁴⁴
- **Present bias:** People may prioritize immediate benefits and ignore future ones. For instance, someone might hit the snooze button instead of going for a morning jog or indulge in a dessert instead of working toward their long-term goal of losing weight. Similarly, healthcare workers may avoid getting vaccinated due to the inconvenience of scheduling or fear of side effects despite its long-term protection from COVID-19.⁴⁵
- **Availability heuristic:** Factors that are easier to recall or imagine may play a disproportionate role in decision-making. For example, vaccine side effects may appear more likely or frequent than they actually are if they are more memorable. Anti-vaccination activists and media coverage of rare adverse reactions can create vivid messages that stay with people during the vaccination decision-making process, influencing their choices.⁴⁶
- **Optimism bias:** People may believe that health risks are higher for others than for themselves. Studies have shown that regardless of their knowledge of risk factors, people estimated their susceptibility to various diseases as much lower than that of other people of the same race, gender, or age. This bias may lead individuals to underestimate their susceptibility to infections like COVID-19, driving their decision against vaccination.⁴⁷
- **Naturalness bias:** Individuals may prefer natural products or substances, even when they are identical to or worse than synthetic alternatives. This bias can explain why some people prefer natural immunity over vaccine-induced immunity.⁴⁸
- **Confirmation bias:** People may favor information that aligns with their existing beliefs and avoid information that contradicts them. Vaccine-hesitant healthcare workers may seek out information supporting their concerns from anti-vaccine websites or social media groups while avoiding evidence in favor of vaccination from mainstream media or scientific reports.⁴⁹

Research on healthcare workers' vaccination decisions not only uncovers various cognitive biases but also suggests practical strategies to influence behav-

ior. One successful method is to schedule all hospital staff for the COVID-19 vaccine by default. Healthcare workers can opt out, but they have to fill out a form explaining why they won't get vaccinated. This nudges higher vaccine uptake by making it the default choice, with a small burden for those opting out. A similar approach has also worked in schools, where requiring detailed processes for exemptions has led to significantly higher vaccination rates.⁵⁰ Healthcare institutions often use this type of nudge by requiring nonvaccinated employees to wear masks indoors and undergo regular testing. Many would prefer returning to normal by getting the vaccine and not standing out among their peers.

To improve the vaccination rates in healthcare settings, it is essential to include nudges in communication strategies. One effective way to do this is to have trusted figures within the organization deliver the vaccination messages (in some hospitals, that may be the union president, and in others it may be a widely respected nurse or doctor). Studies have also shown that anticipated regret can strongly motivate healthy behavior. Vaccination rates can be improved by reminding employees that vaccination can prevent specific regrets, such as the fear of a loved one getting sick.⁵¹ Another study indicates that sending two text messages three days apart may be effective if they instill a sense of ownership (e.g., there's a vaccine "waiting for you").⁵²

States, local governments, and large companies have rolled out various incentives to increase COVID-19 vaccination rates. For example, New York and Ohio established lotteries with millions of dollars in prizes for vaccinated individuals.⁵³ Hospitals and companies like Instacart and Kroger provided cash rewards to vaccinated employees ranging from \$25 to \$500.⁵⁴ In addition, many employers offered paid time off for vaccination and recovery, with support from the federal government. Some even subsidized transportation through ride-sharing or car services to facilitate access to vaccination clinics. While incentives are typically effective in promoting healthy behaviors, their effectiveness in increasing COVID-19 vaccination rates remains uncertain.⁵⁵ Despite concerns that financial incentives might reduce trust in vaccine safety or altruism in vaccination decisions, studies have not supported these assumptions.⁵⁶ And many incentive programs to promote COVID-19 vaccination have seen limited success.⁵⁷ There could be several reasons why such incentives are less effective in increasing COVID-19 vaccination rates. Incentives usually work better for one-time behaviors, such as cancer screening, and are more effective for the first vaccine dose than the second.⁵⁸ Targeting incentives toward late adopters of vaccination may also be perceived as unfair to those already vaccinated.⁵⁹ Additionally, given the political divisions in vaccine uptake, incentives offered by local governments may encounter resistance in certain groups.⁶⁰



Armed with the research and behavioral insights above, Maria collaborated with other union leaders on a vaccine campaign tailored to the unique needs and motivations of their members. Rather than relying on generic assumptions about vaccine hesitancy, they first created a survey to better understand why those who were under- or unvaccinated had not gotten the recommended vaccines. Survey responses uncovered vaccine myths and misinformation circulating the hospital, along with information gaps and barriers that Maria and her colleagues had not considered before.

The responses also helped the team pinpoint specific groups that shared similar beliefs about vaccination. They decided to focus first on groups that expressed hesitancy rather than those firmly opposed to vaccination. With these groups in mind, they dedicated time at shift meetings, hosted educational sessions, and engaged in direct peer-to-peer conversations to share information about the vaccine and address concerns, highlighting the numerous benefits and the importance of protecting others. They leveraged the voices of trusted individuals from vaccine-hesitant groups to appeal to shared values with messages reflecting unity and collaboration—and used collective terms urging “us” to act for the common good to reinforce each group's collective identity. Recognizing that vaccine misinformation often relies on single cases that evoke strong emotions, they included positive cases alongside statistics about vaccine benefits and shared stories of employees reconnecting with older relatives or families going on vacations after being vaccinated. And they negotiated with hospital management specific interventions to make vaccination more convenient and accessible for everyone, including signing everyone up for vaccination during their work hours (with a moderately cumbersome form for declining the appointment) and paid time off as needed for side effects.

Maria's vaccination campaign also addressed cognitive biases that prevent people from getting vaccinated by incorporating several nudges. She and her team wore and distributed colorful “I Got Vaccinated!” badge stickers to normalize vaccination and alleviate fears among those concerned about potential side effects. They sent text reminders that “A vaccine is waiting for you!” to instill a sense of ownership and responsibility.

These strategies enhanced the effectiveness of Maria's vaccination campaign, helping improve the health and safety of members and their families, and of the patients and communities they serve together.

Practical strategies can help boost vaccination rates and improve the health and safety of patients and staff.



For the endnotes, see aft.org/hc/spring2024/dubov_roberts.

Unions Are Good Medicine

From the onset of COVID-19 in the United States, the value of unions became increasingly apparent to many workers—particularly those in healthcare and education, but also those in more precarious work arrangements. Essential workers like those in nursing homes, food production, and distribution were some of the most vulnerable, typically working side by side with inadequate safety protections. In the face of federal government inaction and an inadequate response by many employers, these workers and

ologists and health experts as the most effective weapon in the fight against the pandemic⁶—so what role did organized labor play in efforts to increase vaccination?

If we turn to major media outlets, the coverage focused largely on the reluctance, or even opposition, to employer-based vaccine mandates by some unions.⁷ Some of the coverage equated this opposition to mandates with an opposition to vaccination all together. However, the reality was more complex. Many unions

the University of Connecticut and Angran Li of NYU Shanghai to conduct an empirical study exploring the relationship between unionization rates and vaccination rates.

Our research, which was published in the journal *Social Science Research*, found that net of other factors, the percentage of workers covered by a union contract in a county was positively related with the county's COVID-19 vaccination rate.¹¹ To explore whether the effect was limited only to politically liberal areas, we also examined the relationship between unions and vaccination rates based upon voter preferences in the 2020 presidential election. Unsurprisingly, counties with high levels of support for former President Trump had some of the lowest vaccination rates, exposing the political polarization around vaccinations. However, we also found that union coverage increased vaccination at a faster rate in the Trump-supporting counties than in the Biden-supporting counties. That is, the dampening effect of Trump support on vaccination rates was partially mitigated where there was a strong union presence. How?

Our findings suggest that when workers have a collective voice in their workplace and beyond, then collective action problems are more easily addressed and the pursuit of common good solutions such as vaccination become more likely. Through social media campaigns, member-to-member organizing conversations, and local vaccine clinics, many unions helped to educate members, their families, and the general public about the safety and effectiveness of vaccination as a tool for stopping the spread of the virus. This sort of formation of a collective identity through workplace solidarity is strong medicine and can lead residents of even the most politically divided counties to embrace the need for vaccines to stop the spread of deadly viruses such as COVID-19.

For the endnotes, see aft.org/hc/spring2024/vachon.

The percentage of union workers in a given county was positively related to the COVID-19 vaccination rate.



their unions used their collective voice to demand better COVID-19 safety and health protections.¹

Nurses, warehouse workers, shop clerks, and workers in other essential roles fought for and in many cases won personal protective equipment (PPE), cleaner workplaces, hazard pay, and, where possible, the ability to telecommute.² Unions joined with worker centers and other allies to support better conditions for nonunion workers, including immigrant workers in precarious work arrangements.³ They fought for furlough plans to keep fellow workers in their jobs rather than getting laid off.⁴ To win these protections, they signed letters, organized sickouts, filed grievances, engaged in bargaining, and, in some cases, engaged in work stoppages.⁵

But what about vaccines? They're recognized by epidemi-

ologists and health experts as the most effective weapon in the fight against the pandemic⁶—so what role did organized labor play in efforts to increase vaccination? If we turn to major media outlets, the coverage focused largely on the reluctance, or even opposition, to employer-based vaccine mandates by some unions.⁷ Some of the coverage equated this opposition to mandates with an opposition to vaccination all together. However, the reality was more complex. Many unions had simultaneously promoted vaccination among their members, including educating them about the safety and effectiveness of vaccines and even hosting vaccine clinics for their members and communities, while also opposing unilateral mandates by employers.⁸ For many, the primary issue was the infringement upon the collective bargaining process that compels employers in unionized workplaces to negotiate over changes to wages, hours, and working conditions.⁹ Other unions were dealing with mixed views among their membership and seeking ways to balance the need for protection against COVID-19 with the intricacies of politically diverse workplaces.¹⁰

Considering the seemingly contradictory stances on vaccine mandates by various unions, I partnered with Michael Wallace of

By **Todd E. Vachon**

Todd E. Vachon, PhD, is an assistant professor of labor studies and employment relations at Rutgers University, the director of the Labor Education Action Research Network, and the author of *Clean Air and Good Jobs: U.S. Labor and the Struggle for Climate Justice*. He is also an AFT New Jersey vice president for higher education.



Healing Ourselves as Indigenous People

An Integrated Approach to Well-Being on the Navajo Nation

In my formative years, my dad and I went running every morning on the Navajo Nation, where I was born and raised. We would wake up at 5:00 a.m., pray to the east with our offering, and then run to the east. On those runs, my dad talked to me. He often said, “When you grow up and you leave the reservation, life is going to be really hard for you because you’re female and because you’re Diné.* We still live in a world that doesn’t understand you. As your father, it’s my job to prepare you to be strong. I’m building up your strength by teaching you discipline, by talking to you every morning, by telling you the challenges you’re going to go through. I’m not always going to be here on this earth with you, so I need to know that you’re strong and capable.”

My dad and I were really close, and when he passed away in the summer of 2023, I went through a very difficult time. In our culture, even in grief we try to find balance. While we know that tears and sadness are natural, our elders have taught us to be mindful that grieving can overtake us in a negative way. All the stress, the anxiety, the depression can impact us physically as well as mentally. I was really struggling to find that balance. I missed my dad so much. I was overwhelmed by grief, and I was having trouble keeping food down. I realized that I needed to have a comfort ceremony.

Our comfort ceremony is very communal. It starts at about 8:00 p.m. and ends at about 10:00 a.m. the next morning. As the grieving person, you sit up all night and your family and community come and pray for you, led by a medicine person. You might not even know everyone who comes to your ceremony, because sometimes they’re helping the medicine person or were invited by them. But nonetheless, you know that everyone there is praying for you and that you’re supported—and you make new relatives in the process because they sat with you all night, and they prayed with you all night. Maybe they’ve cried with you, and maybe they’ve laughed with you too. All of that brings a sense of healing that is tied to the community.

Now, when I reflect on my comfort ceremony, I feel good, like I’m really supported by my relatives. I know that with my father passing, I’m not in this alone. My dad used to come to these ceremonies with me. During my ceremony, hearing the men from my community sing the songs I heard my father and my maternal and paternal grandfathers sing my whole life, and pray the same prayers, brought me a lot of peace and comfort.

That support from my family and the larger community persisted long after the ceremony. That day, I felt like all of the stress and grief that had filled me, that my body was holding in, was lifted off of me. My body felt that sense of comfort too, and for the first time in a long time I was able to keep my food down.

By Crystal Lee

Crystal Lee, PhD, MPH, MLS, was born and raised on the Navajo Nation. Her tribal clans are Tachii’nii (Red Running into the Water), Tabaaha (Water’s Edge), Tsenjikini (Cliff Dwellers), and Kin I ichii’nii (Red House). She conducts infectious disease biomedical prevention research with a focus on Native American health and examines Indigenous health policies at tribal, tribal-state coordination, national, and international levels; she is also the founder and CEO of United Natives, a non-profit that serves Indian Country.

*Instead of using the word *Navajo*, we renamed ourselves. As a nation, we now call ourselves Diné, which means “the people.”

We are interconnected, not only between mind, body, and spirit but also with external elements.



Indigenous Approaches to Health and Healing

My maternal and paternal grandfathers were medicine men, traditional healers in our community, as were other grandparents and elders in my family. My earliest understanding of health and healing came from their practices and what they taught me. I understood that there wasn't just one path to healing—there were multiple ceremonies to address different types of ailments, whether those ailments were mental, physical, or even social. When thinking about health and healing, many people focus only on the physical being, but there are many more layers. We are interconnected, not only between mind, body, and spirit but also with external elements like the environment and our social world.

Our cultural teachings incorporate all parts of ourselves in connection to the world around us. My early morning runs with my dad are a great example. We run because our cultural teachings tell us that the morning deities are waiting for us. If they see that we're sleeping when the sun comes up, then they'll think we must have everything we want in life and don't want their blessing—so we get up and pray with our offering and run.

Early morning running also integrates self-discipline. As my dad would say, it's really easy to sleep in every day, but we need that sense of self-discipline because it builds mental strength. That in turn builds physical strength because we're getting exercise, and it builds spiritual strength because we wake up and we pray in accordance with how we're taught by our

elders. We have a connection to the land and to the sky, and we're strengthening that connection as we strengthen ourselves.

Indigenous* communities have understood for centuries what Western medicine has only recently begun to approach with its focus on social determinants of health, which consider how external factors like income and geographical location impact well-being. This wasn't a scientific term when I was growing up, but the understanding and practice have always been essential parts of my own traditional cultural healing lens. Health is much more than just a physical or biological or physiological construct; there are many more layers to what actually produces health and what outcomes equate to healing, and they're all important.

When you go to a medicine person, you tell them what's happening, just like going to a doctor, but they don't only want to know about physical ailments like allergic reactions or stomach pain. What's impacting you as a human? What are your concerns? Is it your family? Is it your job? The medicine person considers various factors that might be affecting you. High blood pressure can be related to stress because of work or a household problem, and a medicine person hears the whole story.

One of the medicine person's primary goals is to restore balance. That might be related to physical health—like making sure that we are consuming added sugar or alcohol in moderation so that we aren't harming our bodies—but it also applies to the rest of our lives and to our environments. If I harm living entities, that may put me out of balance in the ecosystem because the plants, the trees, the air, the animals, the insects, are all part of our balance—and being out of balance in that way can also affect our physical well-being. As Native people, our homeostasis is not just in the human body, but with everything that's living.

Restoring Indigenous Health

Indigenous tribes in North America have suffered from long historical waves of disease, genocide, and forced assimilation that resulted in loss of languages and culture, relocation, and mass death.† The US government took more than 1.5 billion acres of land from Native nations between 1776 and 1887,¹ squeezing them onto smaller and smaller reservations often more than 1,000 miles from their traditional lands and food sources, and took hundreds of thousands of children to boarding schools to be stripped of their culture.² Traditional healing practices and ceremonies were made illegal, punishable by prison time or the

*Throughout the article, terms such as *Indigenous*, *tribal*, *Native*, and *Native American* and *Alaska Native* are used interchangeably.

†To learn more about how Euro-American colonization affected Native American cultures, food systems, and health, see "Traditional Food Knowledge Among Native Americans" in the Fall 2020 issue of *AFT Health Care*: aft.org/hc/fall2020/segrest_hipp.

withholding of food rations, until the passage of the American Indian Religious Freedom Act in 1978.³

One result is that Native health has suffered significantly. Compared to non-Hispanic white adults, Native Americans and Alaska Natives have lower life expectancy due to chronic disease/illness, geographic isolation, low income, poverty, discrimination in health services, disparate social conditions, language barriers, and cultural differences that make accessing quality healthcare a challenge.⁴ We have higher rates of heart disease, cancer, diabetes, obesity, stroke, unintentional injuries (accidents), substance use, liver disease, hepatitis, poor mental health, suicide, sudden infant death syndrome (SIDS), and teenage pregnancy.⁵ We are also disproportionately affected by infectious disease. The cumulative COVID-19 incidence rate among Native Americans and Alaska Natives was 3.5 times the rate among non-Hispanic white persons, with the Navajo Nation having the highest per-capita case rates in the nation.⁶

Native American and Alaska Native communities have shown remarkable resilience in combating the current and historical social and health challenges—but we still have a lot of work to do. Access to Native clinicians makes a big difference because they bring essential cultural knowledge and context with them. For example, in the Navajo Nation, 21 percent of our community members do not have electricity, and about one-third don't have running water.⁷ The Native physicians I work with bring that knowledge into their practice, asking their patients questions beyond the scope of most physicians. “Do you have running water? Do you have electricity at home? If your medications need to be refrigerated and you don't have electricity at home, what can you do about it? If you don't have transportation, then how do you make your appointments? Do you have a family member who picks you up?” They see all the layers that might affect why a patient isn't “compliant” with their medication or misses regular appointments. These are issues that all clinicians, not only Native clinicians, can consider. Oftentimes, it's the patient who is getting scrutinized. “How come you're not taking your medication? How come you're not being compliant?” But the clinician may not be taking that extra step to figure out why.

Collectively, my colleagues and I are finding strategies to improve health and well-being by bringing together Indigenous holistic medicine practices with Western medicine. That's why, after many years of researching interventions to improve Native health, I began offering integrative healthcare services through my nonprofit organization, United Natives. In our clinics, which focus on treating mental health and substance misuse issues, our teams of Native American clinicians and medicine people offer counseling and traditional Indigenous healing practices both in person and via telehealth/telemedicine. The results

have shown the power of integrative care to restore Native health and well-being.

Valuing Indigenous Ways of Knowing

Some readers may find it uncomfortable to consider Native American health and healing practices in conjunction with Western medical practices. One consequence of the systematic erasure of Indigenous cultures in North America and throughout the world has been the devaluing of *Indigenous ways of knowing*.

In Indigenous communities, knowledge is typically shared through stories and demonstrations, is communicated orally, and is developed and held communally, with mastery proven by practical application. Knowledge is holistic, and while decisions are made by the family, the knowledge and authority of elders is especially valued. But throughout the United States, the predominant scientific and medical training teaches students to prioritize what is measurable and explainable within the physical world, which is compartmentalized and broken into disciplines rather than taken as a whole. Scientific knowledge is typically shared in decontextualized settings and measured with tests that often don't include practical application. Significantly, Indigenous people have often been denied access to this type of knowledge and excluded from contributing to it.⁸

Indigenous ways of knowing are not often measurable by those scientific standards, but they are sophisticated and comprehensive ways of gathering information and understanding the world. If we are truly committed to providing culturally responsive care, addressing racial health disparities, and supporting health and well-being for all, we must respect the hard-earned knowledge and wisdom of others, even if it takes forms we are unaccustomed to.

Integrative Healthcare in Practice

My colleagues and I have chosen to concentrate on mental and behavioral health at our clinics because the lingering impacts of COVID-19 have really brought that need into focus.⁹ Many of the people we work with are dealing with heavy substance abuse. The two most common triggers we have observed are physical or sexual abuse from childhood or from loss of identity, by which I mean connection to their language, culture, spirituality, and community. For these people, one or more of those connections either has never been there or has been disrupted, and they have lost connection to themselves.

Reconnecting to Cultural Identity

Restoring those connections and pride in cultural identity is important because our communities suffer from a lot of shame associated with stereotypes about Native Americans and the discrimination we have faced. We weren't legally allowed to practice our spirituality and our culture until 1978, so it's very new for many of us. Many people were shunned for their faith or pushed toward Christianity.

As Native people, our homeostasis is not just in the human body, but with everything that's living.

Our clinicians and medicine people offer counseling and traditional healing practices to restore Native health and well-being.



There's also the loss of language, which is directly connected to our culture, our spirituality, and our lineage. As a Diné person, my clans are highly important because they tell me my lineage. We have four clans: the mother's, which is always your first clan; the father's, which is your second clan; the maternal grandfather's, your third clan; and then the paternal grandfather's, your fourth clan. It's all matrilineally derived. My first clan is my mother's first clan, which was her mother's first clan and her mother's before her, all the way back. My four clans directly connect me to my ancestral lineage, which is a big part of my self-identity. Not only that, but through knowing my clans, I know who my family is. I was recently at a football game, waiting for food at a concession stand, and started talking to a Navajo man I had never met. I found out that his first clan is my first clan, so we're kin. When I see him again, I won't greet him by his first name—I'll greet him formally as my brother. I've met thousands of other Navajo people I'm related to by our clans, and we're automatically family in the same way.

Knowing who we are from a tribal context is powerfully associated with self-identity because community and family are very important to us. We meet new relatives as we move through the world, and we greet them as family along our life journey. When our patients come in and they don't have that knowledge, whether it's because they don't know one of their parents or because that connection has been lost, they are missing a crucial connection to themselves and to the larger community. So when they come in, we

try to reintegrate the cultural piece, and we focus on what pieces of themselves they already know and how to build on that part or rebuild it if it's been broken.

Many of our patients say that when they come to us, they feel understood in a way that they did not feel in other programs that were not specifically for Native Americans. They may never have engaged in spiritual or cultural practices because their families were Christian or they were ashamed to practice who they were. They may not have been encouraged to learn their culture or their language. Many of them are connecting for the first time, and they are finding true, beneficial healing engagement and better self-understanding as they learn more about their culture.

Providing Integrative Services for the Whole Person

We offer clinical services, including individual, family, and group therapy, as well as referrals to Native physicians as needed. We have worked to integrate cultural aspects into our clinical work where it's appropriate. For example, our group therapy sessions begin with smudging sage, sweetgrass, or cedar, a widely accepted Native practice that helps to set the tone. These are sacred herbs and plants to us, and the sweet smell helps to erase negative energy and bring comfort to our clients. It also elicits an automatic spiritual and cultural connection for them, which enhances their road to recovery. But we also try to be careful. We don't want to make people feel like they have to engage in spiritual practices, especially if the practices are unfamiliar.

Once a month or bimonthly, we also make the services of a medicine person available for those who are interested. They talk to clients, telling stories and discussing how to apply them to their health and healing, offering a more overarching way of understanding themselves. They also offer individual prayers in person or by telehealth to complement the individual therapy sessions. Clients can participate in a group prayer or ceremony (like my comfort ceremony), or they may request individual prayers or ceremonies. We also understand that faith is a huge part of health and healing, and we encourage people to continue practicing any faiths they may already observe. We don't want to discard Buddhism or Christianity, but we do want to give our clients the opportunity to practice Native American spirituality.

Our focus on treating and restoring balance to the whole person means that we also offer programming that helps people reconnect to their culture and their self-identity in other ways. In one cohort, we had several artists who were drawing Native-based pictures, and we started making a coloring book. To each page we then added in how to say numbers in different tribal languages. An activity like that is not necessarily spiritually or culturally based, but the element of language revitalization developed organically, and then we shifted the activities to focus on that.

We also offer education and community engagement opportunities that clients may not have had before. Many Native people do not know our own history because we were not taught it in K-12 public school systems. We have the sense that we are wrong for being who we are and that systems and institutions of the United States are not built to include us, but we don't know why. So we teach clients about US policies and break down the historical contexts of colonization and the impacts of trauma resulting from those policies. When clients are armed with the knowledge that this is why our community experiences economic and health disparities, they can begin to ask, "How am I going to proceed as an individual, and how are we going to proceed as a community?"

We also bring in Native people who hold elected office or have become community leaders or doctors because we know it's important for us to see that our people are smart and capable. Our clients also see our physicians, who are all Native American, and they see me, the owner of the organization. They know that I look like them, and I come from the reservation just like them. I'm "Dr. Lee," but I can make rez jokes with them and talk to them in our language. Our clients are really enmeshed in this community where they're highly supported and they can see and visualize Native Americans in a different way than they may have been able to do before. It's not just the clinical piece or even the spiritual, traditional piece; we're bringing the social and educational elements too.

The Integrative Difference

We've been able to see firsthand how this holistic, integrative practice can make a difference in our clients' lives. One woman who was using fentanyl had been in and out of different rehabilitation programs for years, including ours. She would leave one program, go home, continue to do drugs, and then come back into a program when she decided that she was ready to move forward.

She'd had no exposure to Indigenous healing practices, but one day she asked if she could have a prayer done. She had always practiced the Christian faith, but she had grown curious about cultural forms of faith and healing. When she came out of the room after the medicine person finished the prayer, she was crying. She told me, "I've never felt so rejuvenated and focused on my own sobriety or felt that I was capable of doing it. It never clicked. I never thought that this could actually be a new part of my life, that I could be sober." Before, she felt like she was just going through the motions of treatment, but she didn't really believe she could change. Now, she did.

After that day, her attitude and her self-confidence transformed. It was easy to see in her daily group therapy—she talked more often and was more engaged in general. It was also reflected in her individual therapy sessions. It was like a mental switch had flipped for

her: "Oh yeah, I can do it. I believe I can get sober, and I'm going to do it."

It wasn't just our program that had made the difference—this woman had been in our program before. But she had never worked with the medicine person. That's the story for a lot of our clients. We bring all these elements together, and it's synchronous, and the client finally gets it. Then they can move forward in their sobriety and in their health and healing.

We've had many people in our program who have completely changed their lives. Our clients come in with a lot of attitude because they're trying to get sober and they're dealing with powerful cravings. When they first come in, they don't want to engage in group therapy or talk to anybody. They're very closed off. But once we start to integrate them individually into the cultural, spiritual aspects, their whole attitude changes. They become more receptive. They become more compliant to our schedules. They become more involved in their own health and healing journey.

Really, we're not healing them. They're healing themselves, using the tools we have given them to bridge the gaps with traditional culture, with language, and with spiritual practices. They have a stronger self-identity, which leads to self-respect, self-efficacy, self-responsibility, and better decision-making. We see their emotional changes, their mental changes, and their desire. They want a healthy life, a sober life. Now, they believe that they can have it. +

For the endnotes, see aft.org/hc/spring2024/lee.

Learn More

If you'd like to gain a better understanding of Indigenous ways of knowing and the benefits of valuing many sources of knowledge, here are some places to start:

- Indigenous Research and Knowledges in North America, by the University Libraries of the University of Colorado Boulder: go.aft.org/cif
- *Braiding Sweetgrass: Indigenous Wisdom, Scientific Knowledge, and the Teachings of Plants* by Robin Wall Kimmerer. Watch Kimmerer talk about the book and her work as an Indigenous scientist: go.aft.org/3pu
- *Spirit and Reason: The Vine Deloria, Jr., Reader* by Vine Deloria, Jr. Although Deloria died in 2005, his legacy lives on. For an introduction to his scholarship, watch this commemoration from 2019: go.aft.org/r55
- "Brave Spaces: Community Driven Anti-Racism Partnerships" by Ella Greene-Moton, Suzanne Selig, and Eugenia Eng: go.aft.org/yby
- The Indigenous Wellness Research Institute at the University of Washington offers a wealth of resources; they focus on centering Indigenous cultures and perspectives in collaborative social and behavioral research and education: go.aft.org/xii

—C. L.

We focus on treating and restoring balance to the whole person, helping people reconnect to their culture and self-identity.

Race Is Not a Risk Factor

How Structural Racism Undermines Care



By Brian H. Williams

Brian H. Williams, MD, is a trauma surgeon, working most recently as a professor of trauma and acute care surgery at the University of Chicago Medicine. An Air Force veteran, he was a Robert Wood Johnson Foundation health policy fellow in 2021–22 working with Senator Chris Murphy to increase health equity and reduce gun violence. This article was excerpted from the 2023 book *The Bodies Keep Coming: Dispatches from a Black Trauma Surgeon on Racism, Violence, and How We Heal* by Brian H. Williams with permission from Broadleaf Books.

Within these four walls I have wrecked the lives of far too many Black mothers. The family room is a windowless, white-walled cell in the hospital, with hazy fluorescent lighting, hard-bottomed plastic chairs, and a worn end table with a box of tissues. Four of us have filed into this cramped space, tucked away from the emergency department's main hallway, twisting our torsos to let the door exhale shut behind us.

A public safety officer stands sentry in one corner. He is Black. Beside me, in an opposing corner, is the chaplain. She is Black. Sitting beside the two family members is the violence recovery specialist. She is Black. I am also Black: too Black for some, not Black enough for others. But still Black enough for this story to be meaningless were I anything but.

As a trauma surgeon, I have worked at some of the most stressful and difficult hospitals in the country: Tampa, Boston, Atlanta, Dallas, Chicago. Working to save patients from life-threatening acts of violence brings me tremendous job satisfaction.

Seated across the family room, two women stare at me, their fingers intertwined in a knuckle-whitening grip. "I'm Dr. Brian Williams," I say with somber formality. "I'm the trauma surgeon working tonight." Showing deference to the elder of the two women, I confirm her relation to my patient. Yes, she is indeed the mother. I'm sure the presence of the hospital chaplain must reveal something. She has only one reason to stand solemnly beside me, which the mother may have already deduced. Why else would the chaplain bring them to this private room, away from the mayhem of the emergency department?

"I'll walk you through what happened with Malik after he arrived at the hospital," I continue. "You can stop me at any time if you have any questions." I always use the first names of their injured loved ones, the wounded and dead who cannot speak for themselves.

Speaking in a measured monotone, I don't use confusing medical terms, and I enunciate each word for clarity. There must be no misunderstanding of what I have to say. "Malik sustained several gunshot wounds and arrived in critical condition," I tell them. "The

ILLUSTRATIONS BY DIANA EJAITA

paramedics were already doing CPR in the ambulance when they brought him to us. When he arrived, his heart was not beating, and he wasn't breathing.

"I'm sorry. We did everything we could, but despite our best efforts, your son Malik died from his injuries." I always say it like this—"He died," "She died"—with no Hollywood drama. Direct. Succinct. Clear.

I'm sorry. He died from his injuries: it's a phrase I have said hundreds of times, and it sounds hollower each time I say it.

The mother ratchets open her fingers, freeing her daughter's hand. Her head drops into her ashen palms, which smother her face now slick with tears. Shaking her head and rocking back and forth, she leans into her daughter, who rubs her back with soothing maternal strokes. "No, no, no, no, no," she moans without end.

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The mother of my patient lives in a neighborhood within walking distance of one of the premier medical centers in the nation, and yet she is trapped in a web of disenfranchisement and death. Despite our hospital's noble mission, our neighbors' proximity to first-class healthcare does not guarantee access to routine, preventative care.

In treating these patients, I see myself. In comforting their families, I see mine. My cousin was shot and killed in front of her three young children. For me, working to end the epidemic of gun violence is more than an academic pursuit or my vocation. It is personal. I wrestle with the futile feeling that the nobility of my work does not have a sustainable impact. The essence of my job is plugging bullet holes in young Black men and women, at least the ones I can save—and then sending them back to an environment where they remain at high risk of reinjury and death.

For much of my life, I'd viewed healthcare as the great equalizer. Black or white, rich or poor, we all likely need to see a doctor at some point in our lives, and I thought that medical care, like education, was designed to level the playing field. Even as a doctor who witnessed otherwise, I maintained that fallacious view for many years. But now I see the ways institutional racism undermines our healthcare infrastructure and patient care.

Trauma Deserts

The University of Chicago Trauma Center, where I worked while writing this book, opened in May 2018 as the city's newest Level 1 center. Located on Chicago's South Side, it is proximal to some of the worst gun violence in the country. Nearly 50 percent of the gun violence in Chicago¹ occurs within a five-mile radius of the trauma center. Black people are less than one-third of the city population but more than 80 percent of the gun homicides,² 86 percent of gun homicide victims are male, and most of the gun violence is hyper-

concentrated in racially segregated neighborhoods.

Lakeshore Drive, a major multi-lane highway, extends from the wealthy northern suburbs to the impoverished neighborhoods on the South Side. It's a main vein connecting two opposing manifestations of economic mobility—or immobility. An eight-mile southerly drive—from the predominantly white neighborhood of Streeterville, which abuts the high-end shopping district known as the Magnificent Mile, to the majority-Black neighborhood of Englewood—means a 30-year decrease in life expectancy.³

The trauma center is located in a former "trauma desert," an area where no trauma services are geographically close to the neighborhood. A study published by my colleagues at the University of Chicago, using census tract data from several US cities, found that "Black majority census tracts were the only racial/ethnic group that appeared to be associated with disparities in geographic access to trauma centers."⁴

In the same way that food deserts—areas where there are not enough grocery stores per capita—increase health and nutritional disparities between poor and rich, and Black and white, trauma deserts also worsen healthcare disparities.

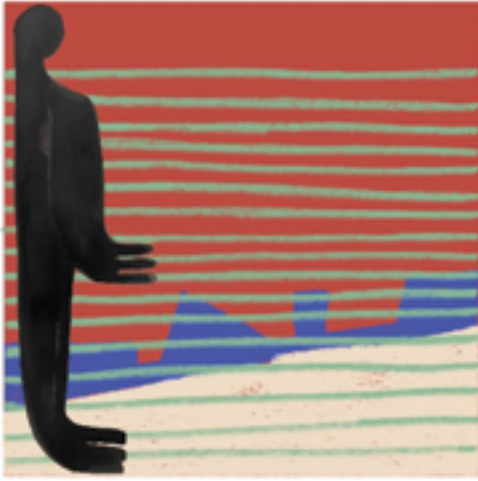
But the term "trauma deserts" is a misnomer because deserts are a naturally occurring phenomenon. We now know that resources in these racially segregated areas—such as food, education, and healthcare—are frequently absent by intent, not accident. Between 1990 and 2005, 339 trauma centers closed across the country,⁵ a higher rate of closure than in previous decades, and the authors of one study found that "hospitals in areas with higher shares of minorities face a higher risk of trauma center closure."⁶

In other words, the neighborhoods most in need of a trauma center were also the most likely to have theirs taken away. As part of a wave of such closings, the previous trauma center on the South Side shuttered in 1991. The closing of that hospital left another racially segregated community to fend for itself. For three decades, gunshot victims died from survivable injuries because they had no place close enough to go. When seconds mattered, they spent minutes in ambulances racing to the north side of town, many dying during transport. I had witnessed endemic healthcare inequity while working in Dallas, Atlanta, Boston, and Tampa and had become numb to what I saw. In those early days I was an eager participant in the healthcare system, ignoring the ways my actions perpetuated the inequities we must eliminate.

During the early years of my career, saving the life of a gunshot victim—or trying to—was exhilarating.



Despite living within walking distance of a premier medical center, many of our neighbors do not have access to routine care.



You don't have to believe systems are rigged to see that they negatively impact some groups more than others.

But in recent years I kept thinking: by the time patients are lying on the gurney in front of me, it's too late. I might be able to save them from immediate death, yes. But what about the circumstances that led them to my trauma bay? What about the forces that shape where they live, work, learn, worship, and play? What access to transportation and banks and grocery stores and parks do they have—or not have? Did my work as a trauma surgeon truly help transform the communities I served?

In 2002, the National Academy of Medicine published the first systematic review of racial and ethnic healthcare disparities in the United States. The landmark report found that, even after correcting for socioeconomic conditions, “race and ethnicity remain significant predictors of the quality of health care received.”⁷ Healthcare systems and providers contribute to these disparities, the report said, and it provided a framework to correct the inequities. This included increasing the number of underrepresented minorities in medicine, educating society at large about racial and ethnic disparities, and collecting better data to guide interventions and resource allocation. Two decades after the report's publication, during the worst of the coronavirus pandemic, not much had improved. Black Americans continued to die at rates higher than white Americans, and the healthcare system was clearly part of the problem.

The problems of healthcare disparities and racism in medicine are not limited to a once-in-a-century pandemic. When admitted to a hospital, Black patients experience more adverse events than white patients. In reviewing patient safety according to 11 different indicators,⁸ a report by the Urban Institute and Robert Wood Johnson Foundation found that “Black adult patients experienced significantly worse patient safety in six indicators when compared to white adult patients who were in the same age group, of the same gender, and treated in the same hospital.”⁹ These disparities occur more frequently in surgery, my specialty, than in some others.

By underinvesting in the health of poor and Black citizens, the infrastructure of the entire nation suffers—which, in some way, impacts all of its citizens. And these healthcare inequities are connected to other types of injustice. But here's the thing: history is not inevitable. People in power make choices, and just because the United States now has massive health disparities does not mean that it had to be that way. Nor does it have to continue.

That is why we must talk about structural racism and how it binds us all.

Unlike what I internalized in medical school, race itself is not a risk factor for health disparities. Race is not a risk factor in chronic diseases, medical errors, or life expectancy.

It's racism.

One review of 293 studies found that racism contributes to worse mental and physical health. Simply put, “being Black is bad for your health,” the Pew Research Center recently declared, with the critical addition: “And pervasive racism is the cause.”¹⁰

When we talk about physical health, we usually focus on choices, habits, cause, and effect. A lack of sleep, no exercise, and an unhealthy diet lead to poor health—in other words, poor individual choices. And healthy choices do matter. But health is more than just exercising, eating right, getting regular check-ups, taking your medications, and visiting the doctor when sick. Health is shaped by the context in which we live. And the context in which we live binds together every sector of American life: housing, education, employment, and more. We may not live in the same neighborhoods, our children may not attend the same schools, and we may not shop at the same grocery stores, but we can all appreciate how much our lives, and our health, would suffer if any of these resources were absent or compromised. You don't have to believe that the systems in which we live are explicitly rigged to see that a system negatively impacts some groups more than others.

Racism manifests in healthcare not only in the way that Black people are treated when they arrive in the emergency room (if they arrive); it's also in the conditions that shape the lives of Black people in America that influence their life chances in the first place. There is no individual to hold accountable, no individual threat we can lock up to prevent the violence from happening, so change requires systemic transformation. Yes, asthma and diabetes put one at more risk of dying of COVID-19, both of which occur at higher rates in Black communities; but so do environmental injustices like exposure to hazardous waste and air pollution, housing inequality, and food deserts.

Structural racism, figuratively and literally, exists in the air we breathe.

Transformation

How do we transform systems resistant to transformation—systems that are actually functioning exactly as they were intended?

First, we begin by asking different questions. Our healthcare and social safety-net systems are replete with old ideas.

One old idea we must discard is the dominant narrative about the lack of leadership in Black communities, which have been systematically disadvantaged for centuries, and actually watch, listen, and learn from the amazing solutions emerging from them. I spent much of my career referring to communities

I served with terms I now consciously avoid: *underserved, urban poor, at risk, marginalized*. We must push back against multiple narratives that are false and destructive.

I now refer to the communities in which I work as *communities of opportunity*.¹¹ Colloquialisms like *urban poor* and *at-risk communities* diminish the humanity of my neighbors and tend to erase the creativity and agency of the communities themselves. Those closest to the problem are often closest to the solution. Therefore, it is time for us to listen.

Another important step is to enact local, state, and federal laws and policies to dismantle structural racism. First, these policies must dismantle de facto barriers intended to exclude Black Americans from mainstream society. Second, they must promote economic reinvestment in communities through federal collaboration with local businesses, public officials, and community leaders. Last, they must acknowledge the role systemic racism plays in our society. Name it. Demystify it. Eliminate it. Radical inclusion through economic reinvestment is needed to ensure every American, regardless of race or ethnicity, has the opportunity to live safely, and thrive, within their communities.

The Centers for Medicare & Medicaid Services defines *health equity* as “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.”¹² Policy makers did, and can continue to, make a difference.

Community leaders, academics, politicians, activists, and more are working together to create health equity. And it is important to understand that the root causes of health inequity are the same root causes of endemic violence, which means that the solutions are similar.

I am not the same person I was when I began my career. Age and experience conjoin to transform us all, I suppose. My own transformation includes moving from assimilation, code switching, and separating myself from the realities of my patients—all in the name of career advancement and acceptance—to now claiming all the ways that my experiences as a Black man connect me to my patients.

As I have changed, so has the scale of my ambitions. My goal, audacious as it may sound, is to work myself out of my job as a trauma surgeon. To never have to tell another mother she has lost a child to gun violence. To stop the flow of bodies arriving in our emergency rooms and trauma centers because of preventable injuries, treatable diseases, and avoidable death. Treating individual patients occurs within the hospital, but healing entire communities occurs beyond it.

Anger has become the fuel that propels me on this journey of justice. The best I can do is dial it down and channel that energy in service of the greater good. Anger can be destructive or productive. We can allow it to hold us in a state of inaction, or we can let it inspire us to challenge the injustices around us. I have long identified my anger with shame. No more. Naming it and embracing it has guided me forward. And now I know what triggers my anger most of all: persistent injustice. Anger ignored can consume us, but anger acknowledged can transform us.

+ + +

This young Black body before me: he is the reason I am here. His life has ended, while mine goes on. So, if only for a moment, I ask my coworkers to unite in silence to honor this stranger. Together we recognize that tomorrow is never promised, and we honor our shared humanity.

At the end of our moment of silence we resume our work. Each member of the team does their part in removing intravenous lines, disconnecting ventilator tubes, and discarding bloodied equipment. Another Black body to be tagged and bagged. Those closest to him will have a funeral, but his death will not receive any national reckoning.

But it’s not true that his story will never be told. I am telling it here. It is a partial story, more about his death than his life. But by reading you know he lived. You know he died. You and I: we can’t unknow these things.

Having spoken to the medical examiner, I have a final duty to complete: the death note. It’s a final version of this young man’s life that I must document. The disembodied voice overhead breaks into my typing. It blares with a reminder that although this young life has ended, our work has not. “Code yellow, level 1, multiple GSW to chest and abdomen, traumatic arrest, ETA 4 minutes.”

The bodies—they just keep coming. We have to make them stop. +

For the endnotes, see aft.org/hc/spring2024/williams.

I wrote this book so the lives I try to save are not ignored. I wrote it to show you the world of a Black trauma surgeon, in a profession lacking role models, who routinely deals with the human toll from the epidemic of gun violence. I wrote it to remind us all that if Black lives actually mattered to policymakers in the United States, they would take action that mattered. Weaving together memoir, medicine, historical records, and scientific research, this book explores various dimensions of healthcare inequity. There are three main threads: a narrative account of my experiences inside the hospital, my personal story, and a critical look at healthcare inequity.

—B. H. W.

We need to dismantle the structural racism at the root of health inequities and endemic violence.



IMPROVING HEALTH OUTCOMES

Increasing Civic Engagement

Civic engagement has recently gained attention as a key social determinant of health, informing the new Healthy People 2030 core objective to increase the number of citizens who vote.¹

Through voting, people can participate in decisions that directly and indirectly affect their health—for instance, voting on ballot initiatives that expand access to Medicaid and reproductive healthcare or clean water and green community spaces. That's one reason communities with high voter turnout tend to have better self-reported general health, fewer chronic health conditions, greater social inclusion and sense of belonging, and lower overall mortality rates.²

The Healthy Democracy Healthy People coalition's Health and Democracy Index (democracy.index.hdhp.us) shows a clear connection between voting and health in the United States. The index compares the Cost of Voting Index (COVI) for the 2020 general election with health outcomes and voter turnout in each state. Factors that influence the COVI calculation include voter registration deadlines and restrictions, voter ID laws, voting inconvenience, and poll hours. Among the 12 health outcomes measured were self-rated general and mental health, chronic disease prevalence, infant and premature mortality, poverty, and community and family safety. States with lower COVI (indicating fewer barriers to voting) showed better health outcomes than states

with higher COVI. On the interactive website, you can see how each health outcome relates to voting access. As shown below, premature mortality has a strong association with voting barriers.

What Healthcare Workers Can Do

While voter participation across the nation has improved, 33 percent of eligible voters did not vote in the 2020 election and half did not vote in the 2022 election³—and some healthcare professionals are less likely to vote than the general population.⁴ But the 2024 election is a renewed opportunity to build support for policies that ensure an inclusive, representative democracy and healthier communities.

There are several ways that healthcare professionals can help improve public health outcomes through improving civic engagement:

1. Vote in upcoming local, state, and federal elections.
2. Encourage friends, family, and colleagues to vote.
3. Talk to patients—in nonpartisan ways—about the importance of voting and share voter registration information (visit vot-er.org/resources for help).
4. Help hospitalized patients get emergency absentee ballots (visit patientvoting.com for more information).

Helpful Resources

- **National Academies “We Will Vote!” Webinar** (go.aft.org/qrd): This one-hour webinar features presentations from Civic Health Alliance, Healthy Democracy Healthy People, and Vot-ER about the links between voting and health and how health professionals can leverage their power to improve civic engagement.
- **Civic Health Alliance “Civic Health Compact”** (go.aft.org/rgs): This guide supports healthcare leaders and organizations with concrete steps to integrate civic engagement into care settings and improve patient, staff, and community health.
- **The Political Determinants of Health**, by Daniel E. Dawes: This book provides a road map for advancing health equity through voting and public health policy. For a briefer overview of the political determinants of health and their impact, read this free article by Dawes: go.aft.org/x58.

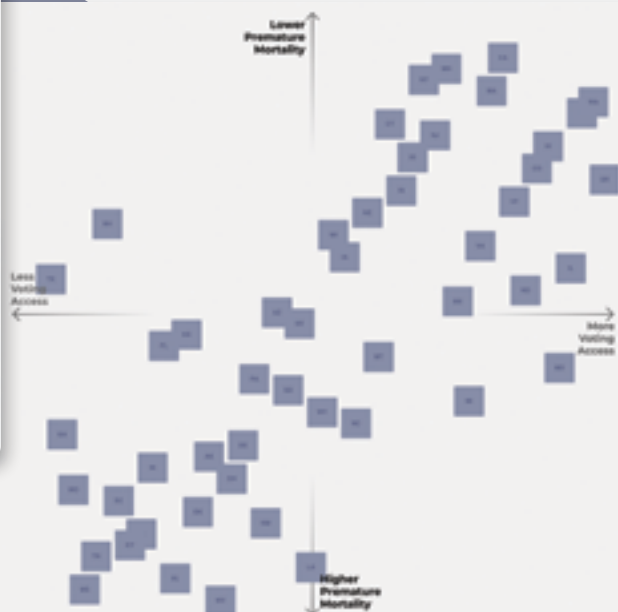
EXPLORE:

Select a public health metric to see how it correlates to voting access across states.

Premature Mortality

This analysis uses a state ranking based on years of potential life lost (YPLL) before age 75. Many premature deaths are preventable. People of color are at higher risk for premature death, and there is some evidence linking this to lost votes over time resulting in significant voting disparities. Lower is better (1 is the best, 50 is the worst).

See this information in an [interactive table](#).



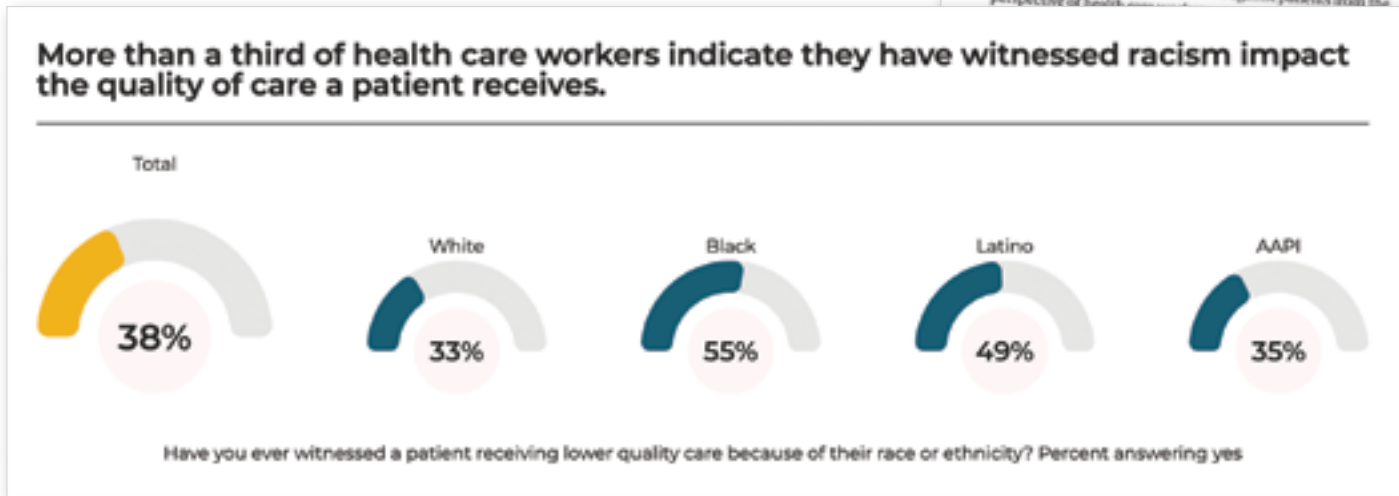
Addressing Discrimination

Racism and discrimination severely impact health. Numerous studies have documented poorer health outcomes for people from racial and ethnic minority groups⁵ and noted that discrimination based on race, ethnicity, and language differences limits patients' access to and quality of healthcare.⁶ A recent report, "Revealing Disparities: Health Care Workers' Observations of Discrimination Against Patients," extends this research with concerning findings about discrimination in healthcare settings.

In early 2023, the African American Research Collaborative and the Commonwealth Fund surveyed 3,000 healthcare workers employed in inpatient and outpatient care facilities across the country. More than half (52 percent) indicated that racial or ethnic discrimination against patients was a major problem or crisis in their workplace, and 47 percent reported witnessing discrimination against patients—with most witnessing it in the past three years. This number was higher for workers under age 40, those in mental health settings, and those in facilities serving majority-Black or majority-Latinx patients.

Racial and ethnic discrimination also impacted healthcare workers, with most experiencing stress related to discrimination. Those who worked in facilities serving majority-Black or majority-Latinx patients were more likely to report "a lot" of stress—and Black and Latinx healthcare workers experienced much higher rates of stress than white healthcare workers and were more likely to fear negative consequences for reporting racism or discrimination in their workplaces.

While 60 percent of healthcare workers had received anti-discrimination training, the majority agreed more should be done to address discrimination in healthcare settings.



"REVEALING DISPARITIES: HEALTH CARE WORKERS' OBSERVATIONS OF DISCRIMINATION IN THEIR FIELD (QUALITY OF CARE)," GO.AFT.ORG/PNI

More than half said that certain patient groups experienced healthcare discrimination or inequitable treatment from care providers, including Black patients (55 percent of respondents); patients with mental health needs (61 percent); patients with low income or no health insurance (62 percent and 55 percent, respectively); patients who identify as transgender, nonbinary, or gender nonconforming (57 percent); and patients whose primary language was not English (60 percent). About half reported that care providers were less likely to accept health self-advocacy—which is related to better health outcomes⁷—from patients of color than from white patients.

The strategies they believed to be most effective included providing more opportunities for healthcare workers to learn to spot discrimination (79 percent of respondents), implementing confidential reporting for those who experience or witness discrimination (74 percent), examining organizational policies to ensure equitable healthcare outcomes for patients of color (71 percent), and creating opportunities for organizations to listen to patients and healthcare workers of color (69 percent).

To learn more, read the report at go.aft.org/gz3.

For the endnotes, see aft.org/hc/spring2024/www.



AFT healthcare professionals are all in for Joe Biden! But he'll need all of us to win.

You're invited! AFTvotes 2024

WHAT: Be part of our fast-growing, nationwide activists' group of healthcare professionals working to get out the vote.

WHY: To build on the progress we've made with Joe Biden and Kamala Harris. Together, we are breaking Big Pharma's stranglehold on drug pricing, keeping our hospitals open and funded, prioritizing student loan forgiveness for healthcare professionals, and working to address the mental health crisis in the healthcare workforce.

We need to keep pushing forward.

WHO: YOU. Your family. Your colleagues. Your friends. Like-minded, engaged people in your community and across the country.

WHEN: All the way to Election Day—Tuesday, Nov. 5.

WHERE: In your neighborhood, in your community or right from your own cellphone.

RSVP here

Tell us what you think at AFTvotes.org.

Help shape our AFTvotes campaign by taking our four-minute member survey.

Get involved at AFTvotes.org.

Activities and actions for every schedule and interest, whether you have a day or an hour.



Be a part of AFTvotes 2024. It's fun! It's easy! And it matters.