aft HEALTH CARE

A BIANNUAL JOURNAL ON HEALTH AND COMMUNITY WELL-BEING

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# Fighting for Our Patients and Our Democracy


## As Authoritarianism and Greed Rise, *We Rise Up*


# Protecting our Patients

# Resources for Immigrants and Refugees

Hospitals are supposed to be safe and welcoming places for all people to receive care, regardless of immigration status or ability to pay. But under the Trump administration, hospitals are subject to Immigration and Customs Enforcement (ICE) raids. For many immigrants—even legal residents and US citizens—seeking treatment for illness or injury now also brings the risk of arrest and separation from their families.

The AFT has resources to help healthcare workers protect patients, families and communities. Visit **go.aft.org/hcw** to find critical information and toolkits in English and Spanish.

1. Know Your Rights for Healthcare Facilities: **go.aft.org/ybc**
2. Protecting Our Patients Toolkit: **go.aft.org/ca4**
3. Sample Healthcare Facilities Pledge with Know Your Rights cards: **go.aft.org/ojt**
4. Checklist for a Family Immigration Emergency Plan: **go.aft.org/aiy**

## Have you witnessed or experienced an immigration enforcement action in your community?

The AFT is working with community partners on a rapid response to help our immigrant communities. Please go to **go.aft.org/hwg** and report enforcement actions in your hospital or community to help us mobilize resources and provide support to those impacted. All reports are confidential.

# Defending Health, Science, and Our Democracy

RANDI WEINGARTEN, AFT PRESIDENT

A CORE PRINCIPLE that guides our union is the fight for dignity, affordability, and opportunity for everyone—particularly the people we represent and the communities we serve. But those aspirations elude too many Americans today. Inequality in the United States has returned to Gilded Age levels. More than 4 in 10 Americans under 30 say they're "barely getting by" financially. About 1 in 6 Americans doesn't have enough to eat. And cruel health inequities persist, from racial disparities in cancer-, diabetes-, and pregnancy-related mortality to rural challenges in accessing care.

All this is happening as the rich get richer: CEO pay has soared 1,085 percent since 1978, compared with a 24 percent rise in typical workers' pay. This isn't just morally wrong—it's putting our democracy at risk. In the 21st century, income and wealth inequality are strong predictors of democratic erosion (see the article on page 13 for details).

One of the most troubling symptoms of our democratic erosion is the recent increase in political violence. Let's be clear: Violence is never the answer. Never. Not on January 6, and not the assassination of Charlie Kirk. It is antithetical to democracy and contrary to the values we stand for as a union of professionals that fights for a better life for all.

Healthcare professionals know this all too well. That's at the heart of our Code Red campaign, which shows how short staffing has led to increases in violence in hospitals across the country. In our communities and in our national rhetoric, it's time to come together, to de-escalate, and to condemn all forms of violence.

But it's not time to stay silent. What I am advocating for is an end to the hate and the smears and a recommitment to the right to civil discourse, to peaceful disagreement, to critical thinking, to debate, to open inquiry, to some of the founding principles of our nation.

We are fighting for a better life for all, and our elected leaders must do the same. President Donald Trump promised voters that inflation would "vanish completely"—but today we're all paying higher prices because of Trump's tariffs and the resulting "Trumpflation."

And then there is Trump's so-called Big Beautiful Bill, which he signed into law on July 4. It is a brazen redistribution of wealth from poor and working-class Americans to the rich. While adding $3.4 trillion to the deficit over the next 10 years, it offsets tax cuts for billionaires by devastating healthcare: Cutting Medicaid and the Affordable Care Act by more than $1 trillion over 10 years, kicking more than 13 million people off their health insurance, forcing many hospitals—especially in underserved rural areas—to reduce services or close, and raising healthcare costs for everyone. Prohibiting the US Department of Health and Human Services from implementing, administering, or enforcing the nursing home minimum staffing rule. Prompting more than $500 billion in automatic cuts to Medicare (because of how it inflates the deficit).

Beyond healthcare, the law also rips food assistance away from over 22 million families, stunts job growth, hurts the climate, and defunds public schools. Trump's big bill isn't beautiful. It is a betrayal that will make Americans sicker, hungrier, and poorer. And Republicans know it—that's why they spread these cuts over many years, with most starting *after* the midterm elections.

Even though the worst impacts are years away, healthcare professionals—and their patients—are already suffering the consequences. As the three AFT leaders in the Q&A on page 8 explain, some healthcare executives are using the future Medicaid cuts as an excuse to fire staff now.

Then there's this administration's war on science: Rescinding thousands of National Institutes of Health–funded grants for research that supports advances in clinical care. Undermining or dismantling numerous independent science-focused federal advisory committees. Fueling distrust in vaccines—and hampering access to COVID-19 vaccination (and so much more) for many.


PHOTO © AFT

> To move elected leaders, we have to **show up and stand up**.

We can't be silent while this administration engages in its unprecedented attack on healthcare professionals' ability to provide quality, evidence-based care and on the public's ability to find trustworthy information to keep themselves and their families healthy.

To move elected leaders, we have to show up and stand up. We have to be on the streets—nonviolently and peacefully—showing that we care for everyone's humanity, dignity, and opportunity. No one can do everything, but we all can do something (as I explain in the excerpt from my new book that begins on page 3).

Here's one way to make your voice heard: Be out on the streets on October 18.

On June 14, dubbed "No Kings" day, millions of Americans mobilized peacefully to say no to Trump's authoritarian power grab. We're doing it again on October 18 in another "No Kings" nationwide day of action. Be part of it—for our democracy, for your patients, and for your profession. To find an event near you, go to go.aft.org/nokings. +

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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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# Why Do Fascists Fear Unions?

## BECAUSE COLLECTIVE POWER IS THE ANTIDOTE TO AUTHORITARIANISM


PHOTO © AFT

By Randi Weingarten

As President Joe Biden often points out, "The middle class built America, and unions built the middle class."[1] It is incredibly powerful to look at historic charts of union membership versus income distribution in the United States.[2] When unionization rates rise like a mountain, income inequality craters into a valley. Unions level the playing field. But, of course, the opposite is also true. When unionization declines, income inequality rises.

The earliest forms of labor organizing in America were enslaved Black people and enslaved Native Americans leading rebellions throughout the 18th and 19th centuries.[3] In 1794, the first known union in the United States—a union of shoemakers—was founded in Philadelphia.[4] Mill workers in Lowell, Massachusetts—including girls as young as 12—formed the first union of working women in the nation and in 1834 went on strike over wage cuts.[5] In 1867, around 3,000 Chinese laborers building the Transcontinental Railroad launched what was at the time the largest strike in the nation's history, stopping work to demand better wages.[6]

In the mid-1800s, Americans regularly worked 12 hours a day or even longer.[7] Between 1890 and 1910, almost one out of every five children between the ages of 10 and 15 was working.[8] And conditions were abysmal. As just one example, the nation was rocked in March 1911 when the Triangle Shirtwaist Factory in lower Manhattan caught fire.[9] Poor ventilation meant the fire spread quickly, and locked doors and a single faulty fire escape meant workers couldn't get out. That day, 146 burned alive or leapt from windows to their death.

But it was only because unions pressed for change that, in 1938, the federal government passed the Fair Labor Standards Act.[10] The law established a maximum workweek of 40 hours and required that anyone working more than that be paid overtime. Plus, the law established a federal minimum wage and

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banned child labor. It would take over 30 more years for unions to win the Occupational Safety and Health Act in 1970, creating minimum workplace safety and health standards.[11]

As the power and influence of unions grew, so did attacks from employers. It became common for businesses to "spy on, interrogate, discipline, discharge, and blacklist union members."[12] So unions also pressed for and won the National Labor Relations Act. Enacted in 1935, the law guarantees workers "the right to self-organization, to form, join, or assist labor organizations, to bargain collectively through representatives of their own choosing, and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection."[13] This is the foundation of labor rights—giving real voice and workplace democracy to millions of American workers who had for too long been powerless.

Why do fascists, oligarchs, autocrats, and the far right hate unions so much? To understand that, it's important to first understand how unions work.

## Unions Give Workers a Voice—and Power

On the one hand, unions are like any other membership organization that people join because of shared interests. If you care about the environment and want more green space in your community, you might join a garden club or local environmental group. Well, if you care about your job and want to make sure you and other workers are treated fairly at work, you start a union or join one that already exists.

**When unionization rates rise like a mountain, income inequality craters into a valley.**

But unions have power that few other organizations do because, legally, they can represent groups of members in a workplace and bargain on behalf of those workers over the terms and conditions of work. And the right to do so—the right to form a union and collectively bargain with other workers—is protected under a mix of federal and state laws.[14]


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Unions are also unique in that they are democratic organizations. Locals have constitutions and elections. All of the leaders are elected, including, in the case of national unions like mine, the members electing leaders of their national unions. I am elected to a two-year term by the members of the AFT at its biennial convention. Together, we express shared interests with a shared voice. One of the best examples of this is through collective bargaining, which is the way that unions and the employers they work with arrive at a contract—where the terms and conditions of the working relationship are agreed upon. Whatever the size or strategy, it's called "collective bargaining" because workers are coming together through their unions to negotiate as a group with employers on work-related issues. And workers have power in those negotiations because of their members joining together as one.

Unions make a powerful difference in the lives of working people. Unions raise wages for their members by an average of 10 to 15 percent.[15] Over 9 out of 10 union members have employer-sponsored health benefits and paid sick days, significantly higher rates than for nonunion workers.[16] And union workers are more likely to have employer-sponsored retirement plans than nonunion workers.[17] Importantly, where there are strong unions, average wages are higher across the board, even for nonunionized workers.[18] For every 1 percent more that private workers are unionized, wages for nonunion workers go up 0.3 percent.[19] And the effect is even greater for workers without college degrees.

It's no surprise that fascists don't like unions. Unions make life better for all working people. Fascists rely on what political scientist Jean Hardisty called "mobilizing resentment," but that strategy doesn't work if there's no resentment to mobilize.[20] Fascists need extreme economic inequality to provide the fertile ground for scapegoating immigrants and other vulnerable minorities. And the same playbook used to crush unions is deployed to silence journalists, demonize activists, and suppress voters—because fascism can't survive in a world where we, the people, have power, information, and opportunity.

Plus, of course, some fascists are oligarchs—or are aligned with oligarchs—who personally reap the benefits of wealth inequality. Elon Musk—the wealthiest person in the world and the top supporter of Donald Trump's second presidential campaign—has profited by exploiting workers.[21] Musk reportedly gloated about his employees trying to impress him by working 20 hours a day and sleeping in the office.[22] And a US appeals court ruled that Musk illegally threatened that Tesla workers would lose benefits if they unionized.[23] He once said he disagrees with "the idea of


PHOTO © REGINALD MATHALONE / NURPHOTO / ASSOCIATED PRESS

unions" because they create "a lords and peasants sort of thing."[24] Labor reporter Steven Greenhouse comments, "That the world's richest human dissed the idea of unions should certainly be seen as a selling point for unionizing. Musk's statement shows that he realizes that unions can be highly effective in harnessing the collective voice and power of workers."[25] As a result of Musk's philosophy, nonunionized Tesla workers earn significantly less than auto workers covered by the United Auto Workers union—in some cases as much as 40 percent less.[26] Meanwhile, amid mounting accusations of abuse against workers at SpaceX, Musk filed an audacious suit in federal court arguing that the National Labor Relations Board (NLRB) is unconstitutional.[27] This is one of dozens of lawsuits that Musk's SpaceX, Jeff Bezos's Amazon, and other corporations have filed against the NLRB.[28]

Look, no institution is perfect. That's why I work tirelessly to make the labor movement more effective. But while unions face almost constant scrutiny, wealthy, powerful special interests are often let completely off the hook. For instance, when some of the largest private banks in America made massive mistakes leading to the 2008 financial crisis, they weren't held accountable. They were bailed out and propped up.[29] So bear in mind that when the friends of these bankers and other billionaire special interests attack unions, they don't really believe in "accountability" in any real sense. They just want to destroy the ability of unions to be a check on their unfettered power.

It's one thing for business owners or the government to disagree with labor unions about wages and other aspects of a contract negotiation. But attacks on the very existence of labor unions is a hallmark of fascism, as philosophy professor Jason Stanley explains. "Antipathy to labor unions is such a major theme of fascist politics that fascism cannot be fully comprehended without an understanding of it," writes Stanley.[30]

"Fascism is most effective in times of severe economic inequality," explains journalist Spencer Bokat-Lindell.[31] But fascism also relies on individuals in society feeling isolated, what philosopher Hannah Arendt called being "atomized."[32] After all, when we don't know our neighbors, it's easier for fascist propaganda to turn us against each other. Unions show how our fates are linked and not only deliver better material conditions but make people feel connected to each other and engaged in their lives, jobs, and communities. Labor unions "promote solidarity across differences that fascism depends on exploiting," writes Bokat-Lindell.[33]

## Unions Strengthen the Middle Class—and Democracy

When unions are strong, America's middle class is strong, too. Between 1985 and 2011, when the proportion of union membership in the United States dropped by 8 percent, the number of middle-class households in the United States also dropped by 8 percent.[34] In fact, between 1973 and 2007, data show that anywhere from one-fifth to as much as one-third of the growth in economic inequality in the United States can be attributed to declines in union membership—"an effect comparable to the growing stratification of wages by education."[35]

Yet as economic inequality has skyrocketed, and exploitation by billionaires and big business has skyrocketed, support for unions has risen. In 2024, 7 out of 10 Americans had a favorable view of unions—nearly the highest approval rating in 60 years.[36] In fact, as confidence in every other major American institution—from the criminal justice system to Congress to TV news to the military—has fallen, trust in unions has increased.[37]

**Fascism can't survive in a world where we, the people, have power, information, and opportunity.**

## What Is Fascism?

Fascism is an approach to politics that rejects independent critical thinking and instead mobilizes people around fear and rage—which makes them more receptive to strongmen leaders who then strip away collective rights and freedoms. Fascists construct an extreme story of us versus them, replacing facts and critical thinking with propaganda that romanticizes the nation's past while casting ethnic, religious, and social minorities as fundamental threats to that nation's present and future. That scapegoating whips up not only resentment but also dehumanization and violence. Meanwhile, freedom and democracy decline. As do pluralism and a sense of community.

While there are important, subtle distinctions between fascism, authoritarianism, oligarchy, anti-government extremism, and the far right, in practice at this moment in history these forces and others are conspiring to destroy the building blocks of opportunity for all. Which exact word we use isn't as important as the warning.

Today, fascism is an amalgam of people who either outright oppose diversity and pluralism, want to shrink government as much as possible, or both. Whether they're motivated by ideology or plain greed, what fascists and oligarchs and autocrats of all sorts have in common is that they don't want to solve problems. They want to create problems so they can exploit our anger and fear—to give themselves more power and more money, and take power and opportunity away from ordinary citizens. That's it. That's their whole playbook.

–R. W.

Unions build the middle class. And unions also build democracy. Historian Heather Cox Richardson talks about how "regular people having agency" is fundamentally disruptive to the fascist agenda that puts all power in a singular authoritarian leader.[38] She adds that "people feeling as if they have agency and taking a stand for their rights" is the point of democracy. It's also the point of the labor movement. Instead of feeling isolated and "atomized" and outside of decision-making—where resentment and even conspiracy theories can fester—union members feel integral to systems of power and clear on their own power to make change. That's good for all of us as individuals and good for our nation as a whole. Unions practice democracy internally by voting on leadership and contract negotiations. And they strengthen democracy in our nation not only by endorsing candidates but by encouraging people to vote. Union membership increases civic participation. In swing states like Pennsylvania and Michigan, an estimated one in five voters is a union member, and research shows that union members are at least 3 to 5 percent more likely to vote than nonunion members.[39]

Political scientists Patrick Flavin and Benjamin Radcliff explain that belonging to a union is a form of "political participation in the workplace" that "translates beyond just the workplace and increases a member's likelihood of becoming involved in the political process and, ultimately, voting."[40] But just like unions boost wages for all workers, not just union members, unions boost rates of voting for all Americans. Even nonunion members living in states with strong unions are more likely to vote.[41] Plus, of course, unions take all that agency and engagement and voice and use it to fight for what our communities need. That's especially true for unions that represent teachers, which fight not only for members in negotiations over wages and benefits but also for what our students need to succeed. And it's what our nurse locals are also starting to do in our Code Red campaign for patients—raising the alarm about staffing shortages in healthcare facilities.

Voting is the first step in protecting democracy and opportunity, but creating and joining unions is even more powerful for working people—because collective power is the true antidote to authoritarianism. As the labor strategist Michael Podhorzer puts it, "Voting is like going to a restaurant and choosing between entrees on the menu. Collective power is like sitting at the table deciding what's on the menu."[42] In a true democracy, more and more people have power not just in elections but in deciding how the economy and business and schools and every aspect of society are governed and run. That's the power of unions. And that's what truly threatens fascists.

The good news is that unions in the United States are growing, surging in both numbers and popularity. As I've already noted, support for unions has grown as Americans have become frustrated by the rise of billionaires and mega-corporations and fed up with leaders like Donald Trump who keep giving more tax cuts and privileges to the super-rich while squeezing the middle class. And unionization has grown, too. In 2021, there were 1,638 groups of employees filing paperwork with the National Labor Relations Board seeking elections to form new unions. But in 2022, 2,510 such petitions were filed—a 53 percent increase.[43] Meanwhile, between 2022 and 2024, the AFT organized 185 new bargaining units across the fields of education, healthcare, and public services.[44]

**Attacks on the very existence of labor unions is a hallmark of fascism.**


PHOTO © OHIO NURSES ASSOCIATION

Authoritarians and the far right fear unions building power because that power is used to make people's lives better—to rebuild the middle class and ensure that more and more people have access to the American dream. Plus, union power is used to increase wages and pensions and health insurance and other benefits.

While we don't yet know everything Trump will do—or try to do—in his second term as president, we know that prioritizing the billionaire class at the expense of ordinary Americans amounts to a great betrayal from the man who sold himself during the election as the savior of the working class. In his farewell address, President Biden issued an urgent—and accurate—warning: "Today, an oligarchy is taking shape in America of extreme wealth, power, and influence that literally threatens our entire democracy, our basic rights and freedoms, and a fair shot for everyone to get ahead."[45]

Americans want a better life and more opportunity, not less. They want to be treated with dignity and respect, and they want the same for others, too. From my lifetime of working with Americans across the political spectrum, I know this to be true. We are in a profoundly consequential fight between fear and hope, between anger and aspiration, between chaos and community. And I know, with every fiber of my being, that hope and aspiration and community always win—when we fight for them. Yes, the story of America has included too many dark chapters enabled by our worst impulses. But what makes our nation great isn't that we've always been perfect but that we have fought for justice and have learned from our mistakes—that just as our forebearers forged a new nation to improve upon the one they fought for freedom, so too did our grandparents and our great-grandparents fight to make America more just, more fair, more equitable, more inclusive. An America of boundless opportunity. An America where the next generation has a pathway to the American dream. Just like we, in this moment, must fight for those values and that vision—and educate our children and grandchildren so that they, too, can continue to write the story of America that continues to reach toward hope and aspiration and opportunity and liberty and justice for all. ✚


PHOTO © AFT

**Collective power is the true antidote to authoritarianism.**

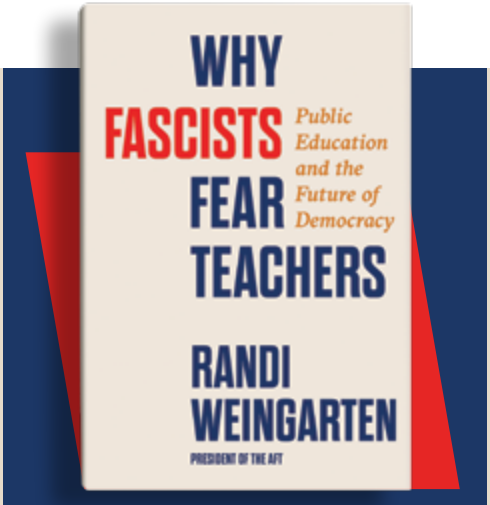
**For the endnotes, see aft.org/hc/fall2025/weingarten.**

I am a schoolteacher, a lawyer, and a union leader. I am not an academic, and this is not an academic book. This book is a warning. I want to explain why the attacks on public education are intensifying and how they connect to a concerted strategy. My views reflected herein are informed by a lifetime of work, an analysis of historical and current events, and, importantly, the perspective of teachers—who, along with nurses, are some of the most trusted leaders in the United States but never get the support they need or the pay they deserve and are increasingly besieged by baseless smears and attacks. Why? What's going on? And for those of us who respect teachers and value public education, how can we respond?

Fascists fear teachers because education is essential to democracy. And education is essential to broad-based opportunity and empowerment. Yes, we teach reading and math. But we also teach young people to have agency and confidence, to problem solve and be resilient. And we also teach core American values, including patriotism. We teach the fundamental building blocks for a nation unlike any in human history—a nation founded on the radical idea that we all are created equal, that we all deserve the opportunity to succeed, and that power belongs to the people, and we all must have a voice. And though those ideals have not always been realized, we have prepared generations of young Americans to strive for that vision anew.

Our fight for those ideals is why fascists fear unions—especially when we engage in "Bargaining for the Common Good" and put communitywide demands on the negotiating table. In the AFT, educators and healthcare professionals are joining together with families and communities to fight for housing, healthcare, inclusion, public education, and more. Because that's what unions do. Just like nurses fight for what patients need, unions fight for what communities need. And we all do better when *we all do better*.

–R. W.




This article was excerpted with permission from Randi Weingarten's new book, *Why Fascists Fear Teachers: Public Education and the Future of Democracy*, published in September 2025 by Thesis, an imprint of Penguin Random House LLC. Weingarten is donating half of her proceeds from the book to the AFT's Disaster Relief Fund and Educational Foundation.

# "We All Feel Less Safe"

## HEALTHCARE CORPORATIONS ARE USING TRUMP'S AUTHORITARIANISM AS AN EXCUSE FOR THEIR GREED

On July 4, President Trump signed into law a set of devastating cuts to programs that families depend on—including slashing at least $900 billion from Medicaid[1] over the next decade—to partially offset massive tax cuts for the ultra-wealthy. More than 10 million people are expected to lose health insurance. Already struggling rural hospitals and clinics and safety net hospitals that depend on Medicaid reimbursements to serve low-income communities may have to close. The people who will be most affected are those who can least afford it: Children from low-income families. People with disabilities. Senior citizens and nursing home residents. While communities nationwide rallied in the streets and lobbied Congress to fight the cuts, some hospital systems saw opportunities to boost profits by cutting staff, with little regard for how that might affect patient care.

To learn more about how employer greed and the Trump administration's authoritarianism are combining to create dangerous conditions for patients and healthcare workers, we spoke with three leaders of AFT affiliates at two PeaceHealth hospitals where staff cuts were made in May. Jodi Atteberry is a patient access representative and referral coordinator in the heart and vascular clinic at PeaceHealth Southwest Medical Center in Vancouver, Washington. She is chair of the Service and Maintenance bargaining unit of the Oregon Federation of Nurses and Health Professionals (OFNHP), and she serves on multiple OFNHP and hospital committees. Dawn Marick, RN, is a nurse on the resource team at PeaceHealth Southwest. She is co-chair of the PeaceHealth Southwest Medical Center bargaining unit of the Washington State Nurses Association (WSNA), co-chair of her hospital's staffing committee, and an alternate member of the Washington State Department of Health Hospital Staffing Advisory Committee. Amanda Stout, RN, is an ICU nurse at PeaceHealth Sacred Heart Medical Center RiverBend in Springfield, Oregon. She serves on her hospital's nurse staffing committee and on the executive committee for the Sacred Heart Medical Center bargaining unit of the Oregon Nurses Association (ONA).

–EDITORS

**EDITORS: Tell us about your backgrounds. How did you come to work in healthcare with PeaceHealth and to be involved in your unions?**

**AMANDA STOUT:** I've been a nurse for almost 16 years, and I've been at PeaceHealth RiverBend for my entire career. I first considered nursing because I needed a good job, but it's been a great match. I had just graduated from the University of Oregon and was going through a divorce with young kids, and I didn't want to disrupt my family by moving. I discovered that I could take nursing classes at the community college, so I chipped away at the prerequisites, and eventually I got into the nursing program. PeaceHealth RiverBend was the hospital game in town, so that's where I did my clinicals and where I ended up after graduation. I was a charge nurse and worked nights for many years. Eventually, I wanted to learn more, so I transitioned to the ICU.

I knew a little bit about unions because my mom was a teacher, so I was happy to join ONA when I started working at PeaceHealth RiverBend. But it wasn't until several years in, when I discovered that my coworkers and I hadn't been receiving the correct

ILLUSTRATIONS BY CAROLE HÉNAFF

certification pay (in some cases for years), that I really saw the power of the union. Winning back pay for my fellow nurses and myself felt great, and I started paying more attention and encouraging my coworkers to do so too. One of our stewards worked with me in the ICU and encouraged me to take on more leadership roles, so I became a steward, then a member of the staffing committee and now the executive committee.

**DAWN MARICK:** PeaceHealth Southwest is something of a family hospital for me. My grandma retired as the surgical secretary from what was then just called Southwest. She wasn't allowed to attend nursing school as a younger woman because she was married, so when she saw how much I loved caring for people and animals, she encouraged me to pursue nursing. I'm so glad I did. I've been at PeaceHealth Southwest for 16 years, and I've worked on the resource team supporting various areas throughout the hospital for about half of that time.

It was my former co-chair who suggested I join the bargaining team about eight years ago. That was my first foot in the door as far as union activism. Then I realized we only had one grievance officer, so I jumped into helping with that, and within a few years I was co-chair. I'm also co-chair of our staffing committee. It's easy to identify problems in our workplace, and I love being part of the solutions as an officer—even though it can be very frustrating.

**JODI ATTEBERRY:** I got into healthcare because both of my parents worked in this field, and I saw the impact they had. Healthcare isn't all rainbows and butterflies—it's helping people get better or helping them transition and making sure they and their families are supported. My dad was a union member. I remember being on the strike line with him one winter when I was a kid. It was cold out there, and I didn't understand everything, but I knew that we all stood together to fight for what was right.

I've worked in many areas of PeaceHealth Southwest in my 27 years here; I'm so proud that we successfully unionized in 2017 and of how strong we have become. OFNHP represents the service and maintenance staff; the technical staff; and the occupational, speech, and physical therapists (referred to as the pro unit), who are bargaining their first contract. One hospital leader told us, "We've never had as many grievances and meetings as we have with OFNHP. You guys are relentless." To me, that's a sign we're accomplishing our mission. We're staying the course and keeping management in check. We work closely with our sister unit from WSNA and with the engineering union. We have seen a lot of bad behavior from PeaceHealth, and we've come together to hold the employer accountable for the nasty things they're doing without regard for patient or staff well-being.

**EDITORS: What can you tell us about the layoffs PeaceHealth announced in May?**

**DAWN:** I'm the primary officer in our bargaining unit who handles reductions in force (RIFs). On May 22, I was notified by HR that the observation and same-day surgical overnight units would be closed and that two of our remote care managers would be laid off, affecting a total of 22 nurses. The nurses were notified later that day. In addition, we learned that critical OFNHP members of our care teams would be laid off.

The email didn't give any rationale for closing those units or eliminating those positions. Based on conversations in staffing committee meetings, the general sentiment from hospital leaders seemed to be that the decision was related to the political climate and concerns about Medicaid and Medicare reimbursement. There hadn't actually been any changes to reimbursement in Washington state at that point; they were making cuts in anticipation. It was part of a 1 percent reduction that was supposed to be across PeaceHealth, and more than one hospital leader expressed relief that it was only 1 percent.

**JODI:** We got an email on May 21 that PeaceHealth would be laying off 46 OFNHP members across all three bargaining units, as well as WSNA members and non-union staff. The eliminated positions included all of the LPNs and unit coordinators in the emergency department (ED) as well as unit coordinators and patient team support (PTS) staff in same-day surgical, social workers, leads for equipment and the supply team on the night shift, mobility aides, and the night shift in the diagnostic imaging library. It was a very disorganized and poorly communicated process. When we went through the job classifications, we saw that on the same day that social workers had been laid off, HR had posted two new social worker positions at the hospital. It was like the hospital's right hand didn't know what its left hand was doing.

We got only vague official explanations. Most of the information came through the staffing committee and unofficially from supervisors, who told us that PeaceHealth was anticipating cuts in Medicaid reimbursements and was worried about being financially solvent. Most hospitals are required to have 90 days of ready cash if they receive no reimbursement payments. PeaceHealth has 291 days of ready cash. But this excuse about financial solvency is not surprising if you consider PeaceHealth's pattern with layoffs in the past. They always happen before the end of the fiscal year (June 30)—and then the executives get their bonuses. Last year, the bonuses were more than $2.2 million. We estimate that the wages for just the 46 OFNHP positions they cut were $1.9 million.

**AMANDA:** At PeaceHealth RiverBend, we also got an email on May 22 informing us that because PeaceHealth was worried about fiscal health, they

**"It's shocking that PeaceHealth would make these cuts and … potentially endanger our patients and staff."**

**–AMANDA STOUT**


were looking at a 1 percent workforce reduction and "streamlining" measures. They said that layoffs wouldn't include "frontline caregivers" at our hospital—their term for clinicians who provide direct care—and that affected units would have more information by the end of the day. That same email announced that they were filling high-level management positions, which was an odd contrast. There was a lot of confusion and anxiety about who would be losing their jobs.

Later that day, the ICU manager and director sent an email telling us that we would be losing our security team, which is responsible for managing the flow of visitors in the ICU and handling other security concerns. We also learned that the women's complex would be losing its security. There was no date for the elimination of security beyond "at some point in June," and we didn't get any further communication from them despite multiple requests for clarity. Each day we wondered, "Is this the last day that we have security? Are they going to unlock the ICU doors?"

**EDITORS: How have these layoffs affected healthcare workers and their ability to provide care?**

**AMANDA:** Our security team's last day was June 22. Before that, we had security staff for the ICU daily from 8 a.m. to 11:30 p.m. They would come in each morning and get a roster of patients and a list of the nurses and their phone numbers from the charge nurse, and they'd ask, "Is there anything we need to be concerned about?" Sometimes we'd have agitated patients, a tense family situation, or a private patient who needed to be protected. So they would get oriented before visiting hours started.

One of the most important things the security staff did was manage visitor access to the ICU. Visitors at the bedside are extremely important because they can have positive effects on both patients and loved ones,[2] and we allow visitors most of the time—but we still have to consider safety and our patients' needs. We have a locked, secure unit, and we don't allow visitors during morning and night shift changes except under very select circumstances. We only allow two visitors at a time per patient, and sometimes we don't allow them at all if there are procedures happening or if the patient doesn't want visitors. So having the security team there to help manage access was huge.

Our security staff was well-known and had a great presence. They helped people who were waiting and anxious to understand the rules and the process. And their presence let people know that this was a space where we maintain respect, where the rules are followed, and where people behave appropriately. The ICU is a stressful environment for everyone. Some visitors don't think the rules should apply to them, and they try to sneak in or won't leave when asked. We frequently have patients who are victims of crime or have active police investigations, situations where we need to be especially careful about managing patient information and access. And sometimes patients are agitated or aggressive, and we need security to assist healthcare staff. They were well-trained and always exhibited calm, respectful professionalism, often working to build genuine rapport with patients. They really were a key part of our team.

It's shocking that PeaceHealth would make these cuts and, from my perspective, potentially endanger our patients and staff in the ICU and women's complex—two areas where the need for security has recently been highlighted in tragic ways.[3] Management's announcement to us didn't include any plan to address this major change in our daily operation. When we asked what we were supposed to do, they gave us a form to post the phone numbers of the nurses covering each patient's room. Now when visitors come, they dial the nurse's number from the waiting area phone, and the nurse is expected to make the determination and escort visitors in. If they can't answer the phone, the call goes to the unit phones, and sometimes it gets forwarded to the charge nurse phone, which is used for all kinds of patient care tasks. Every time someone interrupts that, they're interrupting patient care. If we need security, we now have to call dispatch; they'll send somebody up from wherever else they're working, like the ED. So we're all basically winging it. The nurses are increasingly frustrated, and we all feel less safe.

**JODI:** Our contracts allow members subject to RIFs to fill open positions in the hospital or to take severance, so about half of the people who were laid off were reabsorbed into other hospital departments. But the folks who stayed and the folks who lost their jobs are all devastated. I have seen a lot of tears from people making these tough choices about what to do with their lives.

The employer has really shown carelessness throughout this process. For example, we negotiated stronger severance packages in impact bargaining, but at no point during that bargaining did PeaceHealth disclose that in order to receive the healthcare benefit continuation, people would have to elect for COBRA,

which PeaceHealth would pay a portion of. Instead, people were told at their doctor's offices that they didn't have insurance and would have to pay out of pocket. I've spent hours on the phone with people who didn't know how they were going to pay for their surgery or their child's dental checkup. When we asked HR how this happened, they didn't have any answers. They just didn't do what they were supposed to do, and they treated people like they were disposable.

That's also how they're treating the staff who are trying to keep these departments running without essential team members. PTSs are certified nursing assistants (CNAs) who work as coordinators in the nursing units and can be an extra pair of hands when needed. The coordinators were the information hub of the ED. They coordinated every single phone call and page for physicians. Instead, management expects the ED techs to cover the eliminated positions. Other staff have similarly been asked to do additional duties on teams where there have been cuts. When we asked management how they expect staff to do all of that additional work on top of their usual assignments, they offered to post a relief position. How is one relief position supposed to fill all of the gaps? They also suggested nurses can perform these tasks—but that's our bargaining unit work. Nurses should be at the bedside, working in their scope, not sitting behind the desk taking phone calls. Management is using our passion and compassion for patient care and our coworkers against us, and people feel very defeated.

The effect on patients is serious, too. Within the first week without our mobility aides, we had two patient falls that I'm aware of, which is a significant increase. And there is a snowball effect from other cut services, like the diagnostic imaging library night shift. Without that position, you can't get images pushed through to transfer a patient to another hospital or access images during system downtime for computer upgrades (which typically happens at night). In other departments, it's the unit coordinators and PTSs who knew the procedures that kept those units functioning during computer downtime, which can last for four or five hours. Cutting staff who know those downtime processes can compromise and delay patient care, with negative outcomes that can include a sentinel event. But all PeaceHealth corporate sees is numbers, and they're eliminating staff without understanding the effects of these decisions.

**DAWN:** Our contract language also allows RNs who have been laid off to fill open positions in the hospital, so fortunately we were able to place the RNs who wanted to stay in other departments. But the layoffs still tore apart nurses' entire professional world. When you work on a unit, you get really close to your team, and it's hard for that to be abruptly ended.

And it's not like those units aren't needed. The same-day surgical overnight unit would hold patients if the surgical floors were full, and they handled pre- and post-op tasks and discharge for patients whose procedures or recovery extended into the night shift. Management assumes that our post-anesthesia care unit nurses will take on those post-op and discharge duties, but that will require training and education because these nurses usually just recover patients and send them to the same-day unit.

The observation unit cared for patients who were expected to stay fewer than 24 hours in the hospital; they prioritized those patients and made sure their imaging and other tests were done quickly so the patients could either be sent home or switched to inpatient status if a longer stay was needed. Now everyone will need to be educated about the difference in priority. We don't want anyone sitting in the ED for 13 hours waiting for an x-ray or CT when we could have gotten them home.

Closing those two units was bad enough, but we've also lost the PTSs, mobility aides, and others who provided vital patient support on multiple units. For example, mobility aides help patients when nurses are triaging patient care, and they make a crucial difference in patients keeping their ability to walk and getting stronger to go home instead of to a facility or community partner. When that staff is taken away, nurses are forced to run from task to task instead of being person focused, and patients notice the difference. If I don't see my patients often enough to get to know them, I can't pick up on the subtle changes that tell me they're having respiratory compromise or that something else is going on. We're just reactive, and that makes it harder to care for patients and for ourselves. How can we take meal and rest breaks without the support we depend on to make sure patients are safe while we're off the floor?

Many of our nurses are concerned there will be more reductions. Hospital administrators don't have to tell us their intentions, but hearing in staffing committee meetings that they were happy it was only 1 percent makes it seem like more layoffs could be coming. That has a terrible effect on morale for everybody, but especially for our early career nurses. As a new nurse, you're trying to absorb and learn everything and get comfortable in what you're doing, which can take years—plus you're worried about student loans and other things. Adding anxiety about job stability makes all of that more stressful.

**"Management is using our passion and compassion for patient care and our coworkers against us."**

**–JODI ATTEBERRY**

**EDITORS: How are your unions addressing these problems?**

**DAWN:** All of our nurses buttoned up in support of our OFNHP brothers and sisters. Some of the ED staff had worked at the hospital for decades—the most senior PTS had been there for 45 years. That role and expertise were critical to the operation of the department. We need management to know that. And we're encouraging members in units with reductions to file

assignment despite objection (ADO) forms. Those forms go to the WSNA co-chairs, the manager, and our chief nursing officer in real time. We need to know, and we need management to know, how these layoffs are impacting work and patient care.

We're also taking advantage of the protections in our new staffing law. We were required to submit staffing matrices to the state Department of Health in January, and any changes to those matrices must be approved by 51 percent of the staffing committee. Failure to comply leads to financial penalties. Our previously approved matrices included some of the support staff roles that were eliminated, and when the staffing committee met in July, we had difficult conversations with management about the changes they wanted to make. We voted on one of the areas where the PTSs were cut, and the proposed matrix did not pass. It was a clear statement that we did not think it was a safe decision. Their plan laid off people in positions that they're required to staff to be in compliance. We have also filed a complaint with the Department of Health for laying off caregivers who were part of submitted matrices without first presenting the plan to the staffing committee for a vote. Of course there are roles that aren't included in those matrices, like the educators on all our units. There are a lot of staff members who make sure we all have a safe place to work, and the employer could decide to lay them off any time.

**JODI:** We began impact bargaining right away. We bargained for 21 hours to get additional benefits for our members, including the pro unit and the social workers, whose contract was still being negotiated. We made sure they had a seniority roster and that they would get standard severance and consideration as inside candidates for five months. We're still sorting out the medical benefit continuation. And we are working with the AFL-CIO to get members help with unemployment and educational opportunities and continuing to meet with the members who elected severance to support them through this horrible process.

We've filed grievances for staffing law violations and are working with WSNA to make sure the staffing committee is aware that the people in those eliminated positions are essential to their areas and to the function of the hospital. And we're continuing impact bargaining for our members who are being asked to take on additional work. PeaceHealth's mentality is that ED technicians can assist with secretarial duties, but that's not their role or training, and it's not what they were hired to do.

In the meantime, I have told my members that we can't enable PeaceHealth's gross misconduct by trying to pick up all the slack. This is a problem PeaceHealth created; it's not OFNHP's problem to solve. We work to scope, we don't skip breaks or lunch, and we don't take on extra work to enable their greed. Something has to give, and it can't be healthcare workers' well-being.

**AMANDA:** We also filed a grievance in mid-June because our contract has provisions that specify a process for this kind of change—including, for example, consulting the unit-based practice committee about safety impacts. If PeaceHealth had come to us in advance, we could have presented a case for keeping security or at least proposed a plan for going forward without them. The grievance included a request for information about security and safety events and related data for the ICU and the women's complex. We received some information back, and we plan to meet with hospital management soon to discuss it further.

Along with several other people, I also wrote to the director with our questions. I got the impression that he didn't understand the essential role the security staff played. After the layoff announcement, we asked security staff to log their calls; between 8 a.m. and 4 p.m., the guard would take more than 100 calls. We told management, "This is the work you're now pushing onto nurses." It seemed like they had no idea.

Now those calls are being directed to nurses or going unanswered. If our other work is done, we'll try to step in, but patient care always comes first.

Families are seeing the difference. We have had some families of ICU patients complain, and we've encouraged them to contact the hospital's risk management team or the Oregon Health Authority with their frustrations. Sometimes it takes a long time for a nurse to be able to leave the ICU to bring visitors in. I just tell families the truth: we used to have dedicated staff to do this, but now it's on the nurses. Many of our patients' families have been reasonable, but sometimes they are already angry and scared when they come in, so long waits with very little information can lead to trouble. We don't have trained security guards in the waiting room who can see trouble starting, so when a nurse comes out to get a visitor and walks into something volatile, I have serious concerns that someone is going to get hurt.

**"How can we take … breaks without the support we depend on to make sure patients are safe?"**

–DAWN MARICK

**For the endnotes, see aft.org/hc/fall2025/atteberry_marick_stout.**

# Economic Inequality Threatens Democracy

In the mid-20th century, democracies around the world were descending into authoritarianism—descents sparked by military coups. Today, military coups have become much less common, yet the threats to democracy have not abated. They now come in a different form: democratic erosion (also known as democratic backsliding).

Democratic erosion is a process by which elected leaders gradually dismantle democracy from the inside, aggrandizing executive powers and weakening institutions of accountability. Backsliding leaders harass the press, reduce the independence of the courts, defy legislative oversight, and undercut the public's confidence in elections. In recent years, democracy has eroded in countries as varied as Brazil, Nicaragua, the Philippines, Poland, South Africa, Turkey, and the United States.[1]

Studies of democratic stability during the era of coups told us that wealthy and old democracies were the most resilient.[2] And yet, the United States—the world's oldest democracy, and one of its wealthiest—has shown new cracks in recent years. In 2016, the country elected a president who routinely attacked the free press, threatened to jail his political opponents, and expressed a consistent disdain for democratic norms in both his words and actions. He undermined confidence in elections by continually insisting that electoral fraud was widespread. When he lost the election in 2020, and even when he won the election but lost the popular vote in 2016, he maintained that the elections had been engineered through massive fraud.

During Donald Trump's first term as president of the United States, many debated whether his election—and his subsequent eroding of democracy—was merely a fluke or something with more structural roots. Older models of democratic decay, which pinpointed low levels of economic development and a recent transition to democracy as risk factors, did not square with American democracy being in jeopardy. Indeed, some scholars argued that the threats to US democracy were overstated. Just two years ago, one model suggested that the "probability of democratic breakdown in the US is extremely low" and estimated that in 2015, US democracy faced less than a 1 in 3,000 chance of degrading to the level of Hungary.[3] Viktor Orbán's government in Hungary has eroded judicial independence, consolidated control of media outlets to promote propaganda and suppress dissenting voices, taken control of state universities, and changed electoral laws to favor his Fidesz party. At the same time, his government has targeted asylum seekers and LGBTQIA+ individuals, and corruption has skyrocketed.[4]

Our research shows that recent democratic decay in the United States is not a fluke—and the risk of further democratic decline is serious. Although the United States is often thought to be immune to democratic instability, it is not an outlier among countries experiencing democratic backsliding. In fact, it looks a lot like

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ILLUSTRATIONS BY ADRIÀ FRUITÓS

**Recent democratic decay in the United States is not a fluke.**

other eroding democracies in the 21st century. Today, the key structural factor that predicts democratic erosion is not wealth or economic growth or the age of the democracy: it is economic inequality. Highly unequal democracies are far more likely to erode than those in which income and wealth are distributed more equally.

## Predicting Erosion

Where and when does democracy erode? The first step in answering this question is determining what features qualify a democracy as "eroding." How do we distinguish between system-threatening executive aggrandizement (attempts to erode democracy) and more conventional executive overreach of the sort that could happen in any democracy? Recently, scholars have identified cases of erosion by tracking trends in horizontal and vertical accountability.[5] A healthy democracy depends on heads of government—presidents and prime ministers—being constrained by voters (providing vertical accountability) and by the courts and the legislature, among others (providing horizontal accountability).

Expert surveys carried out by the Varieties of Democracy project allowed researchers to identify 23 distinct periods of erosion in 22 countries between 1995 and 2022. These countries are Benin, Bolivia, Botswana, Brazil, the Dominican Republic, Ecuador, Hungary, India, Mexico, Moldova, Nicaragua, North Macedonia, the Philippines (twice), Poland, Senegal, Serbia, South Africa, Turkey, Ukraine, the United States, Venezuela, and Zambia.[6]

What differentiates countries that have experienced erosion from those that have not (such as Canada, Finland, and Portugal[7])? Are there factors that tell us that a democracy is more at risk of backsliding in one time period than in another? To answer these questions, we analyzed data from democracies around the world. We included information that generations of researchers have demonstrated help to predict military coups, including national wealth (gross domestic product per capita) and the age of the democracy (the number of years since a country became democratic and remained so, without interruption). We also included measures of economic inequality (including disparities in income and wealth). Inequality was not a highly reliable predictor of democratic vulnerability in the 20th century, when the threat was mostly military coups. But the connections (discussed below) between inequality and partisan polarization, and between inequality and public skepticism about institutions, made us suspect that democracies with especially big gaps between the rich and the poor might be prone to eroding.

We also suspected that backsliding by leaders is, in a sense, contagious. Backsliders often draw inspiration from other such leaders around the world. Hugo Chávez, for example, began his first term in 1999 by orchestrating a rewriting of the Venezuelan Constitution; his tactic was adopted by Latin American leaders who would erode their own democracies, such as Ecuador's Rafael Correa in 2008 and Bolivia's Evo Morales in 2009. Viktor Orbán began his drive to undermine Hungarian democracy in 2010. President Trump openly admired Orbán in 2019 when the two met; he claimed the Hungarian leader as his "twin."[8] On January 8, 2023, supporters of Brazil's recently defeated president, Jair Bolsonaro, stormed the National Congress, Supreme Court, and presidential palace, convinced that the election had been "stolen" from Bolsonaro. The insurrection bore a striking resemblance to the January 6, 2021, riots by Trump supporters in the United States. The implication is that over time, erosion becomes increasingly likely: for each democracy that erodes, other aspiring autocrats around the world have more examples to draw from to undermine democracy.

Our analyses of these international data produced a consistent picture. In the 21st century, the key feature that distinguishes eroding democracies from those that hold strong is economic inequality. Income inequality is a highly robust predictor of where and when democratic erosion will take place. So is inequality in levels of wealth—that is, differences not just in income but in people's overall economic assets. Either way, in more than 100 statistical models we ran, inequality was consistently related to the chances of erosion.

Some of the factors that had been shown in prior research to predict coups were less important in predicting democratic backsliding by way of power-aggrandizing elected leaders. National income per capita played a role but a smaller and less consistent one than inequality. And being an old, long-established democracy did little to protect democracies from the recent wave of erosion. By contrast, in the 20th century, older democracies were virtually immune to being toppled in military coups.

The figure on page 15 illustrates the relationship between income inequality and the risk of erosion. Where income inequality is low, the predicted probability of democratic erosion is near zero. But where inequality rises, the threat of erosion skyrockets—reaching a 30 percent chance in the most unequal democracies.

For the estimates presented in the figure, we measure inequality with the Gini coefficient. The Gini coefficient takes a full distribution of incomes (or assets when examining wealth) in a given population and summarizes the level of inequality with a single number: higher values indicate greater inequality. In brief, we calculate it by ordering individuals in a population from lowest to highest income, then measuring the cumulative share of income earned by the bottom X percent of the population. In a situation of perfect equality, this cumulative share of income would be equivalent to the share of the population (50 percent of the population earns 50 percent of the total income, 95 percent of the population earns 95 percent of the total income, etc.). The Gini coefficient measures how

much the actual income distribution deviates from this situation of perfect equality.*

This finding—that inequality robustly predicts democratic erosion—is not sensitive to the particular measure of inequality we use. In the figure, we looked at actual income after taxes and assistance from social safety net programs (like the Supplemental Nutrition Assistance Program), but the results were similar when we looked at wealth inequality and at the share of wealth or income concentrated among the top 1, 10, or 50 percent of the population. Across each of these metrics, higher inequality is associated with a higher risk of erosion. The greater the share of income going to—or wealth controlled by—the top 1 percent (or the top 10 or 50 percent), the greater the likelihood of backsliding.

## Inequality and Polarization

Having observed that unequal countries are more prone to erosion, what are the mechanisms linking inequality to erosion? Why are unequal democracies more likely to erode? One of the key factors is polarization.

Specifically, there is great risk in *affective polarization*, a phenomenon in which individuals grow to detest members of opposing political parties.[9] A central feature of affective polarization is that political identities become social identities. This is distinct from, say, *ideological polarization*—a measure of how far apart two parties are on policy positions. In an affectively polarized society, political affiliations take on a larger role in interpersonal relationships. People sort themselves into opposing camps and might be unwilling to engage with those who identify with a different party—or might engage with hostility. Politics becomes increasingly insular, and elections are often characterized by the fear of a despised opposing party coming to power.

Comparative research documents a robust relationship between inequality and polarization, both at the subnational level and in large cross-national studies.[10] Countries with more unequal distributions of income have more polarized societies than those with more equal distributions of income; citizens living in US states with particularly high levels of inequality are more polarized than those living in states with less stark economic inequality.

In highly unequal settings, leaders can cultivate a sense of grievance among citizens who feel they have been left behind. Sometimes that grievance is aimed at economic and social elites; other times, at migrants and ethnic, racial, or religious minorities.[11] Political leaders in countries like Turkey, Venezuela, and the United States have taken advantage of long-term inequality to exacerbate "pernicious polarization" among the "left-behinds."[12]

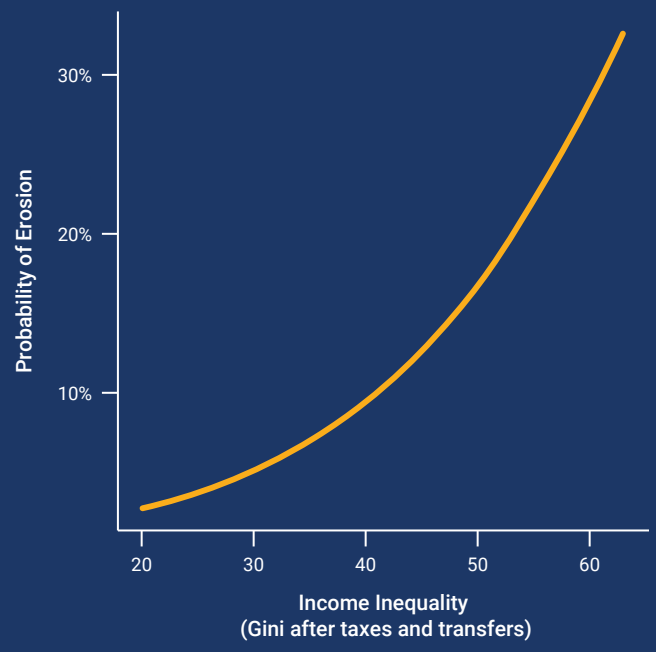
Polarization, exacerbated by economic inequality, makes democracies more vulnerable to backsliding. Voters who live in highly polarized societies are often more tolerant of attacks on democratic institutions. When facing "acute society-wide political conflicts," the stakes of elections grow.[13] Aspiring autocrats leverage this situation to gain power: they present voters with a choice between safeguarding democracy or avoiding the presumably dire consequences that would follow a despised opposing party coming to power. Voters thus face a tradeoff between the cost of undesirable election outcomes and the value of democracy. As politics grows more polarized, the cost of undesirable outcomes rises and begins to outweigh the value of safeguarding democratic norms.

### Tear It All Down

Polarization plays a central role in democratic backsliding, yet it's not the only factor. In fact, democracy is on the defensive even in countries where parties are weak and few citizens identify with a political party. Even in the absence of partisan polarization, democracy is vulnerable to erosion if citizens place little value on protecting their current democratic institutions (or, in some cases, actively wish to see them dismantled).

**Income and wealth inequality are highly robust predictors of where and when democratic erosion will take place.**

## Income Inequality and Democratic Erosion




*Here are additional details to visualize what the Gini coefficient means. We first order individuals in a population from lowest to highest income. We then create a graph, marking on the x-axis the cumulative share of the population (following this lowest-to-highest-income ordering) and on the y-axis the cumulative share of income earned by the bottom X percent of the population. If there were perfect equality, the graph would show a 45-degree line (x = y): for any value X, the "bottom" X percent of income-earners receive X percent of the total income. Next, we draw the line of perfect equality and the curve representing the actual income distribution (where the bottom 95 percent of the population might only be earning, say, 60 percent of the total income)—this is called the Lorenz curve. The Gini coefficient is a measure of how far the Lorenz curve falls below the line of equality (we calculate the area between the Lorenz curve and the line of equality as a proportion of the entire area below the line of equality).

**In highly unequal settings, leaders can cultivate a sense of grievance among citizens who feel they have been left behind.**

When voters come to see, or can be led to see, their institutions as deeply flawed, a kind of cynicism can set in. Voters in effect ask themselves, "Why rally to the defense of institutions that are ineffective or corrupt?" When democracy fails to deliver positive outcomes for individuals, they grow more receptive to the appeals of aspiring autocrats who denigrate democracy. Put another way, when the game seems "rigged" in favor of the ultra-wealthy elite, why bother playing by the rules anymore? We call this public mood *institutional nihilism*, which we define as the belief that a democracy's current institutions are incapable of solving critical problems. This is often expressed in a desire to "tear down" or "burn down" existing political institutions and start over with something else.[14] In theory, this inclination could lead to a push for a more fair and democratic system—tearing down the institutions that foster systemic inequality and replacing them with new institutions that generate more equal opportunities for all citizens. But in practice, institutional nihilism is often wielded effectively by aspiring autocrats who promise to tear down the current system without presenting any clear plan for something better.

Why might people living in unequal societies be prone to institutional nihilism? Rampant inequality lends itself to a sense that the economic system is unfair. Those who are struggling see others thriving. The problem, then, is not that there isn't enough to go around; it's that the system is generating an unfair distribution of resources and opportunities. And if the rules are unfair (in the economic system), then why bother following them (in politics)?

Research shows that people who view inequality as the result of hard work or ability tend to view it as fair;[15] however, when inequality is very high, people tend to see it as unfair, and it undermines people's belief that they live in a meritocracy.[16] High inequality also tends to reduce upward economic mobility.[17] The scant prospects for upward mobility amid high inequality further contribute to a sense that the economic system is unfair and not meritocratic.[18]

The rhetoric of backsliding leaders leverages these feelings of unfairness and grievance. They frequently denigrate their countries' institutions with interpersonal comparisons, noting that the rich and powerful take advantage of ordinary citizens, getting rich at their expense. In the 2016 US presidential race, Trump complained that "the people getting rich off the rigged system are the people throwing their money at Hillary Clinton."[19] In the context of a drive to undermine the credibility of Mexico's electoral administration body, former President Andrés Manuel López Obrador accused it of enjoying "privileges" and "extremely high salaries." In a similar drive against the courts, he complained of having "one of the world's priciest judicial systems and one of the most inefficient. We're wasting citizens' taxes on a broken system."[20] According to backsliding leaders, institutions are failing because they are controlled by corrupt and nefarious actors who are indifferent or hostile to the interests of regular citizens.

Just as polarized constituents may reason that attacks on democracy are justified if they are necessary to keep the hated opposition out of power, nihilistic constituents may reason that attacks on democracy are justified given how flawed their democracy is in the first place. When backsliding leaders go after the courts, the press, the civil administration, or the electoral authorities, they can claim that they are not in fact harming a healthy democracy. Whereas autocratizing leaders' polarizing rhetoric carries the implication that the capture of power by opposing political parties would be catastrophic, their democracy-denigrating rhetoric implies that the state is already corrupt and incompetent.

As a candidate for Brazil's presidency in 2018, Jair Bolsonaro claimed that the Workers' Party "has plunged Brazil into the most absolute corruption, something never seen anywhere [else] in the world."[21] Trump, similarly, drew a dire picture of the Democratic Party in 2018: "The Democrats have truly turned into an angry mob, bent on destroying anything or anyone in their path.... The radical Democrats, they want to raise your taxes, they want to impose socialism on our incredible nation, make it Venezuela.... They want to take away your health care.... Destroy your Second Amendment and throw open your borders to deadly and vicious gangs.... Democrats have become the party of crime."[22] And in 2023, Mexico's then-President López Obrador regularly excoriated institutions, such as the federal courts, to convince the public that they were not worth saving. He asserted that Mexico's courts were "riddled with inefficiency and corruption," "taken over by white-collar crime and organized crime," and "rotten." He also attacked the people working in the judiciary, saying that they were "often influenced by money and grant protection to criminals" and were "not people characterized by honesty."[23]

## What's Next? And What Can Be Done?

Do eroding democracies necessarily end up as dictatorships? That has not been the case thus far. Some countries have started out as democracies, undergone a process of erosion, and ended up as full autocracies. One sign of this decay is that they end up as countries in which heads of government are not chosen in free and fair elections. Such was the trajectory of Venezuela. In 1999, it was certainly a troubled democracy, but a democracy nonetheless. A quarter-century later, the president of Venezuela, Nicolás Maduro, lost the 2024 presidential elections, probably in a landslide.[24] The regime claimed victory, Maduro remained in office, and his opponents are in prison and in exile.

Turkey is another country that at best teeters on the brink of full authoritarianism. Russia never became a full democracy but appeared headed in that direction, only to drift toward what is now a full dictatorship.

Yet this outcome is by no means inevitable. Backsliding leaders sometimes leave office, opening the way to a restoration of a better-functioning democracy. One route from power is by losing an election. In Poland, the conservative party (PiS) held control of the government beginning in 2015. Over the next eight years, PiS reduced the independence of the courts and the press and followed a series of strategies in the would-be autocrats playbook—but in 2023, PiS lost its parliamentary majority and hence its hold on power.[25] Depending on how far backsliding has gone, and on leaders' determination to cling to power even when they lose, backsliding leaders do not always respect the outcomes of elections. Trump tried to flout the outcome of the 2020 presidential election in the United States, and Bolsonaro did the same in the 2022 election in Brazil. In both cases, the courts remained sufficiently independent and respectful of the rule of law to stand up against these attempts.

Other backsliders have been forced out by their own political parties. This is what happened to the South African leader Jacob Zuma in 2018. His political party, the African National Council, forced him to resign.[26] Something similar happened in the United Kingdom in 2022. Prime Minister Boris Johnson had not taken his country fully down the path toward erosion. But he had sidelined the Parliament, reduced the right to protest, threatened unfriendly news outlets, and undermined the integrity of elections in the public's eye. His Conservative Party forced him to resign.[27]

Though these paths to ousting backsliding leaders appear distinct, they both boil down to these leaders losing popular support. Trump in 2020, Bolsonaro in 2022, and PiS in 2023 all commanded insufficient electoral support to stay in office. Zuma in 2018 and Johnson in 2022 were forced out by their parties because they were viewed as likely to lead their parties to defeat should they stay in office.

A critical question, then, is what leads the public to withdraw support from backsliding leaders? We saw that institutional nihilism and polarization—and behind these two factors, income inequality—shore up backsliders' public support. Do they leave power only when confidence in institutions increases, partisan polarization ebbs, and wealth becomes more equal?

Since such progress would presumably take hold only over long periods of time, it is fortunate that the answer to the question is no. Sometimes the public turns against presidents, prime ministers, and their governments in reaction to their attacks on democracy. The arbitrary exercise of power can put voters off, especially when times are hard. In the United Kingdom, voters, including Conservative Party voters, suffered greatly during the COVID-19 pandemic. When they became aware that their prime minister and people around him flouted the restrictions that they imposed on their constituents, the hypocrisy combined with the hard times led to a caving of support for the government.

Indeed, though studies of backsliding governments have emphasized polarization and loss of confidence in institutions, backsliding leaders are often evaluated on the standard metrics of performance, especially economic performance. Trump was hurt in his 2020 reelection bid by the pandemic and the economic travails that it brought in its wake. In turn, he was aided in his 2024 reelection by voter frustration with inflation and the high cost of living.

Still, social scientists have learned a great deal about how to de-polarize people and increase their confidence in democratic institutions. On the former, a polarized public views political identities as correlated with most other aspects of their lives. The hated "other side" likes different food, wears different clothing, has a different sense of humor, etc. In fact, research shows that polarized individuals have exaggerated views of how far apart they are from opposing partisans even on matters of public policy. Exposing people to those with opposing party identities has been shown to reduce their levels of mutual animosity.[28]

Exposure to accurate information can also boost people's confidence in democracy and its institutions. An experiment that showed people videos of protesters suffering postelection repression in authoritarian or backsliding countries made them more favorable toward measures that would strengthen democracy, even measures that were not closely related to freedoms of speech, assembly, or protest.[29]

We have also learned that backsliding leaders' disparaging statements about institutions can be neutralized by more accurate, positive statements. For instance, in one study, the researchers first exposed Mexican respondents to their president's caricatured account of the country's national election administration body, in which he claimed that it was utterly corrupt and sponsored mass voter fraud. They then exposed some respondents to a corrective statement that rightly noted the high international reputation of that body and its role in helping Mexico transition into democratic governance at the beginning of the 21st century. The rebuttal improved people's views of the election body, even those who were supporters of the backsliding leader's political party.[30]

Of course, in addition to positive messages and the correction of misinformation, there is a longer-term need for structural reforms. When institutions work badly, it is easier for leaders to claim that not much is lost when they tear them apart. And our research shows that, whatever the moral and economic arguments for more equal distributions of income and wealth, there is a powerful political argument. Improving income and wealth distribution turns out to be an investment in a resilient democracy. +

**Improving income and wealth distribution turns out to be an investment in a resilient democracy.**

For the endnotes, see aft.org/hc/fall2025/rau_stokes.

# The Trump Administration Is Trying to Wreck Our Democracy

## WE CAN FIGHT BACK


On June 14, more than five million people rallied in about 2,000 "No Kings" protests, including this one in Philadelphia.

By **Ruth Ben-Ghiat**

Ruth Ben-Ghiat, PhD, is a professor of history and Italian studies at New York University. She is the author or editor of seven books, including *Fascist Modernities* and *Italian Fascism's Empire Cinema*. Her most recent book is *The New York Times* bestseller *Strongmen: Mussolini to the Present*, and she publishes a Substack newsletter, *Lucid*, about threats to democracy. A winner of Guggenheim, National Endowment for the Humanities, and Fulbright fellowships, she is also an advisor to Protect Democracy and to various civil society and faith organizations.

We are living through historic times, when the global clash between democracy and autocracy is coming to a head. Authoritarianism is ascendent and now governs over 70 percent of the world's population.[1] The United States has become a key front of this struggle between tyranny and freedom, with President Donald Trump's administration taking unprecedented actions to transition America from a democracy to an autocracy.

My specialty as a historian is authoritarian leaders. As my most recent book, *Strongmen: Mussolini to the Present*, demonstrates through detailed analysis of 17 authoritarian leaders over the last 100 years—including Hungary's Viktor Orbán, Italy's Benito Mussolini and Silvio Berlusconi, Russia's Vladimir Putin, and the United States' Donald Trump—authoritarians share key traits and tactics. They capitalize on polarization, resentment, and uncertainty to take power, and then they stay in power with a toxic mix of propaganda, corruption, machismo, and violence.[2]

This essay focuses on the infusion of propaganda into education and attacks on medicine, science, and child welfare to underscore how the Trump administration seeks not only to destroy our political system of democracy in the present but also to create the conditions for future American societal decline. Educators, healthcare professionals, and activists in the United States have a special role to play in pushing back against this agenda.

### The Stakes of Our Authoritarian Moment

Authoritarianism may be defined as the expansion of executive power and the personal power of the head of state to the detriment of the independence of the judiciary and other branches of government. That way the executive becomes beyond the reach of law and, along with close allies, can plunder the workforce, the environment, women's bodies, and the economy.[3]

Since January 20, the Trump government has sought to crush democratic rights and institutions, intimidate the media and individuals who dissent from its policies, and destroy oversight and inspection mechanisms meant to hold government officials accountable.[4] It has in addition imposed a white Christian nationalist purity agenda with roots that go back to the fascist era.[5] That agenda entails detaining, disappearing, and disenfranchising the "wrong" people (nonwhite immigrants and US citizens[6]) and encouraging the "right" people to produce more children for the state.[7]

This sober summary does not, however, capture the Trump administration's ultimate goal: to wreck the United States as a democratic power so that the autocrats Trump is allied with can flourish. "If you have a smart president, they're not enemies," Trump said of Russia, China, and North Korea at a campaign rally in Virginia in June 2024. "You'll make them do great."[8] And how do you make them "do great"? By taking down their greatest adversary, a country with the world's most powerful military and an economy that at the end of 2024 was seen as "the envy of the world."[9]

The magnitude of this task is why the Trump administration has acted with dizzying speed on all fronts. In its first few months, the administration laid the foundations for the advent of mass distress, hardship, and disease. Wrecking the state by authorizing Elon Musk's so-called Department of Government Efficiency to colonize and impede the operation of federal agencies; banning books; pulling federal funding from research; abandoning established public health and medical protocols; and defunding disaster response, climate crisis mitigation, and humanitarian and social assistance to children, the elderly, and other vulnerable populations.[10] All of this will set the United States back decades.

PHOTO © LISA LAKE / STRINGER / GETTY IMAGES

Authoritarians think big and long term. What the war on education and the war on medicine, science, and child welfare have in common is that both degrade the population of the future, creating the potential for America to become a second- or third-rate power.

## The War on Education: Gaining Power Through Propaganda

To understand why education is targeted by authoritarians, we need to view propaganda in a broader frame. It's about not only getting people to believe individual lies—say, that Jews are taking over the world or that Trump won the 2020 election—but also changing the public's worldview on many subjects. That's why basic concepts of diplomacy, health, and education take on new meanings as a country loses its democracy and the "upside-down world" of authoritarianism comes into being.[11] In that world, lies become official dogma, and truth-tellers and those who labor on behalf of the enlightenment and well-being of humanity—including educators, librarians, and journalists—are discredited, locked up, or killed.

This view of propaganda as a way to influence behavior and thought means that autocrats don't just shut down intellectual freedom and change learning content to reinforce their ideological agendas. They also remake educational institutions into places that reward intolerance, conformism, suspicion, and other values and behaviors authoritarians require. Far from being "ivory towers" closed off from society, educational institutions are often frontline targets of those who seek to destroy democracy. What happens in and around classrooms reflects—and often anticipates—transformations of societies as authoritarianism takes hold.

The regime of Italy's Benito Mussolini (1925–43) provided the template for right-wing authoritarian actions against faculty, staff, and students deemed political enemies.[12] Leftists, liberals, and anyone who spoke out against the fascists were sent to prison or forced into exile. Since most schools and universities were public, most professors and researchers were civil servants and could be pressured through bureaucratic means. First came a 1931 loyalty oath to the king and fascism, then a 1932 requirement to join the National Fascist Party to apply for jobs or promotions. Student informers monitored their peers and teachers, recording any critical remarks or anti-regime jokes, and new student organizations inculcated fascist values.

In the Cold War era, Chilean dictator Augusto Pinochet, who seized power through a 1973 US-backed coup, claimed that universities were hotbeds of Marxism and targeted them for "cleansing."[13] This entailed the closure of ideologically objectionable departments, such as philosophy, and the purging of tens of thousands of students, faculty, and staff in the first few years of the regime (thousands were also sent from universities to prison, as were many other Chileans). Under this military dictatorship, civilian university rectors were replaced with military officials. Air Force General César Ruiz Danyau announced his arrival as rector of the University of Chile in Santiago by parachuting onto campus. The public school system was starved of funds and, in tandem with the neoliberal economic policies* introduced in Chile, was partly privatized, leaving the very poor without means of education.[14]

Today's right-wing autocrats mostly come to power through elections and extinguish freedom slowly, as Viktor Orbán has done in Hungary. Yet, the education sector continues to be the target of leaders who seek to eradicate free thinking and turn campuses into sites where surveillance by the state, through the presence of student, faculty, and staff informers, creates an environment of mistrust and fear. Like his fellow far-right strongmen, Orbán aims to discredit and dismantle all liberal and democratic models of education to produce a new authoritarian-friendly population. As someone who grew up under communism, Orbán knows the power of political socialization. He also knows that universities have always been sites of resistance to authoritarianism, and so he has placed some universities under the authority of "public trusts" run by his cronies.[15]

The crusade of Trump and the Republican Party against LGBTQIA+ representation in educational materials has a precedent in Hungarian policies. A 2018 ban on gender studies preceded the end of legal recognition of transgender and intersex people in 2020.[16] In 2021, a law outlawed any depiction or discussion of LGBTQIA+ identities or sexual orientation.[17]

This was followed by a crackdown on *anyone* in the educational sector who dissented from the state. A 2023 measure dubbed the "revenge law" has punished teachers, staff, and students who protest against low pay and disappearing intellectual freedoms.[18] These people have been protesting because Orbán has slowly defunded public education, subtracting 16 percent from its budget over the past decade, while Hungary already has a dire teacher shortage.[19]

This law, which Hungarian opposition politician and European Parliament member Katalin Cseh called "a brutally oppressive tool" to elicit "compliance with a police state apparatus designed to silence them," has placed educational policy under the jurisdiction of the Ministry of the Interior, which is also in charge of law enforcement.[20] It allows the state to monitor teachers' laptops and video-record their classrooms. No wonder a protest in front of Hungarian Parlia-

**In the "upside-down world" of authoritarianism, lies become official dogma, and truth-tellers are discredited, locked up, or killed.**


**After David Huerta, a California labor leader, was arrested in Los Angeles while protesting an immigration raid, demonstrators in Washington, DC, demanded his freedom on June 9.**

PHOTO © ALLISON BAILEY / NURPHOTO VIA AP

*See "Neoliberalism, Inequality, and Reclaiming Education for Democracy," an article that defines neoliberalism as "capitalism on steroids" and describes how it increases inequality, in the Fall 2025 issue of the AFT's *American Educator*: aft.org/ae/fall2025/kraus.

ment spelled out the word "future" in melting ice.[21] Educators and their students see their possibilities vanishing, and thousands of teachers have resigned.

Hungary matters because its policies directly inspired the educational and other precepts of Project 2025 (the far-right policy playbook that the Trump administration is following[22]) as well as US state-level efforts to re-engineer education in an authoritarian key. In Florida, Governor Ron DeSantis has been influenced by Orbán's policies regarding the press, LGBTQIA+ individuals, and education. The remaking of Florida's New College as a model of far-right pedagogy* takes a page from Orbán's crusade against Central European University, which had to move from Budapest to Vienna to continue operating. In 2023, a Florida House bill would have barred Florida's public colleges and universities from offering gender studies, critical race studies, and queer studies—and an ambiguous version of that bill, designed to stand up to legal challenges and strike fear in educators, became law.[23]

"Florida could start looking a lot like Hungary," commented Michelle Goldberg (a *New York Times* opinion columnist) in 2023.[24] The Trump administration has been able to move quickly with federal-level action in 2025 because states such as Florida have been testing grounds for the removal of DEI (diversity, equity, and inclusion) from educational curricula and policy. Now the entire United States could follow the Hungarian model, but on a far more destructive scale, starting with Trump's executive order to abolish the US Department of Education.[25]

## The War on Knowledge: Discrediting Librarians and Teachers

To speed the transition to autocracy, it helps to discredit authorities associated with public spaces, such as libraries and schools, that encourage intellectual curiosity and democratic values. This is why public and school libraries, along with librarians and teachers, are always targeted by authoritarian parties and governments.

**Autocrats have no interest in public welfare, "good governance," or governance at all.**

Public libraries and public schools are places where people of all backgrounds, political beliefs, and economic situations gather. Libraries have long been cited by social scientists as spaces that bolster civic life and encourage community: they combat polarization, disinformation, and isolation.[26] School and public libraries also have long provided refuge to people of all ages with difficult home situations, and librarians and teachers can become trusted mentors and guides. This can bring them into conflict with authoritarian parties and governments that wish to indoctrinate youth, extend their control over the family, and discourage independent and critical thinking. That's why whenever authoritarians are ascendent, and books become threatening objects, authority figures who recommend and read books are singled out for harassment or worse.

In the United States, myriad state laws and book bans seek to remove the history of white racism, slavery, and fascist genocides as appropriate subjects of study, along with writings about LGBTQIA+ identities and experiences—particularly from school libraries.[27] Carolyn Foote, a retired Texas librarian and co-founder of the advocacy group FReadom Fighters, notes that when school districts pull books off shelves without following a clear process for reviewing them, they are "breaking that contract of trust" with parents, teachers, and students and degrading professional ethics.[28] The authoritarians' goal is not just to create a hostile work environment for library and teaching staff but also to pressure administrators to submit to corrupt tactics such as banning books on spurious grounds and accepting slanderous speech used against their colleagues.

For the same reason, authoritarians organize personal attacks on library employees and teachers, such as accusations that they are "groomers" who encourage inappropriate behaviors and relationships with the children they serve.[29] It also lies behind the frightening attempts to criminalize librarians.[30] In Clinton Township, New Jersey, in 2022, the police department received a request for criminal charges to be brought against librarians whose institution had a book with "obscene" content.[31] This, too, is an imported tactic. The attempt to associate LGBTQIA+ individuals and their allies with pedophilia is an established strategy among the global right, including in Orbán's Hungary.[32]

Unsurprisingly, many librarians have left their jobs, either resigning or being fired for refusing to remove books from their collections.[33] In some small towns, like Vinton, Iowa, the consequences have been serious indeed: the Vinton library endured the now-usual attacks by activists objecting to its LGBTQIA+ staff and its displays of LGBTQIA+ books, and the library itself has had to close for lack of staffing. "We couldn't function correctly as a library," former Vinton Library Director Janette McMahon said about why she left her job.[34] Undermining and discrediting institutions such as libraries and exhausting those who stand up for professional ethics and pluralism are how you degrade democracy.

Authoritarian claims on children are also why librarians and teachers are subjected to attacks from "parental rights" advocates. During Joe Biden's presidency, far-right parents promoted parental rights to discredit schools seen as incubators of democratic values and common-sense public health protocols (masks and vaccines against disease).[35] For Mike Pompeo, who served as secretary of state during Trump's first term, parental rights was a bludgeon to discredit teachers' authority and disenfranchise them from decision-making. "I think parents should decide what their children are taught in

Benito Mussolini, Italy's fascist leader from 1925 to 1943 (shown giving a speech in 1936), had student informers on college campuses.

PHOTO © PHOTO12 / ARCHIVES SNARK / ALAMY

*To learn about the attack on New College, see "Defending Academic Freedom" by Patricia Okker, New College's former president, in the Fall 2024 issue of *American Educator*: aft.org/ae/fall2024/okker.



**Left: Lighting a candle in 1998 to remember those who disappeared during the reign of Chilean dictator Augusto Pinochet. Above: Protesting attacks on Central European University by Hungarian Prime Minister Viktor Orbán in 2017.**

schools," Pompeo tweeted in October 2021.[36] Now that Trump is back in office, the parental rights crowd (which includes Vice President JD Vance) is backing privatization of schools and Christian homeschooling—anything to get children away from the multi-faith, multi-racial communities of public schools.[37]

## The War on Medicine, Science, and Child Welfare: Wrecking the United States' Future

Like the use of propaganda, much of what the second Trump administration is doing tracks with authoritarian tradition. Since the days of fascism and early communism, autocrats have wanted to reshape government and society in their own image.[38] This has meant destroying institutions as they have been understood democratically, giving them different purposes and staffing them with loyalists who do the bidding of the leader and close allies.[39]

Yet the Trump administration's crusade to wreck the United States' prestigious science, medicine, and research sectors, seemingly as fast as possible, is unusual within the history of authoritarianism. Science and medicine are almost always politicized as autocracies grow more extreme. The history of Nazi racial science and the Soviet practice of deploying mental health professionals to have dissenters committed to psychiatric institutions are two examples.[40] Yet most dictatorships proceed gradually in this area, and they often expand social welfare programs, including medical care, to win over the population—at least until state corruption and the costs of hiring incompetent loyalists to key administrative positions undermine service.

An administration *starting out* with a conspiracy theorist as secretary of Health and Human Services is uncommon. Also uncommon are the immediate planned destruction of child welfare programs, such as the Supplemental Nutrition Assistance Program, speedy bans on discussions of racial bias and other social determinants of health, and the resolve brought to pulling federal money for research and curtailing the work of America's most prestigious institutions, such as the National Institutes of Health.

While these attacks opportunistically play on lingering fear and resentment from the COVID-19 pandemic, they are also intended to undermine the concept of expertise. Physician Dhruv Khullar is correct to frame the damage this administration is doing to medical training and biomedical innovation as "subversion."[41] Engineering the isolation[42] of the country from beneficial circuits of trade and knowledge exchange that support medical and scientific research also harms American prosperity. Arresting international students and detaining foreign scholars speed the United States' removal from intercultural networks and educational and scientific collaborations.[43]

The degradation of public health and fact-based knowledge, along with state intervention in family politics, converges in the tragic attacks on child welfare being waged by the Trump administration.[44] There is no better example of this government's zealous efforts to wreck the United States' future than the aggressions directed at children's rights to learn and to grow up healthy and safe.

Two recent articles characterized this crusade as a "war on children," sharing stories of purposeful cuts to services that provide children with food, instruction, and medical care and protect them from exploitation, abuse, and neglect.[45] Even programs to investigate missing children are on the chopping block, as are children's services offices inside of the US Department of Justice as well as the US Department of Health and Human Services.

Research shows that government spending on children's health and on education "offer some of the highest returns on investment,"[46] but that only holds if your aims are democratic. The goal here seems to be to create multiple challenges to childhood development through exposure to disease, environmental pollutants, and gun violence, coupled with rescinding funds for care and protection, including Social Services Block Grant program funds. In the Trump administration's quest to produce a collective failure to thrive, no area has been neglected: even farm-to-school programs, which provide fresh meat and produce to schools, are at risk due to the administration canceling grants from the US Department of Agriculture.[47]

**President Trump signed the so-called Big Beautiful Bill on July 4, a cruel law that slashes funding for healthcare, food assistance, clean energy, public schools, and colleges to pay for tax breaks for the ultra-wealthy.**

PHOTOS: TOP LEFT © ROBERTO CANDIA / AP PHOTO; TOP RIGHT © ZOLTAN BALOGH / MTI VIA AP FILE; BOTTOM RIGHT © BLOOMBERG / CONTRIBUTOR / GETTY IMAGES

There is a logic that unites these measures: a holistic plan to destroy our nation so that its enemies—Russia's Vladimir Putin and China's Xi Jinping among them—can prosper. No wonder *The Economist* recently ran a story on how Trump could "make China great again" at America's expense.[48] The only parallels for this are measures imposed by leaders of puppet states that were created by foreign occupations; those leaders were often treated as traitors after those puppet states ended.

## Striking Back on Behalf of Democracy and Our Children's Futures

Although I have painted a grim picture in this essay, I am optimistic for the long term. In their authoritarian arrogance, the destroyers of America have not realized that a reckoning will come. In his first 100 days back in office, the president's popularity had already begun to sink.[49] We are in the early stages, but soon the real-world, everyday-life effects of the disruption and corruption perpetrated by this government will be impossible to ignore. This will start to open the eyes of many.

It will be Americans' turn to discover the hard truth that autocrats have no interest in public welfare, "good governance," or governance at all. They transform their public positions into vehicles for private enrichment and turn political institutions and the press into instruments for amassing so much power that they will not have to leave office. In the end, they are hated by the majority of the population. Many of them meet a bad end because, rather than promote collective well-being, autocrats produce mass suffering and sometimes mass death as well.[50]

Educators and healthcare professionals, who keenly feel the effects of corruption and politicization, can be vital communicators to the public of this hard-earned wisdom. And organizations such as the AFT and its thousands of affiliates can be key in the mass mobilizations to come, when enough Americans have understood the situation to participate in collective actions, whether that means a general strike or sustained nonviolent protest.[51] Educators and healthcare professionals can be on the frontlines as we take our country back from those who wish to silence and intimidate us while they make our children less informed and less protected from pathogens and predators.

More broadly, the history of resistance suggests that pro-democracy movements that claim the mantle of moral authority and show care and solidarity in the face of plunder and violence can have an impact. In fact, even a tiny percentage of the population—often just 3.5 percent, according to one study of successful civil resistance movements—can make a difference if they mobilize on behalf of democratic values in situations of tyranny.[52]

Creating a big-tent opposition movement that includes progressive faith traditions and organized labor—two sectors of civil society that privilege values-guided action—is key. Joining with others, we transform our individual righteous indignation into a potent moral force for good.

Other actions can take place at the individual level, such as having conversations with family and community members who support Trump and the MAGA movement and explicitly raising with them questions of dignity and decency and the ruination of our children's futures. As the government paralysis deepens and affects everyday life, these conversations will likely become easier.

Each time we show solidarity with others or support those who are protecting the rule of law, helping the targeted, or exposing lies and corruption, we are standing up for democratic values of justice, accountability, equality, and more. In doing so, we model the behaviors the authoritarian state wants us to abandon. This is especially important for those of us who work as educators and organizers alongside young people, who may look to us as mentors and moral guides. A reckoning will come for this corrupt and cruel administration; when it does, we can be on the right side of history. ✚

**For the endnotes, see aft.org/hc/fall2025/ben-ghiat.**

**In their authoritarian arrogance, the destroyers of America have not realized that a reckoning will come.**


**On April 5, people in New York City—and across the country—held "Hands Off" rallies to protest attacks by the Trump administration.**

PHOTO © ANADOLU / CONTRIBUTOR / GETTY IMAGES

# THE POWER OF SOLIDARITY

## OREGON NURSES ASSOCIATION'S HISTORIC WIN


On January 10, 2025, 5,000 frontline caregivers across 11 Oregon Nurses Association (ONA) bargaining units from eight Providence hospitals and six clinics went out on strike—the largest healthcare strike in Oregon history[1]—when contract negotiation efforts failed to produce agreements over wages, benefits, and staffing. One of the bargaining units was a group of hospitalists—physicians and advanced practice providers—and marked the first time in Oregon history doctors had walked a picket line. After 46 days, ONA secured a historic victory with agreements that included staffing plans to improve patient safety, substantial wage increases and bonuses to improve recruitment and retention, and stronger benefits.

To learn how ONA members organized to achieve these extraordinary wins, we spoke with leaders of four of the bargaining units represented in the strike. Richard Botterill, RN, is an emergency department nurse at Providence Portland Medical Center, the chair of his bargaining team, and a member of the ONA board of directors. Lesley Liu, MD, is an internal medicine and pediatric hospitalist at Providence St. Vincent Medical Center and a member of the bargaining team. Virginia Smith, RN, is a medical-surgical nurse at Providence Willamette Falls Medical Center, the chair of her bargaining team, and a member of the ONA board of directors. Breanna Zabel, RN, is a medical telemetry nurse at Providence Medford Medical Center, the chair of her bargaining unit, and a member of the ONA board of directors.

–EDITORS

**EDITORS: What challenges have you faced with Providence?**

**RICHARD BOTTERILL:** I joined Providence Portland in 2010, when it was still operated by the Sisters of Providence. They were much more interested in community health and in those who were caring for patients. When they retired and St. Joseph Health System came in—and eventually merged with Providence—the sisters' values supposedly still guided the organization's approach to healthcare delivery. But you could feel the difference as soon as you walked into the hospital. It was now all about money.

I also noticed a change in ONA in response. Many more nurses got involved and began advocating for change. With new upper management and a new board, ONA's whole perspective shifted. We became more of a labor-driven and organized union.

In 2023, we were negotiating a new contract, but Providence wasn't interested in working toward an agreement that would ultimately benefit everyone. So, after conducting a member survey to gauge support for action, we held a five-day limited duration strike in June 2023.[2] We had tremendous support from the community, including local businesses, other unions, and nurses around the city. We ultimately won some important changes to our contract, like additional RNs to cover meals and breaks, more paid time off, and more competitive salaries—but we knew that we were still going to have to push Providence to follow the state's new staffing law, which established minimum staffing levels in many units.*

**VIRGINIA SMITH:** My independent community hospital, Willamette Falls, was acquired in 2009 by Providence, which was growing but still a relatively small organization. They were a "typical" employer that said they wanted a partnership with us. But in 2016 they merged with St. Joseph's, and our relationship changed.

Having partnered in the past, we were unprepared when, with eight hospitals and eight contract expira-

*For more information on Oregon's staffing law, see "Policies to Achieve Hospital Nurse Staffing Adequacy" on page 28.


PHOTOS COURTESY OF THE OREGON NURSES ASSOCIATION

**"We realized that we needed to organize so we could do this work safely and protect its future—even if that meant striking."**

**–Virginia Smith**

tion dates, we found that Providence was unwilling to budge on anything—like competitive wages to retain nurses, safe staffing measures, or paid leave after exposure to illness or injury at work. We also had very little coordination between bargaining units.

In 2018, Providence replaced our accrual-based extended illness time with a short-term disability benefit that they claimed was better—but it was a bait-and-switch that made it harder for sick nurses to take leave. We really got the message that Providence didn't care about us. And we realized that our union needed more internal structures in place to fight for us.

While Richard and I and some other bargaining leaders were starting to develop those structures, the pandemic started, and we really had to organize to address staff and patient safety. As soon as the worst of the pandemic was over, we coordinated to track employer activity and contract expiration. We made sure each bargaining unit had a contract action team (CAT) and a network of stewards. We had members in every hospital initiating conversations, having regular meetings and social gatherings, and building power for escalation.

In my earlier days, we used to say, "Nurses don't go on strike," not realizing it was because of our comfortable relationship with our employer. When Providence made it uncomfortable, and then when the pandemic made it *very* uncomfortable, we realized that we needed to organize so we could do this work safely and protect its future—even if that meant striking.

**BREANNA ZABEL:** My history with union activism at Providence Medford goes back to 2023, but Medford nurses had been raising concerns, filing grievances, and calling on leadership to listen for years, only to be ignored, dismissed, and pushed further each time.

In January 2024, we began negotiations for our contract, which expired that March. We tried everything. We organized informational pickets and rallies. We came to every bargaining session with real solutions. We filed staffing complaints, met with lawmakers, and rallied our coworkers. But Providence continued to refuse to bargain in good faith, even after we joined five other bargaining units in a three-day limited duration strike with a two-day lockout in June 2024.[3]

Still, none of that effort was wasted. We built our organizing muscle through CAT membership meetings, community canvassing, and countless meaningful one-on-one conversations with fellow union members. When Providence pushed harder, we didn't back down. We refused to keep waiting to fight for the care our patients and communities deserve. And that determination helped build the power we needed to lead the largest healthcare strike in Oregon history just a few months later.

**LESLEY LIU:** The hospitalists at Providence St. Vincent are a new bargaining unit, organized in August 2023. The top issue that led us to organize was staffing. The population in our area has steadily increased over the last 10 years, and we are seeing more and sicker patients, so the workload is much greater. St. Vincent opened an intermediate care unit for patients who previously had been under the care of critical care specialists. We also started taking heart transplant patients after the state university hospital lost its accreditation; our only training was a one-hour presentation from a nurse practitioner. We didn't feel comfortable taking care of these patients, but we had no say. The decisions were all being made way above us.

There are 21 internal medicine and pediatric hospitalists working on an average day shift, but just four working the night shifts—caring for around 300 patients. We were being put in patient care situations that didn't feel safe. But we weren't getting anywhere with our requests for more staff, and people were getting burned out. We wanted to be able to voice our concerns and actually be heard.

After unionizing, the administration agreed to add an extra night hospitalist on weekdays. So now we have five hospitalists working at night, which has helped. But we asked for years, and management didn't agree to it until we unionized.

**EDITORS: Please share more examples of the conditions that galvanized you into action.**

**LESLEY:** As I mentioned, we were concerned about unsafe staffing, especially during swing and night shifts. During one shift, I got called about two patients who were crashing and a third who was dying. At the same time, a nurse called to tell me that another patient had died unexpectedly, and I needed to notify the patient's wife. As I was giving this person the worst news of her life—and getting more calls that I couldn't respond to—I heard that I was being paged overhead, which is unusual. It was the nurse, calling back to say the patient hadn't actually died. I felt horrible. But so many things were happening at once that everything was chaos.

In January 2024, we started bargaining our first contract to address staffing and other issues. By the time the 2025 strike rolled around, we'd been bargaining for

a year and were frustrated with our lack of progress. So we ended up coordinating our bargaining with the nursing units toward the end of last year. Going on strike together gave us more power and more voice, and ultimately it helped us come to an agreement on our contract much sooner.

**BREANNA:** Safe staffing was one of our primary concerns. We're a smaller hospital, so our medical telemetry unit functions more like a step-down unit. We care for patients who require close monitoring, like stroke patients, those on cardiac drips, and others who are critically ill but not quite ICU-level.

Despite the acuity, my nursing colleagues and I were regularly assigned five of these high-needs patients each. Week after week, we witnessed fatal or near-fatal arrhythmias and responded to full-blown cardiac arrests, with little to no support to help us process the trauma afterward. We fought hard to secure a four-to-one staffing ratio on our unit, and while that was a significant win, some nurses are still assigned five patients, and acuity and intensity often aren't taken into account. This is not safe for nurses or for patients.

We're doing everything we can, but it's a constant struggle to provide the level of care our patients deserve. Our nurse manager hasn't been a nurse on our floor and doesn't understand what we're facing day to day. Yet we're constantly pushed to do more with less, regardless of the toll it takes on us or our patients.

**RICHARD:** Having enough nurses has always been an issue for us, and salary and benefits are also a big part of the problem. About seven years ago, we started calling attention during our contract negotiations to the fact that we need to stay competitive so we can attract and retain more nurses. But that had been ignored across the board.

Many staff have stayed despite the challenges we face because we really are family. Everyone supports and covers for each other. But even so, we are often shorthanded, especially as our census has gone up dramatically. We recently expanded our emergency room from 46 beds to 80, and we're full on any given shift. We typically have dozens of people in the waiting room—with a nearly five-hour wait time to be seen—and we've still got ambulances coming in the back door. Many of our beds are used to board patients because other floors don't have room or staff. The fact that patient care hasn't suffered says a lot about how our nurses push themselves for our patients—and not much about the support that we're getting from management.

The summer 2024 strike by the other hospitals in our system helped Providence Portland and Providence Seaside Hospital get the best wage structure we've had in a long time when we started bargaining in the fall. But Providence was still digging in its heels with our other units and showing they had no intention of resettling their contracts. At that point, we surveyed our members, finding that over 95 percent of our members wanted to support these other units by joining them in a strike. It's a testament to the solidarity of our union that even though Providence Portland nurses didn't stand to get much direct benefit from this action, the vast majority of us were ready to go out on a lengthy strike for our siblings. And we were able to use the salary structure we established in the fall as a model for the other bargaining units.

**VIRGINIA:** My med-surg unit is 50 beds, and we're contiguous with the same-day surgery unit. We have a 28-bed ED, but some beds are in the halls—so some patients with broken hips or who are using bedpans have no privacy.

At about 2 a.m. during one shift, we had 26 med-surg patients waiting for beds, but I was already full with 50 patients and another 40 waiting. Two ICU patients came in, but the ICU was also full, so we had to put them in our lobby. I knew they couldn't stay there, so I moved 10 patients from the ED to short-stay beds—meaning surgeries scheduled for later in the day would have to wait. I mobilized my staff, put my strongest nurses in charge, and we physically moved patients to make rooms available. Those patients didn't get where they needed to go for another 10 days because our census was so full. We were in a constant state of stress like that for three years.

Before Oregon's 2024 staffing law, we'd been told for years that the budget didn't support hiring more nurses. But we're bursting at the seams with sick people. Now, a year into having the staffing law, my unit is well-staffed. But we still have days when we're short-handed. So ultimately, we got into this contract fight to make sure our patients have what they need.

And the employer can't just buy us off with wages. We also need metal detectors at entrances to keep patients and staff safe, and better health benefits. Our insurance is so expensive that I can go get better insurance *from Providence* in the marketplace for a lot less.

**EDITORS: How did you build solidarity internally and communitywide leading up to and during the 2025 strike?**

**VIRGINIA:** We had three contracts expiring in December 2023, three more expiring in the first six months of 2024, and two expiring at the end of 2024. So we knew this was our time to act. We built solidarity across units through conversations about long-term strategy and how these contracts would affect each other.

As we negotiated throughout 2024, we kept up to date on what different bargaining units were experiencing, how the employer was behaving, and how that impacted our union power. When members asked why

**"By the time the 2025 strike rolled around, we'd been bargaining for a year and were frustrated with our lack of progress.... Going on strike together gave us more power and more voice."**

**–Lesley Liu**

**"Our communication was key to solidarity. We've established an environment in which we talk regularly and support each other."**

**–Richard Botterill**

we weren't settling, we reminded them what we were fighting for. It took a lot of patience for our bargaining unit members, especially those whose contracts had expired earlier, and a lot of trust in the bargaining teams to continue that slow and steady pressure.

The strike in June 2024 was a test of our power and the employer's determination to resist. At that point, we had 3,000 nurses working under expired contracts for as long as six months. We didn't know if we'd have to convince members to take action, but it turns out they were ready to show the employer how much we needed them to care.

**RICHARD:** Our communication was key to solidarity. We've established an environment in which we talk regularly and support each other. So people were talking about the potential for going out on strike long before anything happened. We held meetings leading up to the strike to talk about contracts and strategy. ONA put out weekly and sometimes daily status updates. And there was a lot of support for our bargaining teams. Members knew we'd put in a lot of volunteer hours to work toward a contract because we care about our units.

As far as external solidarity, we had an aggressive publicity campaign to increase awareness about our working conditions, which are patient-care conditions, and we saw very positive support from the community, as well as from nurses at nonstriking hospitals. Some—even from California—came to our rallies and stood on the line with us, and others from even farther away expressed support. Tamie Cline, ONA president and the chair of our board, heard from a friend of hers in Australia who saw the strike on the news there. My sister is a nurse in England and the news was being covered there too. So, a big chunk of the world saw what we did and what was possible, which is huge.


**BREANNA:** We knew Providence would try to control the narrative with polished statements, paid advertisements, and rehearsed talking points, so we made sure the public heard directly from us. Nurses spoke out about what it's like to care for too many patients, to experience moral distress, to go home each day wondering if something was missed because we were stretched too thin. They made it clear: this fight wasn't just about a contract. It was about advocating for the kind of safe, dignified care every patient deserves.

When an informal ONA survey found that 70 percent of Oregonians believed Providence prioritized profits over patients, and a patient survey confirmed that short staffing is a public safety crisis, these gave our fight undeniable weight. We met with city and state elected officials to ask them to intervene. We wrote to Providence's board and to the Sisters of Providence, canvassed local businesses, and reached out to anyone with the power to demand better. We made it clear that unsafe staffing and nurse burnout ripple through the entire community. We were on the news throughout the strike to make sure our message was louder than Providence's spin. Many of us were on the line for all 46 days. And when the community saw that we weren't backing down, they showed up for us. Elected officials, including Governor Tina Kotek, joined us on the line.

We built our solidarity daily, conversation by conversation, with members. We developed trust by meeting members where they were, especially those who were hesitant about union action. Having a genuine interest in people, talking with them about why this fight matters to them, their patients, and their families, is important.

All of our units stood strong and settled together—even the units that had already reached contract agreements. We showed up for each other physically, emotionally, and financially. We donated food, money, and personal hygiene items, picked up strike shifts to help out, and even offered childcare. That's how we made it through 46 days. And what we gained—solidarity, strength, and a seat at every table—will protect our patients, our profession, and one another long after this contract ends.

**LESLEY:** I heard someone describe the strike as the best team-building activity imaginable. It was reassuring and powerful to be with so many other people who share your opinions and support your cause. We had a big WhatsApp group that allowed us to share photos, comments, and event details to keep everyone in the loop.

Social media also helped build community engagement. I'm in a Facebook group for women physicians, and physicians from other hospitals and clinics reached out to me and even came out on the line with us. One of our OB hospitalists has a big Instagram following, and she made a lot of posts throughout the strike. And as Breanna mentioned, a few of our elected officials also came out on the picket line with us—two are physicians, and one is a pediatrician who worked at our hospital, so it was powerful to have their support.

**EDITORS: Is there anything you would have done differently that may help other unions facing similar situations?**

**VIRGINIA:** I'd like to have had a financial plan in place to provide for all of our members. My husband has two jobs, and he carried us through, but most weren't in that position. At Willamette Falls, we had seven couples who were both out on the line. They plowed through their savings and took out 401(k) loans, so they were really feeling a financial strain by six weeks.

**RICHARD:** To that point, I'd want to develop a central database of options, from picking up shifts at other hospitals to finding other work. We have a lot of members who are single parents, and there were bills to be paid.

ONA had strike funds that many districts around the state contributed toward. A team of nurses from all the hospitals worked several long days each week to assess applications for those funds. Implementing an electronic process and a process for determining eligibility would help them move much more quickly and better ensure that all the members who need help can get it.

**BREANNA:** I'd focus on preparing people emotionally and practically for how hard something like this really is. We were organized and had a plan, but I don't think any of us fully grasped how much it would take out of us. If I could go back, I'd start building up our hardship resources and emotional support systems sooner. At Providence Medford, we could've used a better communication system that could reach members who weren't always checking social media or email. And I wish we'd built in supports like a mental health check-in table and more wellness volunteers to make this effort more sustainable.

**LESLEY:** It's also important to remember that the bargaining team can't do everything. In my unit, in addition to bargaining, we were expected to rally support, talk to the media, draft letters, and send updates to everyone. It became a huge workload. If I had to give advice to other new units, it would be to organize and solidify the teams responsible for nonbargaining activities. We could've used a stronger internal support structure within our group.

I also wish we as a bargaining team had settled on the tentative agreement language for each section as we were working it. We saved it all until the very end, which made finalizing the contract take longer.

**EDITORS: What's next? How will you maintain your solidarity and power?**

**LESLEY:** One huge benefit of the strike is that we have a voice. Now, the administration has to discuss things with us before making changes, which was one of our big objectives. We're also seeing more organizing from other teams. After the hospitalists unionized, our cardiology advanced practice clinicians followed suit, as did the neonatology nurse practitioners.

I think what's next is more learning and growing as a union. Getting thrown into the deep end has strengthened our relationship with other Providence bargaining units. I'm not sure we would have had much interaction with the other units otherwise, but now we're talking to more nurse units as well as other physician units.

**RICHARD:** We're also seeing a lot more solidarity with our colleagues throughout Oregon because of what we accomplished. Legacy Health just voted to unionize, which boosts our membership from 19,000 to 23,000. And many other hospitals and clinics are in the process of organizing right now. So we're going to continue to grow and become stronger.

Of course, Providence is still doing everything possible to fight the 2024 staffing law, including proposing things like monitoring patients through TV screens and cameras mounted on patients' beds, which conveniently allows management to staff fewer nurses and not adhere to the four-to-one max ratio. We're interested to see what they're going to do now that the full weight of the staffing law has gone into effect.

**VIRGINIA:** We're a lot stronger now. All the energy, solidarity, and collegiality that we built by standing up to Providence and fighting for what's right—we brought it with us now that we're back to work taking care of patients. We're more aware and determined to not let contract violations slide. We fought for our contract, and it's up to us to make sure it's followed.

We're also connecting with all our members, including the ones who were less engaged and wanted to get back to work and the relative few who eventually crossed the picket line. We want to give everyone a chance to talk through their experiences and continue to build trust and solidarity. Many members got really involved during the strike and are ready for more, so we need to get them plugged into steward training and other opportunities. And it's important that we take time to celebrate this very hard-fought win, knowing that we are on the right side of this fight for our profession, and that our sacrifice was worth it for our patients.

**BREANNA:** At Medford, many of our nurses are continuing to stay involved. People are asking how they can become stewards and join committees, and at our last election every position had at least two candidates, which hasn't happened in a long time. We're seeing a greater sense of ownership across the board, and we are capitalizing on the momentum of this victory to make our union stronger.

With this strike, we showed that we don't have to accept burnout, unsafe staffing, or corporate silence. We can organize, and we can win. Now we're considering how we are going to enforce the contract, hold management accountable, and make sure that this never happens again. That shift was earned through struggle. Now, we get to decide what we build next. ✚

**For the endnotes, see aft.org/hc/fall2025/botterill_liu_smith_zabel.**

**"With this strike, we showed that we don't have to accept burnout, unsafe staffing, or corporate silence. We can organize, and we can win."**

**–Breanna Zabel**

# Policies to Achieve Hospital Nurse Staffing Adequacy

## Evidence About Impact

By **Linda H. Aiken**

Linda H. Aiken, PhD, RN, FAAN, FRCN, is an internationally recognized expert on human resources in health, workforce shortages, nursing outcomes research, and health policy evaluations. She is a professor in and the founding director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing, a senior fellow at the Leonard Davis Institute of Health Economics, and an elected member of the National Academy of Medicine.

Safe nurse staffing is common sense. Patients have better outcomes, and healthcare workers suffer less burnout and are more likely to stay on the job. But too many healthcare executives place profits over patient care. Throughout the United States, clinicians and their unions have spent decades fighting for safe staffing through collective bargaining, community pressure, actions like informational picketing and strikes, and legislation.

The fight has been long and hard, and strategies have differed at times. To keep working together, and to keep our coalitions strong, we need to listen to each other and continue learning from our successes and setbacks. Here, we are fortunate to offer the perspective of a true pioneer in safe staffing research and policy, who shares the data and offers some ideas on the road forward. While some readers may not agree with everything in this article, we are confident that everyone will be informed by the research and recommendations. Together, we will continue to fight for and win staffing levels that ensure quality care for patients and good working conditions for clinicians.

–EDITORS

Nurses are the primary surveillance system for early detection of complications and the launch of rapid interventions to rescue patients. But nurse surveillance is compromised by inadequate nurse staffing when nurses are not able to directly observe, assess, and quickly act on patients' conditions. This often results in life-threatening delays in clinical interventions, health disparities, and moral distress for nurses.[1]

More than two decades ago—and again in 2014—research conducted by my colleagues and me established that each one patient added to a nurse's workload is associated with a 7 percent increase in the risk of hospital mortality and failure to rescue patients.[2] Subsequent research has also found significant evidence that adequate nurse staffing is a key hospital resource that impacts nurse well-being and retention, patient mortality and complications, patient satisfaction, and favorable financial metrics driven by nurses, such as cost savings produced by shorter lengths of stay and reduced nurse turnover.[3] And yet, variation in patient-to-nurse staffing ratios across hospitals is long-standing and remains common.[4]

The World Health Organization's recommendations for addressing nursing and other healthcare shortages make it clear that relying on training new members of the workforce is insufficient; hospitals must significantly improve nurse retention.[5] Among the top reasons that nurses leave jobs in healthcare are burnout and insufficient nurse staffing.[6] Research consistently shows that high patient-to-nurse ratios are associated with high nurse burnout, increased job dissatisfaction, and greater intent to leave their current job.[7]

But nurses, nurse and patient advocacy groups (including nurses' unions), and concerned citizens are not sitting by the sidelines. Across the country, they've been fighting for safe staffing legislation.

ILLUSTRATIONS BY ALEX NABAUM

## Establishing Safe Hospital Nurse Staffing Requirements

Legislative activity to mandate safe nurse staffing in US hospitals has been increasing, as has the evidence showing that these policies improve nurse retention and well-being as well as patient outcomes. Two states—California and Oregon—have implemented legislation mandating comprehensive hospital minimum nurse-to-patient ratios, and two states—Massachusetts and New York—have passed hospital-mandated nurse staffing for critical care only. Eight states have adopted mandated hospital nurse staffing committees, and 11 states require hospital staffing plans. Five states have mandated public reporting of hospital nurse staffing.[8]

### Comprehensive Staffing Ratio Laws

California implemented a comprehensive safe staffing law in 2004. The legislation did not include specific ratios but directed the California Department of Health Services (now the California Department of Public Health) to establish minimum, specific, and numerical licensed-nurse-to-patient ratios by hospital unit type for acute-care, acute-psychiatric, and specialty hospitals.[9] The ratios apply at all times, including during meals, breaks, and excused absences. Some rural hospitals were eligible for delayed implementation. Hospitals can use up to 50 percent licensed vocational nurses (LVNs) to meet the ratios. To float nursing staff between units, the law requires staff to receive orientation and have validated current competence.

The ratios outlined were intended to be a floor, not a ceiling, with hospitals required to increase nurse staffing based on patient acuity. The law was implemented in phases, with the final phase going into effect on January 1, 2008, tightening ratios for some unit types. Initially, for example, no nurse could care for more than 6 adult medical or surgical patients at one time; over an 18-month period, that number was reduced permanently to 5 patients per nurse. The table below shows a sample of unit ratios as of 2008.

**California Statutory Minimum Nurse-to-Patient Staffing Ratios**

| Hospital Unit Type | Nurse: Patient |
|---|---|
| Adult medical and postoperative surgical | 1:5 |
| Pediatric | 1:4 |
| Intensive care | 1:2 |
| Telemetry | 1:4 |
| Oncology | 1:5 |
| Psychiatric | 1:6 |
| Labor/delivery | 1:3 |

Nurse staffing improved significantly in California hospitals after the legislation's implementation. According to comparisons of hospital data from 1997 to 2016, patients received up to three hours more RN care per day than patients in hospitals in other states.[10] Nurse staffing improved rapidly and significantly in safety net hospitals, with the implication that mandated nurse staffing ratios can improve health outcomes for underserved populations.[11] Despite what some feared, there is no evidence that hospitals closed or reduced services because of the staffing policy, and no evidence of erosion of nursing skill mix with hospitals replacing RNs with LVNs.[12]

Evidence of positive impacts of California's nurse staffing legislation on nurses' well-being is strong. As a direct result of the legislation, nurse job satisfaction improved and nurse burnout was reduced.[13] However, the impact of the legislation on patient outcomes is sometimes said to be "mixed." Large-scale studies with sufficient statistical power to find associations between the legislation and patient outcomes provide evidence that mortality and failure to rescue decreased in California following staffing improvements. But some studies of "nurse-sensitive indicators" at the unit level, such as pressure ulcers and falls, had null findings that could well be due to outcome measurement error and faulty research design.[14]

Oregon became the second US state to implement comprehensive nurse staffing legislation in 2024. The initial ratio was no more than 5 patients on adult medical and surgical units per nurse, tightening to 1:4 on June 1, 2026. To ease implementation, rural hospitals may receive a two-year variance from the law's requirements if approved by the nurse staffing committee.[15] As in California, this law sets a floor, not a ceiling. Hospital nurse staffing committees may create staffing plans with higher standards.

Oregon's statutory ratios, or higher standards solidified by staffing committee–approved plans, are enforced at all times, including during meals

**Each patient added to a nurse's workload is associated with a 7 percent increase in the risk of hospital mortality and failure to rescue patients.**

**Among the top reasons that nurses leave jobs in healthcare are burnout and insufficient nurse staffing.**

and breaks; hospitals must pay nurses $200 for each missed break or meal when the nurse files a valid complaint within 60 days. Additional penalties may be levied on hospitals that fail to adhere to the ratios or the standards set forth in a unit's staffing plan. The only time facilities can deviate from the legal ratios is when nurse staffing committees pursue an innovative care model by including other clinical staff; in those cases, the model must be approved by the staffing committee and then reappraised every two years.[16] The table below shows a sample of unit ratios mandated in the legislation.

**Oregon Statutory Minimum Nurse-to-Patient Staffing Ratios**

| Hospital Unit Type | Nurse: Patient |
|---|---|
| Emergency department (trauma), active labor & delivery, operating room | 1:1 |
| Intensive care, not active labor & delivery, post-anesthesia care | 1:2 |
| Intermediate care | 1:3 |
| Emergency department (non-trauma), postpartum couplets, medical surgical, oncology, telemetry | 1:4* |

*Medical surgical ratio began at 1:5 in June 2024 and drops to 1:4 in June 2026.

## Targeted Ratio Staffing Laws

Massachusetts in 2014 (with implementation beginning in 2016) and New York in 2021 (with implementation in 2023) passed legislation setting minimum nurse staffing requirements only in intensive care (or critical care). These more targeted laws were enacted after comprehensive minimum nurse staffing ratio bills failed to pass.

In Massachusetts, the law mandated all hospital ICUs maintain a ratio of 1 nurse to 1 or 2 patients, depending on patient acuity. An outcomes evaluation compared ICUs in six academic medical centers impacted by the law with 114 academic medical centers outside of the state. The researchers concluded that the legislation was a failure because they found no differences in Massachusetts hospitals in ICU staffing over time compared to ICUs in other states and no changes in patient outcomes associated with the legislation. (Nurse outcomes were not studied.)[17] However, the null findings were to be expected because there is not as much variation in ICU nurse staffing as in other types of units like medical and surgical, especially in the academic medical centers included in the study. If the legislation had a significant effect on nurse staffing in ICUs, it would have been more likely in community hospital ICUs, which were not studied. Additionally, the ICU quality outcomes evaluated—including incidence of hospital-acquired pressure ulcers and patient falls with injury—were not ideal nurse staffing-sensitive measures of improvement in ICU morbidity.[18]

The New York ICU staffing ratio rule, enacted by the New York State Department of Health in 2023 pursuant to the 2021 Safe Staffing for Hospital Care Act, requires—at all times—a minimum of 1 RN for every 2 ICU and critical care patients, increased as appropriate for the acuity level of the patient. Unlike in Massachusetts, there were baseline data collected on New York hospitals, documenting that ICU staffing ranged across all NY hospitals (not just academic medical centers) from 1.8 to 4.3 patients per nurse, with an average of 2.5 patients per nurse.[19] Thus, implementing a required minimum staffing of 1 RN for every 2 ICU patients can potentially improve ICU staffing in some New York hospitals.

One bill that failed to pass, the NY Safe Staffing for Quality Care Act (S. 1032/A. 2954), called for nurses to care for no more than 4 patients each on adult medical and surgical units. Published baseline research showed nurse staffing varied across adult medical and surgical units in NY hospitals from 4.3 to 10.5 patients per nurse, with an average of 6.3 patients each.[20] Half of nurses in NY hospitals suffered from high job-related burnout, close to 30 percent were dissatisfied with their jobs, and over 1 in 5 nurses said they intended to leave their jobs within the year.[21] Based upon observed differences in hospital outcomes at all nurse staffing levels, researchers predicted that passage of the NY Safe Staffing for Quality Care Act would have significantly improved nurse well-being and intention to stay. They also estimated that 4,370 in-hospital deaths would have been avoided just among elderly Medicare patients admitted for common surgical and medical reasons during the two years of the study, and many more deaths would have been avoided if all patients who benefit from improved nurse staffing were counted. Additionally, a minimum savings of $720 million was estimated over two years because of shorter lengths of stay and fewer readmissions[22]—funds that could have been reinvested in hiring the additional nurses needed to meet the proposed ratios. Despite this compelling research, New York did not pass the comprehensive hospital safe nurse staffing bill but defaulted to ratios in ICUs only.

Interestingly, legislation that mandates changes in care, as opposed to staffing ratios, has been more successful in getting passed. For example, in 2013, New York state passed a bill mandating that all hospitals implement a sepsis care bundle to prevent sepsis deaths. Researchers estimated that more deaths from sepsis would be avoided by adopting New York's minimum nurse staffing bill than by the sepsis bill mandating an evidence-based care bundle.[23] Obviously, adherence to the sepsis bundle will not happen without adequate nurse staffing, so this is a good example for nurses to use when advocating for staffing legislation. Another example is the Health Care Workplace Violence Prevention Act that passed in the Pennsylvania House of Representatives in May 2025. Although nurses rightly celebrated, this bill's effective-

ness will be limited because a comprehensive nurse staffing bill that the state House passed in 2023 is still stalled in the state Senate.[24] Nurse understaffing is a root cause of violence in hospitals;[25] without solving that, it is unlikely that violence against nurses will be eliminated whether there is a law or not.

### Pending Ratio Legislation

The Illinois Safe Patient Limits Act, which has not passed, calls for hospital nurses outside of ICUs to care for no more than 4 patients each.[26] Researchers documented large variation in nurse staffing in Illinois hospitals, from 4.2 patients on adult medical and surgical units for each nurse in some hospitals to as many as 7.6 patients per nurse in others. Using these staffing data by hospital linked with objective patient outcomes data for the same hospitals, researchers estimated that if all Illinois hospitals staffed at not more than 4 patients per nurse on medical and surgical units, about 1,595 deaths could have been avoided among Medicare beneficiaries during the study period. Additionally, over $117 million could be saved *per year* just among Medicare patients—and likely considerably more across all hospitalized patients.[27]

In addition to ratios proposed for other hospital units, Pennsylvania's pending Patient Safety Act restricts nurses on adult medical and surgical units to caring for no more than 4 patients at a time.[28] University of Pennsylvania researchers testified at legislative Health Committee hearings that the average medical-surgical hospital nurse in Pennsylvania provides care to 5.6 patients, and nurses' workloads range across hospitals from 3.3 patients per nurse to as many as 11 patients per nurse. If all Pennsylvania hospitals were staffed in medical and surgical units at the proposed ratio of no more than 4 patients per nurse, an estimated 1,155 deaths annually could be avoided. Moreover, patient length of stay could be reduced by approximately 39,919 days, resulting in cost savings of over $93 million per year.[29] A previous study showed that if Pennsylvania hospitals staffed at levels mandated in California (5 patients per nurse), surgical mortality rates in Pennsylvania hospitals could be reduced by nearly 11 percent.[30]

### Alternative Staffing Policies

In the United States, there are two other types of legislated nurse staffing policies besides ratios that aim to improve nurse staffing adequacy in hospitals: mandated committees and public reporting. Mandated hospital nurse staffing committees, usually required to comprise at least 50 percent direct care nurses, decide on nurse staffing levels and skill mix. This is the most common form of hospital nurse staffing legislation in the United States and is currently implemented in eight states (Connecticut, Illinois, Nevada, New York, Ohio, Oregon, Texas, and Washington).[31] Mandated hospital nurse staffing committee legislation is often considered a compromise in highly contentious debates between hospital stakeholders over mandated minimum nurse staffing ratios. However, research suggests that nurse staffing committees alone do not improve nurse staffing.[32] And there is no evidence that nurse staffing committees significantly improve nurse well-being and retention or patient outcomes.[33]

Five states (Illinois, New Jersey, New York, Rhode Island, and Vermont) have mandated public reporting of hospital nurse staffing, and another three states (Massachusetts, Minnesota, and Washington) have voluntary public reporting. Research suggests that mandatory reporting is, by itself, not an effective policy to significantly improve nurse staffing or nurse well-being.[34] There is little evidence that consumers in states with mandatory public reporting of hospital nurse staffing are accessing or acting upon the information, which is not standardized and may be difficult to locate and interpret.[35] The most consumer-friendly healthcare website in the United States, Care Compare (available at go.aft.org/1fe), was established by the Centers for Medicare and Medicaid Services (CMS); it provides information that enables consumers to compare quality outcomes across hospitals, but it includes no information on hospital nurse staffing. Adding hospital nurse staffing through administrative action by CMS could be a useful goal for advocates, as such information would be widely available to the media for inclusion in their frequent stories about nurse shortages.

### Continuing Legislative Advocacy

Evidence is building that minimum safe nurse staffing policies are in the public interest, and more US states (and international jurisdictions) have policies under consideration. Advocates for such legislation should heed the following five lessons from previous policy experiences. First, the role of regulation in the United States is largely to protect the public rather than to foster optimal quality. Pending legislative efforts, such as the push for 1 nurse for every 4 patients, may be striv-

**Developing consensus among nurses on proposed staffing legislation before bills are introduced should be a priority.**

ing for "optimal" staffing policies rather than those that research indicates are safe. For example, patient care clearly improved in California with a minimum requirement of no more than 5 patients per nurse on medical-surgical units. Politically, proposing ratios of 1 nurse for every 4 patients may be overreaching, especially if baseline data show that most hospitals in a state do not currently meet a 1:4 ratio, thus requiring almost all hospitals to add additional nurses, as was the case in New York for the staffing bill that failed.[36] Second, many bills are too complicated with too many requirements; simpler is better. Any detail that cannot be defended by evidence risks undermining support for the entire bill. As there is currently no research evidence to justify different ratios on many different specialty units, specifying ratios for every type of unit is a risk to passage of proposed legislation. Third, many bills try to punish hospitals through complex fines, are difficult and expensive for the state to implement, and have not been shown effective in gaining compliance. Fourth, nurses are not speaking with one voice to support ratio legislation. Nurse executives and leaders, in particular, often testify in state hearings against nurse staffing legislation, confusing elected officials and undermining the chances for positive votes. A high priority should be developing consensus among nurses on proposed staffing legislation before bills are introduced, including considering new provisions that might exempt hospitals that show consistent evidence of meeting minimum ratios. Fifth, policies limited to ratios in ICUs have limited benefits, as staffing is already best there, and these policies derail more comprehensive approaches.

## "New" Nurse Staffing Models

Despite US and global evidence showing that policies establishing minimum safe nurse staffing requirements in hospitals are effective in retaining nurses and in improving patient safety and quality of care, powerful stakeholders remain opposed to ratio policies. Their alternative approaches are implementing "new" nurse staffing models to solve difficulties recruiting enough nurses by trying to reorganize care to require fewer RNs.

Justification for new nurse staffing models is premised on a scenario of a nonexistent nursing shortage in the United States. The number of US graduates from nursing programs has been steadily increasing for years,[37] resulting in the nation adding about a million net new RNs to its national supply in the decade preceding COVID-19. Even if 60,000 nurses a year reach retirement age, the nearly 200,000 new US graduates annually could more than replace retiring nurses.[38] Additionally, the United States remains at the top of the international nurse recruitment pyramid,[39] offering another option for recruitment of RNs if necessary—although current US immigration policy is uncertain.

Team nursing is the most common "new" nursing care delivery model—although it is not new at all, as it was the usual method of nursing care delivery in hospitals before 1980.[40] Team nursing uses fewer RNs to manage a team of licensed practical nurses (LPNs) and nursing assistants. Many rigorous studies have documented that replacing RNs with lower-qualified personnel results in poor patient outcomes and poor RN retention, and it does not save money.[41] Team nursing is not synonymous with interdisciplinary teams that comprise clinicians from different professions. Team nursing has one group of professionals—RNs—who are the target of reductions. A recent evaluation of the outcomes of team nursing estimates that reducing RNs to supervising lower-wage workers poses serious risks of increased preventable deaths and other patient complications; additionally, it will not save money because of expected increases in length of stay, readmissions, expensive complications like hospital-acquired infections, and increasing RN turnover.[42]

Another new model is virtual nursing, in which nurses direct and monitor patient care remotely or in conjunction with in-person care. No evidence yet exists that this will reduce expensive nurse turnover or enable the employment of fewer RNs. There is a possibility that virtual nurses may be able to improve quality of care under some circumstances,[43] but the motivation in moving to virtual nursing is not quality improvement but reduction in labor costs. Technology is another example of improving quality of care under certain circumstances, but almost all technology introduced into hospitals has so far been nurse-intensive, expanding the scope of practice of RNs rather than substituting for RNs.

Practically speaking, the best evidence-based solution for delivering hospital care with fewer RNs is to divert more patients from hospital admissions through better preventive care or better and more accessible community-based healthcare alternatives. The best example of success is same-day surgery for which patients are not admitted. However, retaining good outcomes for patients diverted from inpatient care will require more access to nursing care in the community than is presently available.

**Policies mandating minimum nurse staffing standards improve patient outcomes, quality of care, and nurse well-being and retention.**

The best solution for staffing today's hospitals is adequate evidence-based ratios of inpatient RN staffing. Policies mandating minimum nurse staffing standards are successful in improving not only patient outcomes and quality of care but also nurse well-being and retention. RNs are high-value labor for hospitals. The United States has a robust supply of RNs, so the problem is not a shortage of nurses; rather, too few hospitals are providing expert clinicians with the resources and organizational engagement needed to sustain excellent care and promote institutional loyalty and commitment. ✚

**For the endnotes, see aft.org/hc/fall2025/aiken.**

# Improving Healthcare Access for Patients with Disability

By **Lisa I. Iezzoni**

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**Steffie* is a nurse who became paraplegic following a spinal cord injury. When she began experiencing "unbearable" pain due to what she believed was appendicitis, she went to the emergency room following her doctor's advice. Eight hours later, Steffie was sitting alone in a treatment room with no access to a call bell, no assistance to use the restroom, and no medication to ease her pain—the ER physician and staff "kept telling me that I shouldn't be in pain because I'm a paraplegic."[1]**

**Adriana is a woman with cerebral palsy. At prenatal visits in her first pregnancy, she was dropped three times—by her doctor and ultrasound technicians—during transfers to an exam table. The first drop occurred when Adriana was four months pregnant and the physician lost her grip on Adriana during transfer. Adriana fell and landed directly on her belly. One week later, she began bleeding. At the hospital, an ultrasound confirmed all was well with the pregnancy, but Adriana remained hospitalized for a week.[2]**

**Harry is deaf, and for his first testicular examination, his clinician did not hire an American Sign Language interpreter to accommodate communication with Harry. The doctor began the testicular examination without explaining the procedure or its purpose. Harry later said, "I was scared. I didn't know if I was being molested or raped, or if this was a sexual advance.... They forget I'm deaf."[3]**

*Pseudonyms have been used throughout these patient stories.

About 73.4 million adult Americans (28.7 percent of those 18 or older) report having a disability, as do over 3 million children (4.3 percent of those under age 18).[4] Across the lifespan, nearly everyone experiences some type of disability—and anyone can become disabled in a flash with a major trauma or debilitating health event. Nevertheless, despite its near universality, disability remains frequently stigmatized, and disabled people confront substantial disadvantages in education, income, employment, housing, transportation, and other social drivers of health. In healthcare settings, people with disability face erroneous assumptions about their lives, values, and expectations that contribute to inequitable healthcare and worsen their health outcomes. Physically inaccessible healthcare facilities and failures to ensure effective communication result in disabled people often not receiving equal quality health services as nondisabled people.[5]

This article explores the history of disability and disability rights in the United States and the challenges adult Americans with disability face in accessing healthcare. Throughout, I include real stories from interviews of persons with disabilities that demonstrate their disparate healthcare experiences. Lastly, I discuss ways that clinicians and unions can advocate for greater accessibility and improved care for disabled patients.

ILLUSTRATIONS BY MIA NOLTING

## How We Talk About Disability Matters

At the outset, it is important to acknowledge that word choices convey views of disability.[6] Historically, terms such as *cripple*, *handicapped*, or *imbecile* engendered pity and, at least among some people, reflected beliefs that persons' sins or moral failures caused their disability.[7] As societies began recognizing biomedical causes in the 19th and 20th centuries, language shifted toward highlighting pathology, with terms like *the blind*, *the mentally retarded*, *the mentally ill*, or *the quadriplegic* that reduce people to their impairments.[8] Critics argued that defining people by pathology obscures their humanity. This perspective led to person-first language, positioning personhood before disability (e.g., *people with disabilities*), which is used throughout the landmark 1990 Americans with Disabilities Act (ADA).

**While nearly everyone experiences some disability across the lifespan, disability remains stigmatized.**

Disability language constantly evolves. Today's diversity movement, grounded in civil rights and combating disability stigma, has flipped the word order to identity-first language (e.g., *disabled persons*), which also can connote disability pride.[9] This perspective views common euphemisms that describe disability, such as *special needs*, *differently abled*, or *physically challenged*, as patronizing or infantilizing. Individuals hold deeply personal language preferences. For instance, *Deaf* spelled with a capital D reflects the view of many deaf people (i.e., those with an audiological inability to hear) that they are a linguistic or cultural minority—such as belonging to the American Sign Language community—not disabled. Some persons who are autistic, dyslexic, or neurodivergent self-identify as disabled, while others do not.[10]

For multiple reasons, many people do not view themselves as disabled, despite reporting functional impairments. In a 2021 national survey of US adults, only 42 percent of respondents who reported impairments said they were disabled.[11] For clinicians, the bottom line is to avoid making assumptions about whether people view themselves as disabled and just ask them how they prefer to describe themselves. (In this article, I alternate between person-first and identity-first language.)

## Who Are People with Disabilities?

Disabilities are diverse. Some, like Down syndrome or cerebral palsy, as in Adriana's example above, are congenital; others occur later in life. Some disabilities arrive suddenly, without warning, such as Steffie becoming paraplegic due to an injury; others progress across years, with worsening chronic health conditions. Some are visible; others are not apparent. Disabling impairments affect diverse functions, such as seeing, hearing, speaking, communicating, thinking, learning, emoting, and moving. Disabled people typically perform these various functions, but in different ways than other people. Some people have a single disability, while others have multiple disabilities.

Surveys provide the best data about Americans with disabilities, although surveys have important limitations (e.g., questions must be brief and focused, cultural and other factors may affect responses, and persons may need accommodations to participate). Most federal surveys ask six standard yes-or-no questions about disability, with a "yes" answer to any of them classifying the respondent as disabled.[12] In 2022, 28.7 percent of adults in the United States and its territories reported at least one disability, with disability prevalence rising with increasing age. Women were more likely than men to report any disability. Disability prevalence differs widely by race, although cultural and other personal considerations might affect differences found through surveys. Disabled people are more likely than nondisabled people to face disadvantages in social drivers of health, with lower educational levels, employment rates, and incomes.[13]

Not surprisingly, adults with disabilities are more likely than their nondisabled peers to report being in fair or poor health—37.7 percent compared with 8.8 percent.[14] They are also less likely to be married or partnered. The 2022 survey data do not indicate whether disabled people who report fair or poor health live alone, but lacking family supports could increase their isolation and the challenges of living in their homes and communities. Regardless of disability, few adults want to enter a nursing home if they become unable to care for themselves.[15] It can be easy to focus on these ostensibly negative findings, but it's important to remember the converse: about two-thirds of people reporting disability do *not* view themselves as being in fair or poor health. Indeed, a "disability paradox" may exist, as many people with significant disability adapt to their functional limitations and enjoy good quality of life.[16]

## Who Is Eligible for Support?

Since the Middle Ages, societies have mobilized to assist people who need basic supports to subsist, such as orphaned children, frail elders, and disabled people—so-called "honest beggars" who cannot control their plights.[17] However, among supplicants claiming disability, some people appeared to feign impairments to seek alms or other societal largess. For centuries, therefore, societies have endeavored to distinguish "meritorious" disabled people from imposters.

A breakthrough occurred in the 19th century with the invention of new diagnostic instruments—the stethoscope, microscope, ophthalmoscope, spirometer, x-ray, and others—that exuded scientific objectivity.[18] These technologies could detect disease without relying on what people reported, thereby offering opportunities to determine "legitimate" disability claims. These diagnostic tools also drove discovery of biological causes of functional impairments. By the end of the 1800s, the *medical model* of disability prevailed, positing that disability is a problem of individual persons, resulting from trauma or other health

conditions and requiring treatment by medical professionals.[19] Treatments aim to cure, but if treatments fail, people are expected to adjust to their losses.

By the mid-20th century, perspectives on disability began shifting dramatically,[20] motivated initially by millions of injured veterans returning from World War II. Despite significant permanent impairments, these veterans wanted to start families, return to civilian work, and participate fully in their communities. (Ironically, these vets displaced women and disabled workers who had effectively staffed industry on the home front during their absence.) By the late 1960s, the *social model* of disability emerged, asserting that disability was not an attribute of individuals but instead a result of environmental factors, such as negative societal attitudes, physical barriers, and exclusionary public policies. In failing to accommodate differences and thus isolating people, these environmental factors prevented individuals' full integration in community life. The social model and its newer incarnations, such as the diversity movement,[21] view disability as a human rights issue.

In the United States, no single consensus of disability exists. To determine who merits disability-related public federal benefits, from Social Security to civil rights protections, different definitions apply, and the definitions vary in important ways. For example, the Social Security Act's definition of disability in adults focuses on a binary determination—whether or not someone can be gainfully employed—whereas the US Department of Veterans Affairs quantifies disability along a continuum, assigning benefits based on a disability rating percentage. Most definitions rely on the medical model of disability and demand proof from medical professionals to ensure each applicant deserves support.

## Disability Rights Laws

The first major federal disability civil rights law was Section 504 of the 1973 Rehabilitation Act. This law primarily aimed to update vocational rehabilitation policies in effect for 50 years, but somehow—stories vary about how this happened[22]—Section 504 made it in. Section 504 was the first federal statute to extend civil rights protections to people with disability:

> No otherwise qualified individual with a disability in the United States … shall, solely by reason of his or her disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency.[23]


However, this dramatic expansion of disability rights confronted entrenched resistance from the Nixon, Ford, and Carter administrations, all of which refused to enact regulations to implement Section 504. Frustrated by years of stonewalling, on April 5, 1977, disability rights activists entered the federal Office of Health, Education, and Welfare in San Francisco, riveting national attention as they occupied the space and launched what became a multiweek sit-in. Trying (unsuccessfully) to dislodge the protestors, federal officials cut off hot water and telephone service; at windows, deaf protestors used sign language to communicate with the outside world; Black Panther Party members delivered daily hot meals. After nearly a month, the protestors emerged when the Carter administration agreed to sign Section 504 regulations.[24]

Core to Section 504 is that people must prove they are "qualified" as disabled before they can bring complaints about disability discrimination. This requirement differs from other civil rights laws (e.g., under the 1964 Civil Rights Act, individuals must not first establish their race, sex, religion, or other covered attribute before seeking protection). The ADA, enacted in 1990, followed Section 504's lead in requiring people to first prove they are disabled. Many early ADA lawsuits that rose to the US Supreme Court focused on this issue, and major court rulings narrowed who is disabled under the ADA. To reverse this trend and ensure that courts construe disability broadly, Congress passed the Americans with Disabilities Act Amendments Act (ADAAA) in 2008, which lists multiple conditions as examples of physical or mental impairments that can substantially limit major life activity and validate disability. Episodic impairments or impairments that are in remission qualify as disability if, when active, they substantially limit a major life activity. When determining whether a person has a disability, the ADAAA requires courts to disregard amelioration of functional abilities based on an assistive technology or treatments—with the exception of ordinary eyeglasses or contact lenses. (To learn more about how various agencies and laws define disability and other related terms, see the table at go.aft.org/p87.)

Disability rights laws require not only that public entities and businesses stop discriminatory actions but also that they take proactive steps to provide equal opportunity to persons with disabilities, within the

**Disabled people are more likely to face disadvantages in social drivers of health, with lower educational levels, employment rates, and incomes.**

**Erroneous assumptions about people with disabilities worsen their health outcomes.**

bounds of what is considered "reasonable accommodations" or "readily achievable." Framers of these laws adopted this reasonableness standard because of concerns, largely from business owners, that accommodating disabled people would be expensive and cause undue hardship. The laws recognize that determining reasonable accommodations must be highly individualized, as each disabled person has specific needs and preferences for what works best for them.

The fact is that accommodations often cost nothing or have modest costs. According to employer surveys conducted by the federally funded Job Accommodation Network, 56 percent of employers reported that accommodations needed by their disabled employees cost nothing; 37 percent reported a one-time expenditure with median costs of $300; just 7 percent reported ongoing costs with median annual expenses of $1,925.[25] Some potentially no-cost employment accommodations include adjusting work schedules, welcoming service animals,[26] and providing remote work options. Sally Ann's story offers a good example.

**In the late 1980s, when Sally Ann was in her 20s, her multiple sclerosis worsened. The ADA had not yet been passed, and she worked in an older building that had no accommodations such as stair handrails or designated parking spots; in addition, she had to travel down a flight of stairs to use a women's restroom because the restroom on her floor was designated for men. Navigating her office work became much more challenging, so she requested accommodations—including a designated parking spot, handrails for the stairs, an air conditioning unit for her office, and reassignment of restrooms so that the women's restroom was on the floor she worked on. Sally Ann's boss agreed to make the changes, which cost little, and Sally Ann was able to continue working.[27]**

## What Healthcare Disparities Do People with Disability Face?

Disability rights laws and regulations require that people with disability receive equal access to healthcare, which might necessitate accommodations to meet access needs.[28] Section 504 covers providers receiving federal funds, such as Medicare and Medicaid; ADA Title II applies to providers supported by state and local governments; ADA Title III covers private practices or organizations (e.g., private hospitals) that serve the public; and Section 1557 of the Affordable Care Act (ACA) prohibits any health programs, insurers, or activities that receive federal funding from refusing to treat or otherwise discriminating against people on the basis of race, color, national origin, sex, age, or disability. Despite these mandates, people with disabilities often receive substandard care and experience worse health outcomes than do nondisabled people.[29]

Since 1980, the US Office of Disease Prevention and Health Promotion has published decennial *Healthy People* reports delineating public health priorities for the decade ahead. The 2000 report, *Healthy People 2010*, was the first to designate disabled people as a population experiencing disparities. The report attributed disability disparities at least in part to common misconceptions about disabled people that result in an "underemphasis on health promotion and disease prevention activities."[30]

Relatively little nationwide data are routinely collected about healthcare services received by people with disabilities, apart from limited survey information. Rates of routine checkups in the past year do not vary significantly by disability status, although disabled adults are much less likely to have seen a dentist. Women with disabilities are less likely than other women to receive Pap tests and mammograms, although differences vary by disability type. Colorectal cancer screening rates are comparable by disability status.[31] Importantly, disparities in routine service use are not primarily driven by insurance status (i.e., ability to pay for the service). Because of safety net programs—Medicare coverage for persons under age 65 with Social Security Disability Insurance and Medicaid for disabled adults with low incomes—people with disabilities ages 21–64 are slightly more likely to have health insurance than nondisabled individuals (90.9 percent compared to 88.9 percent).[32]

Over the last three decades, researchers have documented disability disparities in specific healthcare services, especially in sexual and reproductive health services, cancer care, and care during COVID-19.[33] Numerous studies have interviewed disabled people, as well as physicians and other healthcare professionals, providing in-depth insights into their perspectives on disability disparities. Many factors contribute to these inequities; below, I highlight four important concerns, drawing especially from a 2019–20 nationwide survey of physicians about providing outpatient care to adults with disability.

### Inadequate Physician Knowledge

**Caroline, who became quadriplegic from a spinal cord injury, experienced pain following a hemorrhoidectomy. When she asked for Tylenol, her nurse asked, "Why? You can't feel." Caroline explained, "Just because I'm a C-5 quad doesn't mean I still can't feel pain. Some people do; some people don't. You have to ask." Although skeptical, her physician did eventually prescribe medication.[34]**

**As she planned for labor and delivery, Sylvia explored how being a person with dwarfism might affect her care. She brought x-rays of her spine when she met with her anesthesiologist to help plan the epidural approach. The clinician was reluctant to look at the films or listen to her concerns about potential difficulties with anesthesia. Sylvia asked if he'd ever administered an epidural to a little person before, and he replied, "Well no, but it can't be that different." Complications during**

anesthesia administration compromised Sylvia's labor and delivery, which caused Sylvia distress and made her obstetrician's job more difficult.[35]

Diane is a physician and medical educator who uses a wheelchair. She is concerned that disability training is not required in or a core component of medical school curriculum. To her, this omission "reinforces the idea that these aren't really your patients or they're not important enough for you to learn about."[36]

In the 2019–20 nationwide survey, only 41 percent of physicians in outpatient practices reported feeling very confident that they could provide equal quality of care to disabled patients as to nondisabled patients, and just 56 percent said they strongly welcome people with disability into their practices.[37] Patients with disability generally sense when their physicians are uncertain how to care for them—and when they are unwelcome.[38] Physicians' knowledge gaps can be obvious, as Caroline and Steffie learned when they experienced pain. (People with injuries high in the spinal cord can risk life-threatening complications from certain types of pain.) Some people with disabilities, especially those with less common conditions, educate themselves to ensure they get the right care. But as in Sylvia's case, some healthcare professionals dismiss their concerns.

US medical schools do not have a common curriculum, although all students must pass standard national exams. It is unclear how many of the country's approximately 155 allopathic medical schools and roughly 40 osteopathic schools currently include disability in their curricula. Anecdotal evidence suggests that few medical schools systematically teach about it.[39] Depending on their chosen specialty, physicians may receive training on disability during their residencies. However, disability considerations are not included in standard medical licensure exams or, with some exceptions, in specialty board certification exams.

In the 2019–20 survey, 35 percent of physicians indicated that lack of formal education or training was a large or moderate barrier to caring for patients with disabilities. In addition, 36 percent reported knowing little or nothing about their legal responsibilities under the ADA, despite nearly 30 years passing since its enactment. Most worrisome, 71 percent did not know the correct approach for determining reasonable accommodations (i.e., collaborative discussions between disabled patients and their clinicians), and only 80 percent understood that providers or practices (not patients) pay accommodation costs. About 68 percent of survey respondents believed they were at risk for an ADA lawsuit.[40]

### Physical Barriers

Victor has a neurologic condition and uses a wheelchair. Upon arriving for his appointment with a neurologist, he described the "wheelchair accessible" entry as anything but: the arrow indicating accessible entry led him down an alley behind the building to the back door, where there was only a small space barely large enough for him to open the door and turn his chair. Just inside the door, Victor had to maneuver up a four-inch step. "That's their idea of accessibility!"[41]

Ray, who is paraplegic from a spinal cord injury, visited a doctor because of severe groin pain and a growth about the size of a bean in the area. There was no height-adjustable exam table, so the doctor examined Ray while seated in his wheelchair. After sticking his finger into Ray's groin, the physician diagnosed him with an infection and prescribed a week of antibiotics. "After the seven days, that bean turned into a little tennis ball," Ray said; three weeks later, it was "the size of a grapefruit." The "infection" was finally correctly diagnosed as Hodgkin's lymphoma.[42]

**In a 2019–20 survey, 36 percent of physicians knew little or nothing about their legal responsibilities under the ADA.**

Accessibility of physical environments involves not only physical features but also lighting, noise, signage, and other aspects of space that affect people across a range of disabilities. The US Access Board, an independent federal agency mandated by Section 502 of the 1973 Rehabilitation Act, coordinates accessibility regulations across federal agencies. Several laws direct its activities, including the Rehabilitation Act, ADA, 1968 Architectural Barriers Act, and Telecommunications Act of 1996. In 1991, the US Access Board issued its first regulations to implement ADA accessibility standards. Those regulations focus on fixed structures, such as parking lots, sidewalks, building entrances, and aspects of interior spaces, like corridor and door widths, elevators, and restroom features (e.g., toilet heights, grab bars, and positioning of sinks). Despite their patient care mission, few hospitals and health centers met these ADA guidelines. Small practices and clinics, especially those in older structures and rural areas, were often inaccessible.

**We must address barriers to care and ensure that healthcare facilities comply with federal accessibility requirements.**

Not surprisingly, early efforts to improve physical access at healthcare facilities started with the 1991 structural accessibility requirements—with some success. For example, from 2006 to 2010, California used a 55-item tool based on ADA regulations to examine accessibility at 2,389 primary care sites contracting with several managed care organizations serving Medicaid enrollees. The state found that van-accessible parking spaces were inadequate, but otherwise parking, exterior access, building access, and interior public spaces generally met access standards—except for physical barriers that remained in bathrooms and examination rooms. The 55-item tool also included accessible medical diagnostic equipment (MDE), although MDE was outside ADA regulations. Only 3.6 percent of primary care sites had an accessible weight scale, and only 8.4 percent had a height-adjustable examination table.[43] Having accessible MDE is essential for persons with mobility disabilities to receive safe, respectful, and equitable healthcare. Many studies have documented the hazards, indignities, and compromised quality of care of inaccessible MDE, such as wheelchair users like Ray being examined in their chairs rather than on examination tables or patients with mobility difficulties being weighed at a granary, a cattle processing location, or a supermarket because practices lacked accessible scales.[44] In addition to improving patient care, accessible equipment also reduces risks of potentially career-ending occupational injuries for practice staff.[45]

The original ADA accessibility regulations viewed MDE, such as weight scales, examination tables, diagnostic imaging equipment, mammography machines, and gurneys, as furniture (i.e., not fixed structures). In the mid-2000s, congressional attempts to develop access standards for MDE failed. However, Section 4203 of the 2010 Affordable Care Act finally required the US Access Board, in consultation with the Food and Drug Administration, to issue accessibility standards for MDE for adults.[46] The Obama administration finalized these rules in January 2017;[47] in December 2017, the first Trump administration announced it would take these rules no further.[48]

Although standards now exist for accessible MDE, healthcare providers have been slow to acquire this equipment. The 2019–20 nationwide survey of physicians in outpatient practices found that only 10 percent always used accessible weight scales for patients with significant mobility limitations.[49] Although wheelchair users systematically underestimate their weight, 32.4 percent of physicians "usually or always" and 40 percent "sometimes" simply asked these patients their weights. Only 19 percent of physicians "always" and 19.9 percent "usually" used height-adjustable exam tables for patients with significant mobility limitations.[50]

Recognizing the "modest voluntary adoption of accessible MDE by healthcare providers," on May 9, 2024, the US Department of Health and Human Services (HHS) updated Section 504 regulations.[51] All weight scales and exam tables purchased, leased, or newly acquired more than 60 days after publication of the final rule must comply with the 2017 accessibility standards; by July 8, 2026, all settings must acquire at least one accessible weight scale and exam table. (On August 9, 2024, the US Department of Justice issued similar rules mandating accessible MDE at healthcare facilities covered under ADA Title II.[52]) Unlike other disability rights laws, this provision has enforcement mechanisms,[53] but whether the second Trump administration will enforce compliance is unclear.

#### Communication Barriers

**John, who is deaf, was hospitalized with Guillain-Barré syndrome. As he lay in bed, doctors circled him, touching him and talking to each other about his case, but they did not include him. "I didn't know what anybody was saying.... They come in, treat me like some object in a zoo, and leave," he said.[54]**

**Mackenzie is also deaf, and when her newborn son was admitted to the neonatal intensive care unit because of nutrition concerns, his pediatrician became angry with Mackenzie for not following the prescribed formula measurements. The pediatrician, the NICU, and the public health program Mackenzie was enrolled in all refused to hire a sign language interpreter, with the public health program citing the cost. Instead, they relied on Mackenzie's husband to facilitate communication, "but it's still not full information."[55]**

Without effective communication between patients and clinicians, patients with communication-related disabilities may not fully understand their health conditions and treatments, raising risks for poor outcomes and making it more difficult for patients to trust or feel respected by clinicians. Section 504 and the ADA require providers to ensure effective communication after first discussing with

patients their preferred communication accommodation, even if it is low tech—such as by providing written communication to patients. Many approaches are available to accommodate diverse communication needs, including voice amplifiers, in-person and remote (by video) sign language interpreters, telecommunication technologies, augmentative and alternative communication devices, and myriad other communication tools.

Yet, the 2019–20 nationwide outpatient physician survey found that few physicians provided even low-tech accommodations to many patients with communication-related disabilities. For instance, 37 percent of physicians "never" and 19 percent "rarely" provided printed materials in a large font; 24 percent "never" and 26 percent "rarely" described exam rooms verbally to their patients with limited vision.[56] People who are blind or have low vision advocate for these basic steps.[57] Fifty percent of physicians also reported never using an in-person sign language interpreter hired by the practice, and 63 percent never used remote interpreting for their deaf patients.[58] Instead, 31 percent "always" and 30 percent "usually" spoke louder and more slowly to these patients. Physicians who wrote unstructured comments on the survey complained about costs of sign language interpreters, reporting these expenses often exceeded their visit fee and are therefore unfair.[59] The ADA requires practices to cover accommodation costs.

On May 6, 2024, HHS issued final regulations under ACA Section 1557. Section 92.202 of these rules requires healthcare clinicians to "provide appropriate auxiliary aids and services where necessary to afford individuals with disabilities an equal opportunity to participate in, and enjoy the benefits of, the health program.... Such auxiliary aids and services must be provided free of charge, in accessible formats, in a timely manner, and in such a way to protect the privacy and the independence of the individual with a disability."[60] Whether these rules will be enforced under the Trump administration is unclear.

#### Diagnostic Overshadowing and Erroneous Assumptions

Clinicians frequently make inaccurate assumptions about disabled people and their health needs that lead to worse outcomes. One common error is "diagnostic overshadowing"—mistakenly attributing all new symptoms affecting disabled patients to their underlying disabling condition.[61] Diagnostic overshadowing can delay detection of potentially life-threatening health problems. For example, across two years and without testing, multiple doctors attributed one woman's substantial weight loss and abdominal pain to gastroparesis (paralysis of stomach muscles) from her spinal cord injury; she weighed less than 100 pounds when they finally diagnosed her Hodgkin's lymphoma.[62]

Perhaps the most insidious erroneous assumption about people with disabilities is biased and uninformed judgments about their quality of life. As noted above, many people with significant disability adapt to their functional limitations and enjoy good quality lives.[63] Nevertheless, in the 2019–20 survey, 82 percent of physicians reported their perception that people with significant disability have worse quality of life than nondisabled people.[64] The COVID-19 pandemic clarified the risks to disabled people of these stigmatized attitudes.

In January 2020, when COVID-19 took hold in the United States, American hospitals and clinicians were not prepared. They lacked not only basics, such as personal protective equipment, but also adequate capacity of lifesaving interventions, such as intensive care beds and ventilators. In times of resource scarcity, states and hospitals dust off "crisis standards of care" (CSCs)—theoretically objective guidance, developed with community input outside crisis periods, to direct allocation of scarce resources. However, some CSCs explicitly endorsed withholding scarce resources from disabled persons, including people with "severe or profound mental retardation" and individuals with neuromuscular conditions "requiring assistance with activities of daily living." Disability advocacy groups filed complaints against seven states with the HHS Office for Civil Rights alleging disability discrimination.[65] On March 28, 2020, the Office for Civil Rights issued a bulletin stating that "Persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative 'worth' based on the presence or absence of disabilities.... Our civil rights laws protect the equal dignity of every human life."[66]

**Clinicians and their unions can be powerful advocates for equitable care and appropriate accommodations.**

### How Can Clinicians Better Support Patients with Disability?

**Claire had polio and uses bilateral forearm crutches. After surgery for early-stage breast cancer, she was quickly sent home, with no plans for assistance with mobility. "I literally walk on my arms," she said. "I have to take almost 100 percent of the weight off my legs. They never thought, 'How is she going to do that with the 6 to 7 inch scar under her arm?'"[67]**

**Crystal has an intellectual disability. When she sought prenatal care, she needed accommodations such as written communication. The midwife caring for her respected her preferences. She also took time to listen to Crystal without distractions—even turning off her office computers. "It made me feel more at ease to know that she was actually sitting there, listening to me," Crystal said.[68]**

A starting point for better supporting disabled patients is addressing the barriers to care identified in this article and ensuring that healthcare facilities comply with the accessibility regulations and accommodations outlined in the ADA and ACA. Here, clini-

**Collaborating on healthcare solutions that provide dignity and equality for people with disabilities benefits all of us.**

cians and their unions can be powerful advocates. For example, they can bargain for and serve on committees tasked with helping staff better understand accessibility barriers to health, assessing facilities' abilities to provide accessible and disability-competent care, and developing recommendations for improvement.*

These assessments can help uncover challenges patients may experience with structural access—even in facilities purporting to have accessibility accommodations, as in Victor's experience. They can also uncover patients' challenges with information access, such as lack of resources (i.e., sign language interpretation services, augmentative communication devices, or other communication aids) to accommodate effective health communications. And they can help identify areas for improved communication between clinicians, which facilitates greater access for disabled patients across multiple points of care.[69] For example, Claire's experience highlights the need for care coordination, including ensuring discharge planning and appropriate home-based supports.

Assessing disability care competence may uncover healthcare professionals' assumptions and biases about people with disability that could put patients at risk for negative health outcomes—as seen in Caroline's and Sylvia's experiences. Beyond identifying biases, clinicians and union members can work to actively mitigate them by advocating for disability competent care training for health professionals. This is a necessary step toward making clinicians and healthcare staff not only more knowledgeable and supportive of disabled patients' care needs but also more prepared to appropriately meet them.[70]

Clinicians and their unions can also advocate for healthcare administrators to include more disability perspectives in the workforce, including by hiring more physicians and other healthcare professionals who have disabilities, and by making sure their workplaces meet the needs of disabled staff as well as patients. Such moves might influence disability competence and patient outcomes related to patient-provider concordance and fostering patient-clinician trust.† One physician described it this way:

> The single most important insight I have gained from being a disabled doctor is that I really have no idea what life is like for my patients.… The disability I know best is deafness. The profession I know best is medicine. So I accept that I've no idea how life is for, say, an accountant with cerebral palsy. But I do at least know what not to do if I should meet such a person. I won't automatically assume that they can't do certain things—nor will I blithely reassure them that they can. I'll … try to build up a picture of a more complex reality. Above all, I will let them tell me how it is.[71]

Clinicians inviting patients to tell them "how it is" is a crucial point that should be reinforced in the electronic health records. One place some healthcare organizations are adding disability information is in the demographic information section (i.e., where they gather information about race, ethnicity, LGBTQIA+ status, and gender identity). Some hospitals collect information on functional impairments, and they ask a separate question about whether people identify as disabled. Many healthcare providers are also specifying a location in records to note accommodation needs, although that must be continually updated (as indeed all information on disability should).

In terms of policy, health professionals and their unions can advocate for state and federal enforcement of the existing laws described here. In addition, the National Council on Disability's Framework to End Health Disparities for People with Disabilities identifies core components that clinicians and communities can join forces to push for at the federal level, including designating people with disabilities as a Special Medically Underserved Population, requiring comprehensive disability clinical care curricula and competency training, and improving data collection related to healthcare for people with disabilities.[72] In addition to individual and union activism, healthcare workers can join with professional associations and other advocacy groups to increase the pressure on lawmakers to make improving care for patients with disabilities a legislative priority. This is especially important given the substantial Medicaid cuts in the so-called Big Beautiful Bill, which President Trump signed into law on July 4, giving tax cuts to the ultra-wealthy. Although the impact of the Medicaid cuts will vary across states, disabled people in rural regions, where hospitals may close because of these cuts, could face significant barriers to accessing healthcare (e.g., because of longer travel distances).

The number of people in the United States who have some disability is expected to increase in the coming years. Our healthcare system must be better equipped to provide these individuals with safe, accessible, and patient-centered care—and everyone has a role to play. As disability affects all of us in ways large and small, collaborating on healthcare solutions that provide dignity and equality for people with disabilities benefits all of us. ✚

**For the endnotes, see aft.org/hc/fall2025/iezzoni.**

*One resource such committees may want to draw on is the Disability Equity Collaborative (disabilityequitycollaborative.org), which offers a comprehensive array of healthcare trainings, toolkits, and guidelines.

†To learn more about the importance of diverse perspectives and patient-clinician concordance in healthcare, read "From 'Do No Harm' to 'Do More Good'" in the Fall 2024 issue of *AFT Health Care*: aft.org/hc/fall2024/taylor.


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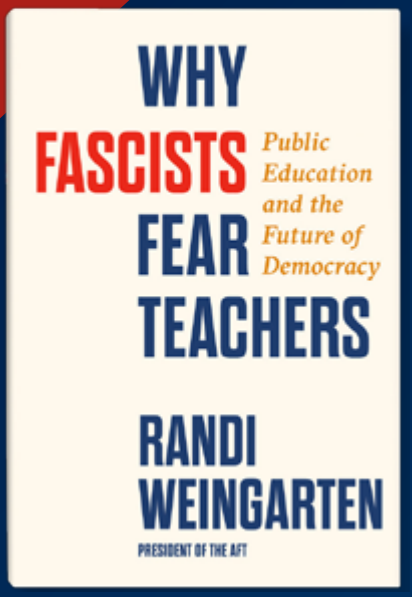



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