



HEALTH CARE

A BIENNIAL JOURNAL ON HEALTH AND COMMUNITY WELL-BEING

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Healthcare's Big Squeeze

RANDI WEINGARTEN, AFT President

TODAY, AMERICANS ARE being squeezed in every direction. Families are finding it harder and harder to keep a roof over their heads, meals on the table, and the lights on. At the center of this crisis? Healthcare. It's a top priority for our union as we fight for a better life for all.

Recent national polling by KFF confirms what we already know: Healthcare now tops the list of what people worry about affording, outranking even groceries, utilities, and gas. And as frontline healthcare workers know too well, this affordability crisis only *compounds* the ills of a healthcare system that puts profits before patients.

For healthcare professionals, the Big Squeeze shows up every day at work—and then follows you home.

Spending time with our healthcare members, I see the toll it takes. At work, even more of your patients are delaying care and rationing medications because cost stands in the way. You were *already* propping up a broken system: Patient care choices too often dictated by corporate owners and their bottom lines. Dangerous understaffing. Crucial departments and even whole hospitals being shuttered. The constant risk of workplace violence—and now of raids by Immigration and Customs Enforcement (which you can read about on page 16). The moral injury of not being able to provide the care your patients deserve. The plague of medical debt, a leading cause of bankruptcy in this country even for insured patients.

At home, you're trying to make ends meet in the same tough economy as everyone else. Many of you carry significant educational debt. You worry about how to afford college for your kids and gas for your

car. In a recent AFT survey, 74 percent of our members reported living paycheck to paycheck. Nearly half reported putting medical or dental care on a credit card in the past year.

This adds up to a public health crisis: Overworked healthcare professionals are crushed by caring for sicker patients, while enormous profits flow to those at the very top.

It's all getting worse under President Trump. The war in Iran is costing a billion dollars a day and increasing the cost of practically everything we buy. And families are already paying \$1,700 a year more for the basics because of Trump's tariffs.

Billions for a war of choice that most Americans do not want—but none for food, housing, or healthcare? The refusal of Trump and congressional Republicans to extend Affordable Care Act subsidies has increased premiums by up to 114 percent for families. The GOP has inflicted massive cuts, nearly \$1 trillion, on Medicaid—plus another \$200 billion in cuts to food assistance, which will impact families' health. (Turn to page 3 to learn more about these and other devastating cuts.) No matter who you voted for, you didn't vote for this.

But we're fighting back—fighting for a better life for all. Here's some of what our union is doing right now:

- Through organizing, contract negotiations, and state legislation, we're winning safer staffing, professional-level pay, and more voice in care protocols.
- Our Fight for Affordability campaign (visit go.aft.org/0gd for details) includes a suite of new consumer empowerment tools and expanded debt and finan-

cial literacy clinics that explain how to prevent and navigate medical debt, from avoiding surprise medical bills to appealing insurance claim denials.

- We're calling on more senators to sign on to the Working Americans' Tax Cut Act, which I was proud to join Senators Chris Van Hollen and Mark Kelly, the Patriotic Millionaires, the AFL-CIO, and AFT members in launching. This act will ensure that multimillionaires finally start paying what they owe and that the working class gets a break.

When we band together, we win—and we're going to show our collective power in November's midterms. We'll be getting out the vote for local, state, and national leaders who understand that families are struggling and will deliver the relief they need.

America is with us because what brings us all together is a vision that goes way beyond political parties. It's labor's vision: Fighting for working people to have a better life. Good wages. Affordable, high-quality healthcare. A secure retirement. Real opportunities for our children to do better than us. For you to be able to practice your profession free from moral injury—so your patients get the care they deserve. +

This affordability crisis only compounds the ills of a healthcare system that puts profits before patients.



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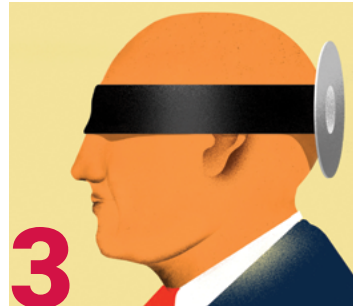
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Our Mission

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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What Donald Trump's Second Presidency Has Meant for Health



By **Scott L. Greer, Holly Jarman, Rachel Kulikoff, and Miranda Yaver**

We have just come through one of the most significant years in the history of American health policy. The first year of the second Trump administration saw enormous changes that will shape every element of health for years to come—from whether future clinicians have professional degrees to whether a particular hospital survives, and from whether we monitor diseases to whether we continue Meals on Wheels.

President Trump only received 49.8 percent of the vote in November 2024,¹ but he pretends to have a mandate from an overwhelming majority of the country, and his administration has been forceful and creative in reshaping healthcare. Its ability to swiftly enact sweeping change has been enabled by unified Republican control of Congress, which has chosen not to check the administration's actions. Shortly after Trump's inauguration, the Senate voted to confirm his nominees to lead the federal public health bureaucracy—most notably, Robert F. Kennedy Jr. as secretary of Health

and Human Services (HHS), despite his long record of disseminating disinformation and pseudoscience on issues ranging from vaccines to fluoride to AIDS.

Under the leadership of Secretary Kennedy, as well as the administrators of the National Institutes of Health (NIH), the Centers for Medicare and Medicaid Services (CMS), and the Food and Drug Administration (FDA), this administration has wrought profound transformations throughout healthcare and public health. It has unleashed damage that will take decades to rectify. This article synthesizes the damage and outlines what can and must be done to protect our health and our democracy.

Dramatic Cuts to Health Spending

The biggest target in 2025 for the administration and Republican lawmakers was healthcare. They called their signature legislation, signed into law on July 4, the One Big Beautiful Bill Act (OBBBA). The OBBBA extended the enormous tax cuts for the rich passed in

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Raising the profile of healthcare and public health cuts and their deadly consequences is not just a service to health: It's a service to democracy.

Trump's first term while massively increasing spending on the Department of Homeland Security (DHS) and especially immigration enforcement (with ruinous results that are outside the scope of this article). Under Senate rules, that loss of tax revenue and increase in DHS spending had to be offset by large spending cuts elsewhere. Republicans went straight to healthcare to find those cuts. The healthcare cuts fall into two major buckets: Medicaid and the Affordable Care Act (ACA); there were also huge cuts in areas that affect health, such as the Supplemental Nutrition Assistance Program (SNAP), which supplements grocery budgets for lower-income families.

Cutting Medicaid

In Medicaid, the big policy changes include an intensive sequence of eligibility checks, eventually mandating state verification of enrollees against federal databases every month, new cost-sharing requirements for Medicaid expansion enrollees, and work requirements for Medicaid. The work requirements are a Medicaid cut disguised as a means of reducing "fraud." They mandate fussy bureaucratic documentation and count on people who are, in fact, eligible for Medicaid being too tired, confused, or sick to complete it correctly, on time, over and over again.

Although work requirements poll well and fit within a familiar "personal responsibility" narrative, they do not produce employment gains and have little to do with the actual Medicaid population, most of whom are already working or are obviously unable to work.² In reality, work requirements weaponize administrative burden, an old tactic that has been given new life by this administration; it has the effect of depriving people of benefits to which they are entitled by tying them up in paperwork and reporting requirements.³ Politically afraid of cutting Medicaid even more, Republicans ordered states to adopt subtle but effective ways to make Medicaid harder to use. And while these burdensome requirements have already been enacted in a small number of states (namely, Arkansas attempted it on a temporary basis in 2018⁴ and Georgia on an ongoing basis in 2023⁵), the OBBBA upends state control of Medicaid by compelling states to impose these constraints. Given the unpopularity of many of the reforms enacted through the OBBBA, it is little wonder that congressional Republicans deferred most of the provisions' implementation until after the 2026 midterm elections—when voters might hold them accountable.

The OBBBA also makes changes to Medicaid that target specific groups, especially immigrants.⁶

The bill is filled with restrictions on the services that immigrants can receive, and, as with the work requirements, the burden of constantly proving citizenship will reduce their access to care. However, in addition to having lower healthcare usage and costs compared with US-born citizens,⁷ documented and undocumented immigrants pay more in taxes than they receive in services overall. They pay a range of taxes, from sales and gas taxes to income tax and the taxes withheld from paychecks to fund Social Security and Medicare. Undocumented immigrants in particular get far less for their taxes than documented immigrants and citizens, since they are ineligible for many programs. An average undocumented immigrant with less than a high school education who arrives at age 25 will pay about \$200,000 more in taxes than they receive in services over their life⁸—so 100 undocumented immigrants could easily mean \$20 million in additional tax revenue over their lifetimes.

The OBBBA's focus on making people constantly prove citizenship to participate in programs makes it less likely that undocumented immigrants will acquire the paperwork needed to contribute through payroll taxes. As a result, there is a decent chance that these changes actually *harm* the Medicaid budget by making it harder for immigrants to pay into the system.⁹ The care that they do receive in the United States, when they become too sick to avoid it, will often be uncompensated care for hospitals, further straining providers' finances. In general, of course, these Republican policies are intended to induce immigrants to "self-deport" (and to dissuade potential immigrants from coming to the United States at all).

Finally, the OBBBA makes cuts to Medicaid provider taxes, the state-imposed taxes on healthcare organizations and on facilities for which at least 85 percent of the tax burden is applied to healthcare items, services, or entities that provide or pay for healthcare items or services.¹⁰ Though provider taxes may seem obscure, all states except Alaska use them to help finance the state's share of responsibility for Medicaid funding. These taxes are a jerry-rigged way to prop up inadequately funded Medicaid programs, but cutting them isn't a fix. As in most other areas of health policy, Republicans don't have a plan for improving or reforming Medicaid. They simply want to pull out the props without any intent to replace them with something better.

Undermining the Affordable Care Act

Under the Affordable Care Act, the marketplaces that enable working-class people to buy insurance combine regulation (the policies have to meet certain standards, including the provision of a comprehensive set of benefits) with subsidies to make the policies more affordable for those with qualifying incomes. The OBBBA drastically cuts the subsidies,¹¹ leading to the sticker shock roughly 24 million marketplace enroll-

ees faced during the 2025 open enrollment period for insurance in 2026; by January 15, 1.2 million fewer people had selected (or continued) insurance plans compared to the previous year (and more reductions are expected in the coming months as people receive their new bills).¹² Over a year or two, the higher costs will filter through to other parts of the healthcare system. Insurers will withdraw options or raise prices to compensate for the loss of marketplace business, health systems will see uncompensated care costs rise, people will get sicker as they forgo preventive care and treatment of chronic issues, and smaller and rural hospitals will lose crucial revenue.

Republicans' commitment to undermining the ACA was so absolute that they refused to end the October–November 2025 shutdown of the federal government by restoring ACA subsidies, despite the popularity of the ACA as a whole and of the subsidies in particular.¹³ Restoring the subsidies would have mostly benefited their voters in time to help Republicans keep their seats in the November 2025 elections, or in the coming 2026 elections, as more than half of all ACA marketplace subsidy recipients live in red states.¹⁴ But all Republican leaders would promise was a Senate vote sometime later in January 2026. This deadline ultimately came and went without a vote to extend the enhanced subsidies.¹⁵ Absent this assistance with plan premiums, America will experience increases in uninsurance as well as underinsurance, compromising hospitals' financial security and patients' health security.

Though the ACA has long been ensnared in partisan politics, it has been a lifesaver for the tens of millions of Americans with preexisting medical conditions such as previous cancer treatment or a chronic disease. Prior to the ACA's implementation, preexisting conditions could lead one to be denied coverage outright or else charged prohibitively expensive premiums. Though some Americans may not really remember what healthcare was like before the ACA, many will soon find out just how far-reaching its impact is—and after years of not being fearful of documenting medical concerns, many more people could be in trouble.

Some will find out because they work for healthcare facilities that depend on the ACA and Medicaid. The impact on healthcare facilities and jobs will be mediated through all sorts of capital market and corporate decisions, but we can identify the facilities at most risk. A high share of Medicaid and ACA marketplace patients—common for hospitals and clinics that serve rural areas¹⁶—is a very bad sign for healthcare providers post-OBBBA. In that vulnerable group, we should worry most about rural providers (many of which were already facing budget crises¹⁷), more remote facilities attached to larger systems, and for-profit providers with margin-minded owners who might reevaluate the viability of the business once the cuts take hold.¹⁸

Aware of the threat to rural healthcare, Republicans stuck a \$50 billion Rural Health Transformation Program into the OBBBA, with the first funds to be distributed in 2026. While \$50 billion sounds like a lot of money, it's much less when divided among 50 states—with the average grant amounting to \$200 million¹⁹—and this initiative is a drop in the bucket compared to the Medicaid cuts and other cuts to programs, including SNAP,²⁰ that help sustain rural healthcare. Don't bank on this \$50 billion saving your local hospital. As more of the draconian Medicaid cuts go into effect, the broader constellation of rural healthcare providers, from hospitals to federally qualified health centers to community mental health centers, will continue to be strained—shrinking services, driving facility closures, and increasing the risk of adverse patient outcomes and death.²¹

Destroying American Science

Evidence-based practice is hard and can be imperfect in execution, but at its core it requires evidence. The development of new treatments, born from insights about topics from gene splicing to the bacterial origins of ulcers, requires science. The US federal government has been, by a wide margin, the world's largest funder of research into basic biomedical science, new treatments, and evidence on the effectiveness of treatments. This has been primarily through its huge National Institutes of Health (NIH)²² and the National Science Foundation (NSF), but also through smaller agencies like the Agency for Healthcare Research and Quality (AHRQ) and those that conducted healthcare research as part of other agendas, like the US Agency for International Development (USAID).

The payoffs of federal research are enormous. One study of 356 drugs approved between 2010 and 2019 found that all but *two* clearly involved NIH research.²³ If you were to look at those two, we bet you'd find people trained on NIH grants, educated by scholars supported by NIH, and using experimental techniques NIH helped develop. In other words, essentially every FDA-approved medication that came on the market in the last decade received NIH support.

Think of any medicine that you were able to start using in patient care between 2010 and 2020. That medication is the result of NIH research. The study ended in 2019, but it's highly unlikely that anything has changed. The federal government, not pharmaceutical companies, funds the basic research upon which medicines are developed. And that's just



medicines. NIH also funds research into vaccines, medical devices and procedures, and population health—even complementary medicine that supplements standard biomedical care.

The National Science Foundation, meanwhile, might be better known for particle accelerators and the US Antarctica research station, but it's also been crucial to healthcare. In theory, NSF doesn't directly fund health research, but if you look into it, technologies as important as MRIs, mRNA, and the internet itself were actually born of its science grants.²⁴

That world-leading science machine is a target of the Trump administration. The White House and the Department of Government Efficiency (DOGE), initiated by Elon Musk at the beginning of Trump's second term, went after the science agencies with big efforts to lay off staff, redirect priorities, and end research programs that the White House found objectionable.²⁵ Their primary target was

"woke" research; grant programs and grants were blocked on the basis of broad searches for terms like *gender*, *bias* (even in the context of statistical analysis), *diversity* (even in the context of biological species), or *women*. Their dragnet approach to identifying "woke" grants fit with an overall attack on diversity, equity, and inclusion (DEI) initiatives that attempted to compel universities to cut programs.*

The result was chaos in science, as patients had treatments cut off because trials were ended, stop-work orders led to sudden layoffs, university programs cut admissions

because their graduate study grants were not funded, and government officials went silent.²⁶ It's not hard to find medical researchers who haven't heard from their government sponsors or received promised funding in months and have had to shut down their studies.

The Republican-led House of Representatives' and White House's proposed fiscal year 2026 budgets both call for drastic cuts to AHRQ (\$369 million and \$129 million in cuts respectively), and these cuts do not just imperil health systems research. AHRQ has been the core source of funding for numerous predoctoral and postdoctoral training programs in health services research,²⁷ which now face existential threats. The result is that even with the restoration of many grants, there will be delays in training the next generation of health researchers who help us work out which treatments are effective and safe.

Republicans don't agree among themselves about this agenda, as evidenced by some stark differences in Congress's and the White House's spending proposals for the 2026 fiscal year (which started on October 1, 2025). Trump's budget proposal included enormous cuts to NIH and NSF, and in fact to most science spending. The House left most funding flat, while the Senate's budget negotiations stalled for months;²⁸ Congress has since passed "minibus" legislation to fund most agencies, including federal science agencies.²⁹ However, the protracted negotiations fueled prolonged uncertainty about the continued functioning, and even survival, of key agencies that support health-related research, training, and services to communities throughout the nation.

Undermining Regulation

The US federal government also has historically regulated health treatments, separating effective treatments from the sorts of products health grifters sell on the internet. That has long made government regulation and the agencies that carry it out an enemy of businesses that sell "health" products, some of them actively engaged in misinformation with products or treatments that can be dangerous to individual and public health.³⁰ With the arrival of Secretary Kennedy and his colleagues in high office, opponents of science-based regulation are now in charge of science-based regulation.

It's very easy to get lost in the weeds with all the committees and processes that make up federal healthcare regulation. But what is happening is simple. The federal system for regulating and recommending healthcare, such as determining the preventive services and vaccines that insurers must cover, was designed on the assumption that impartial and highly skilled civil servants would support committees of experts who would bring together the best evidence to make recommendations that would influence standards of care and insurance coverage. That system is being pulled inside out, with political appointees running committees of people with limited expertise and deep connections to anti-vaccination movements and other purveyors of health misinformation.[†]

Hollowing Out Vaccine Recommendations

These political appointments, combined with other cuts to health agencies and spending, are already resulting in consequential decisions, especially in vaccine policy and communication. On January 5, 2026, the Centers for Disease Control and Prevention (CDC) changed the childhood vaccination schedule, limiting the number

Measles had been eliminated in the United States; now, thanks to anti-vaccination activists, the country is on pace to lose its elimination status.

*For details on these attacks on higher education, see "A Better Future for All: How Our Public Colleges and Universities Save Lives, Power the Economy, and Strengthen Democracy" on page 24.

†To hear from one former federal employee, see "Why I Resigned: A Reflection on Public Health, Scientific Integrity, and Moral Courage" on page 10.

of vaccinations recommended to all children to 11 from a previous 17. Instead, the CDC recommended “shared decision-making” for vaccinations for rotavirus, COVID-19, influenza, meningococcal disease, and hepatitis A and B, meaning that they are offered for those at high risk or in consultation with a physician.³¹ While CDC and HHS leadership have claimed that these decisions will build public trust in science, experts from academics and clinicians to the former chief scientist at the FDA and former members of the Advisory Committee on Immunization Practices agree that they will instead erode trust, decreasing vaccine uptake and increasing childhood disease.³²

Further eroding this trust is the current CDC position on the MMR vaccine. At the top of the CDC’s “Autism and Vaccines” webpage is this false assertion: “The claim ‘vaccines do not cause autism’ is not an evidence-based claim because studies have not ruled out the possibility that infant vaccines cause autism. Studies supporting a link have been ignored by health authorities.” The bottom of the page then delivers a sucker-punch to Republican Senator Bill Cassidy from Louisiana, a physician who forced Kennedy into one paltry commitment to secure his confirmation vote³³ for HHS secretary: “The header ‘vaccines do not cause autism’ has not been removed due to an agreement with the chair of the US Senate Health, Education, Labor, and Pensions Committee that it would remain on the CDC website.”³⁴ Under Kennedy, the CDC is showing only grudging compliance with the demands of a single Republican senator who required that it stand up for the science that should define it.

Perhaps the best evidence of the health consequences of the institutionalization of the anti-vaccination movement is in the handling of measles. The United States is currently having a multistate measles outbreak, with cases from New Mexico to South Carolina to Michigan, and case numbers for this extremely infectious disease are rising. Measles had been *eliminated* in the United States until anti-vaccination activism managed to push down vaccination rates; now, the country is on pace to lose its measles elimination status.³⁵ Instead of evidence-based promotions of measles vaccinations, HHS under Kennedy called for research into treatments, recommending strange or untested alternatives, including vitamin A and cod liver oil.³⁶ Instead of stopping measles, they are pushing measles patients onto healthcare systems. Few healthcare workers in the United States have ever seen measles, but more will soon.

Sowing Confusion About Nutrition

Kennedy and the MAHA movement are no better for chronic diseases. Consider our new dietary pyramid. The new federal dietary guidelines claim to attack processed food in the name of addressing chronic diseases, but they diverge by a lot from decades of nutrition science.³⁷ They explicitly “prioritize ...

healthy fats from whole foods such as eggs, seafood, meats, [and] full-fat dairy” and literally flip the food pyramid that the government long used.³⁸ In the new pyramid, a bowl of oatmeal and a few nuts sit at the narrow bottom while what appears to be a roasted chicken, a marbled steak, and a piece of cheese share the wide top next to some broccoli, peas, and carrots. The dietary guidelines retain previous recommendations to keep saturated fats below 10 percent of daily caloric consumption;³⁹ how people are supposed to do that while eating such foods is not explained. Additionally, while nutritionists caution against eating lots of processed food like packaged sweets or corn chips,⁴⁰ few would dream of suggesting the antidote is full-fat milk and a steak. This new approach turns a reasonable idea (“eat real food”) into something with little scientific backing.

Cutting Critical Agencies

The federal government has many agencies that are mostly known to those who work directly with them, from the Administration for Community Living (ACL) to the Health Resources and Services Administration (HRSA). Of them, perhaps only the Federal Emergency Management Agency, CDC, and FDA have much public visibility, but all of their work is important.

These agencies have been hit very hard by DOGE’s questionably legal cuts, sometimes retroactively made legal in a process called “rescission.”⁴¹ Their workforces are down by huge percentages, though the chaos of DOGE, layoffs, and early retirements make it really hard to figure out headcount or who is actually still employed and working. (ProPublica had to investigate, while websites like the CDC Data Project, cdcdatapoint.org/units-rifs, are crowdsourcing the cuts because the official federal communications are rare and not helpful.⁴²) The White House’s 2026 budget proposal would have cut them extensively,⁴³ and Ken-



nedey has proposed to reorganize most of them in a new “Administration for a Healthy America.”⁴⁴

Imperiling Care for Seniors and Communities

Sooner or later, these agency cuts will have indelible impacts on the federal government. Just consider a couple of these little-known agencies. HRSA is responsible for improving healthcare access in underserved areas and to underserved populations, with its grants often a lifeline for those providers; it also runs nationwide databases that track malpractice and the nationwide organ transplant networks that match kidneys or livers with recipients.⁴⁵ Ken-

nedey and the HHS administration have cut its workforce and are attempting to abolish it entirely, moving bits of it around within the agency.⁴⁶ Over time, the impact on healthcare access, malpractice, and organ transplants, among other things, could be huge. Or look at the ACL, which among other activities funds Meals on Wheels, supports programs that allow people with illness or disability to live independently (e.g., providing transport to healthcare appointments), and plays a critical role in oversight of nursing homes.⁴⁷ As cuts overtake the agency, it will imperil seniors’ and disabled individuals’ abilities to live in their communities. What’s

more, in December 2025 CMS repealed the minimum staffing requirements for skilled nursing and long-term care facilities, such that these facilities will no longer be required to provide at least 3.48 hours of nursing care per resident per day, with additional rescission of the requirement of 24/7 on-site RN services in nursing homes,⁴⁸ undercutting the health and safety of those dependent on this level of care.

Hobbling the US Public Health Response

Let’s hope that there is no global pandemic like COVID-19 anytime soon because no matter how skeptical you might have been of the US response, it relied on better science, preparedness, stockpiling, surveillance, and willingness to support vaccination than we have now. Cuts to NIH are directing research away from mRNA technology in particular and are undermining the base of scientists and labs that work on vaccines, treatments, and diseases. Cutting training programs for scientists means fewer people can staff testing or research into treatments and vaccines. And the FDA has been wracked by decimation of staff and instability; 3,500 personnel responsible for food testing and inspection, among

other functions, were laid off in April 2025, with 20 percent or less reinstated months later, compromising the safety of the nation’s food and drug supplies and defense response.⁴⁹

COVID-19 showed us how quickly scientific capacity can pivot, which is how we went from the first identification of the virus to a tested vaccine in almost exactly a year. There was a vaccine available before the virus was even present in every country in the world. (Tonga didn’t have its first case until fall 2021.⁵⁰) For comparison, it took three years from the first documentation of AIDS to identification of the underlying human immunodeficiency virus.⁵¹ We should not celebrate the stunning achievement of identifying powerful vaccines against COVID-19 by cutting the scientific capacity that made those vaccines possible and destroying the public health infrastructure that made the vaccination campaigns happen.

Public health and emergency management workers—and really anybody who tries to prevent bad things—like to say that they do their best work when nobody notices their work. We are about to find out what they were preventing, from bedsores in substandard nursing homes and understaffing and closure of rural healthcare facilities to the mismanagement of massive natural disasters. We’ll miss them when emergencies arise that force us to notice they are gone.

Defining Professionals

The US Department of Education is being dismantled, but it still retains the legal authority to determine the list of professional degrees that are eligible for the highest caps on federal student loans; the department was mandated in the OBBBA to use that authority to cut student loans. In November 2025, the department proposed rules changes through its advisory committee that would remove many healthcare professional degrees from the list, lowering the caps for student loans from \$200,000 to \$100,000⁵²—and telling healthcare professionals that they aren’t professionals after all.

Degrees that they propose to cut from the list include, remarkably, nursing, physician assistant, and physical and occupational therapy. In fact, if the profession requires fewer than two years of graduate study (e.g., nursing) or requires no credential (e.g., most master of public health degrees), it is likely out. This reduction in student loan caps could decrease the supply of health professionals, leading to workforce shortages, and decrease the number of people from working- and middle-class backgrounds in these fields. This proposal was put forth by the department as a proposed regulation for public comment,⁵³ and it tells us a lot about how this administration regards healthcare workers. This action comes in tandem with others that imperil the healthcare workforce, including anti-immigration actions (over one million non-

Agencies like the FDA have been wracked by decimation of staff and instability, compromising the safety of food and drug supplies.

citizens are employed in healthcare), cuts to Medicaid, and the reorganization of HRSA.⁵⁴

Fighting for Our Health and Our Democracy

What can be done for American health and the health of our democracy?

One thing we can do stems from a worrisome research finding, which is that poorer health makes people more likely to support authoritarian leaders like Trump.⁵⁵ We know that counties with worsening health, greater inequality, more extensive illegal drug problems, and economic decline are more likely to vote for Trump. That is true even if some of the reasons their health is worsening are attributable to Republican policies that close hospitals, minimize access to healthcare, or undermine drug treatment programs.⁵⁶ One study found that rural voters blamed former President Barack Obama for hospital closures that had been caused by states' refusal to expand Medicaid.⁵⁷

Why does poor health make people more likely to vote for radical right candidates like Trump?⁵⁸ The answer seems to be *trust*. Poorer self-reported health means more time spent navigating the healthcare system (as well as human resources departments and social assistance programs). Patients aren't just dealing with their new and old health issues, whatever they are. They aren't just learning to live differently or cope with pain or secure help to care for others in their lives. They are also getting to know the healthcare system better—not just care professionals but also telephone trees, insurance companies, puzzling invoices, long waits for appointments, difficult provider websites, incompatible health records, and all the other things that can make healthcare intensely frustrating.

No wonder many people have lost faith in the healthcare system and in our broader society. More exposure to a difficult-to-navigate healthcare system means more opportunities to feel disrespected, more hours spent in an urgent care or emergency department waiting room or on the phone with insurance companies, and more inexplicable and unaffordable medical bills. All of these interactions with the US healthcare system diminish trust—and, in the United States and elsewhere, lower trust makes people more likely to support authoritarians who exude strength (even when they offer false promises).⁵⁹

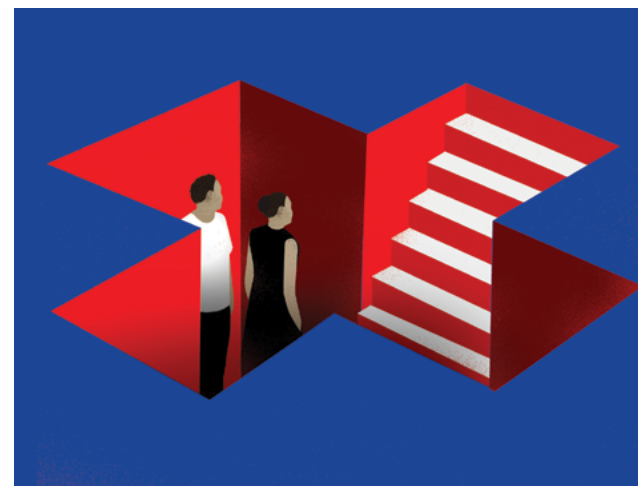
That might actually be more positive for healthcare workers than it sounds. Reforming society is the hard work of many, but perhaps making healthcare more trustworthy is something that can be done one day at a time, one patient at a time. Building trust among your fellow clinicians, and building patients' trust in you, isn't just good practice to get through the day; it's a service to democracy in dark times.

Unions are one of the best ways to build that trust.⁶⁰ They bring workers together, with the goals of enhancing patient care and making workers' lives better so that patients are seeing less-stressed professionals, and professionals have more scope to do their jobs well. Unions build solidarity rather than sow division and allow workers to bargain for the common good, supporting their communities as part of supporting themselves. The Trump administration has actively worked to strip workers' protections and ability to organize.⁶¹ But collective action by clinicians and healthcare professionals, such as fighting facility downsizing or increased reliance on private equity prompted by Medicaid cuts and bargaining for contract provisions that mandate safe staffing and reduce unsafe workloads, can improve the quality of patient care⁶²—and it can help restore trust and the sense that clinicians have the power to positively affect the problems we all face.

Equally, highlighting and explaining the impact of the Trump presidency on healthcare matters a lot, both to our health and to the well-being of our country. The Trump administration has been trying to command the political stage with a “shock and awe” campaign, overwhelming everyone from reporters to legislators to doomscrollers with the speed and fury of their cuts and actions on everything from science and medicine to immigration and international policy. That is not a bad strategy for a party led by a historically unpopular president with a historically thin victory in November 2024⁶³ whose party holds the House and Senate by tiny margins⁶⁴ and suffered a massive rebuke in the November 2025 elections.⁶⁵

Ultimately, we the people will decide whether the Trump administration's agenda will be implemented and survive in health, immigration, taxes, or trade. Health is one of the weakest points for Republicans in general, and the Trump administration's healthcare, science, and public health policies are very unpopular⁶⁶—but more communication and engagement are needed to draw public attention to this administration's harmful health actions.⁶⁷ The more people are aware of the hospital closures, union-busting, rate increases, shuttered labs, and anti-vaccination propaganda championed by Trump and his allies, the less popular Trump becomes, and the less he can do in the future. Raising the profile of healthcare and public health cuts and their deadly consequences is not just a service to health: It's a service to democracy. +

For the endnotes, see aft.org/hc/spring2026/greer_jarman_kulikoff_yaver.



Why I Resigned

A Reflection on Public Health, Scientific Integrity, and Moral Courage



By **Demetre C. Daskalakis**

Demetre C. Daskalakis, MD, MPH, is the chief medical officer of Callen-Lorde Community Health Center in New York City and former director of the Centers for Disease Control and Prevention's National Center for Immunization and Respiratory Diseases. He began his career as an attending physician at Bellevue Hospital in NYC, spearheading public health programs focused on community HIV testing and prevention; he was also the deputy commissioner for disease control for the NYC Department of Health and Mental Hygiene.

Public health has always been more than just a career for me—it is a mission to protect communities, prevent avoidable harm, and foster an environment where everyone has an opportunity to achieve their optimal health. My years in public health, including at the Centers for Disease Control and Prevention (CDC), were shaped by these values, as was my very difficult decision to resign from leading CDC's National Center for Immunization and Respiratory Diseases at the end of August 2025. My resignation represented the culmination of severe ethical conflicts, malevolent policy actions, and a growing realization that the agency I served was being weaponized for ideological ends.

In this essay, I explore the reasons behind my departure, the ethical dilemmas I confronted, and the broader implications for public health, scientific integrity, and the future of public health and our nation's health security. My hope is that my experience will serve as a call to action for those who share my commitment to science and to the health of the people public health serves.

My Commitment to Public Health

Throughout my career, I have been unwavering in my dedication to evidence-based medicine, community health, and the pursuit of equity. I trained to be an infectious disease doctor—a calling that brought me to public health. From testing people for HIV and sexually transmitted infections in nightlife venues to leading major national responses to outbreaks, to my work at the NYC Department of Health and Mental Hygiene, at the White House, and at CDC, I have served in local and national public health for more than 20 years. Whether working on immunization strategies, fighting infectious diseases, or advocating for marginalized groups, my aims have always been to shield the most vulnerable and to provide a path for all people to achieve their optimal health.

CDC, for me, was not merely an institution—it functioned as a collective force for good, where science and compassion came together to shape policy and act with positive force to improve lives. But in 2025, CDC came under attack and was transformed

ILLUSTRATIONS BY YASMINE GATEAU

into a self-serving weapon by the secretary of Health and Human Services, Robert F. Kennedy Jr. Thousands of staff were fired, core public health functions were ended, and CDC's scientific voice was replaced by propaganda and ideology. The remaining CDC scientists, despite being dedicated public servants and true experts, are largely prevented from using science and their collective centuries of experience to interpret data or guide decision-makers.

CDC does not exist in a political vacuum. Neither does any public health issue. From gun violence to immigration, CDC has often found itself in the middle of discussions of complex political issues with occasional (and detrimental) politicization of its public health approach. This was most evident during the COVID-19 pandemic, which resulted in trust gaps with CDC that have facilitated the destruction of CDC's public health mission at the hands of its current political leadership.

Resigning was not an impulsive act. It resulted from my long-standing concerns, diminishing ability to prevent harm, and deep conviction that remaining would compromise my values and my responsibility to the public. "First do no harm" was the oath I took to become a doctor, and I refuse to violate it. I and my colleagues Drs. Deb Houry and Dan Jernigan, global leaders in public health, decided that we would resign together to sound an alarm that could not be ignored. What is happening in public health now is not normal, and its impacts must be known by those public health is supposed to protect.¹

We had to raise a signal through the chaotic noise of Kennedy and his cronies to increase awareness. People's lives and the health of the nation were—and are—at stake. Many of the observations and experiences that led to my resignation from CDC have continued to evolve and have brought us to the point where CDC and the US Department of Health and Human Services (HHS) can no longer be trusted² as credible sources of public health information—especially as it relates to vaccines, vaccine safety, and the vulnerable populations this administration vilifies.

Conflating Health Equity and "Diversity, Equity, and Inclusion"

Until recently, CDC's website defined *health equity* as the state in which everyone has a fair and just opportunity to attain their highest level of health and no one is disadvantaged from achieving this potential because of socioeconomic status or other socially determined circumstances.³ Science is a cornerstone of public health and is an essential part of multi-pronged efforts to achieve health equity. Science designed to generate knowledge that advances equity and reduces health disparities can improve population health and promote health for all members of society.⁴ In contrast, science and interventions not

designed or implemented with equity in mind may inadvertently perpetuate or widen disparities.⁵ By conflating health equity and "diversity, equity, and inclusion" (DEI), Kennedy and his team are attempting to erase decades of progress through doublespeak and purposeful misclassification of evidence-based interventions as "woke." Are Americans going to tolerate this? Are we going to let an ideological battle against a distorted view of health equity hinder the progress we have made to end the epidemics of HIV, drug overdose, maternal mortality, and suicide among LGBTQIA+ youth? Are we going to replace evidence-based science with non-evidence-based and often discriminatory ideologies? Will our federal public health agencies support conversion therapy or involuntary commitment for people who use drugs? I fear that all this may happen—based on ideology and politics, not on science.

Health equity science provides a conceptual framework for scientific endeavors that are designed and conducted to advance health equity.⁶ Health equity science investigates patterns and underlying contributors to health inequities and builds an evidence base that can guide action across the domains of the public health program, surveillance, policy, communication, and scientific inquiry. Its goal is to move beyond simply documenting inequities toward eliminating them.

In contrast to health equity, DEI is a broader organizational and social approach that seeks to ensure diverse representation, equitable treatment, and inclusive environments across workplaces, educational institutions, and communities. DEI initiatives often focus on increasing participation from people of varied backgrounds and categories of identity (including race, gender, sexual orientation, ability, and more), removing barriers to opportunity, and fostering environments where all individuals feel respected and valued.

While health equity and DEI share the goals of fairness and justice, their scope and application differ. Health equity is specifically concerned with striving for equal opportunities for health by addressing the social determinants of health, driven by scientific research and public health action. DEI, meanwhile, encompasses

CDC and HHS can no longer be trusted as credible sources of public health information.



a wider range of sectors and strives for fairness and inclusion in representation, access, and participation beyond just health outcomes. In public health, DEI principles may support health equity by promoting diverse voices and perspectives in decision-making, but health equity is uniquely focused on addressing the social determinants and systemic factors that shape health differences. Health equity is not just about race, gender, sexual orientation, or ability. It is about space and time—rural America and the inner city. It is about economics—access to healthy food, stable housing, adequate care, and more. It is about mitigating bias—creating more welcoming services in which patients are seen and heard. It is about health security—shoring up infrastructure to address everyday public health threats and rarer, more dangerous threats. And health equity is not about one agency or department, but about the core work of all public health.

By integrating equity-focused frameworks into scientific practice, public health efforts can more effectively fulfill their missions and actively work toward eliminating health disparities. As DEI is now

being eliminated, temporarily suspended, or kept below the radar to survive authoritarian policies, the purposeful undoing of health equity reveals a disregard for the health of more vulnerable populations.

To decimate equity in public health is to endorse the philosophy that only the physically strong and socially advantaged deserve to thrive and survive. Strength and weakness are about not just the physical robustness of an individual or a population but also the context in which they live, work, play, and pray. It is the effort to build health-focused resilience within those contexts that supports access to

the science-based interventions that allow people to achieve their optimal health. Decimating access to care, erasing populations (such as the Trump administration's attempted erasure of transgender people by, for example, mandating the removal of demographic characteristics from disease surveillance), and downplaying the critical need for equity-focused public health reveal a system of eugenics that underpins the actions of Kennedy and his

HHS.⁷ Supporting a system in which only the strong thrive and survive advances an “ideal” American society that is whiter, straighter, and wealthier than today's actual US population. This system of eugenics is based on an unrealistic vision of health and inaccurate portrayals of national history, and it is the real mission behind the erasure of health equity as a central aim of public health.

Ethical Crossroads: When Science and Policy Diverge

As a public health professional and physician, I feel a deep moral responsibility to serve the greater good, protect the vulnerable, and defend the integrity of science against political manipulation. In the months before my resignation, I witnessed policies and leadership decisions made by Kennedy and his team that, in my judgment, diverged from these foundational principles.

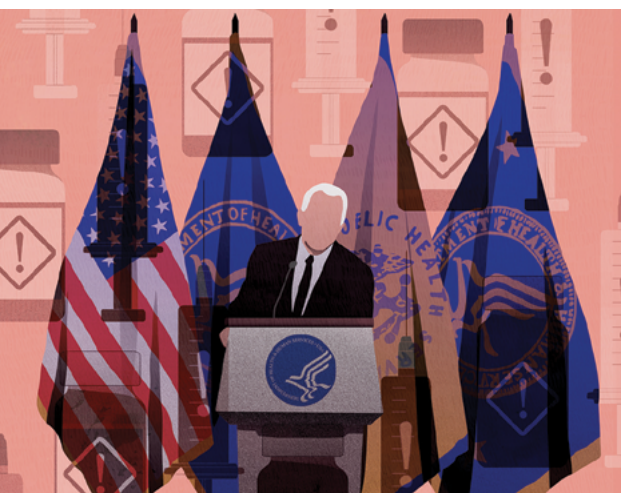
I have always been willing to challenge dogma and question established thinking. But when the highest levels of leadership began treating public health as a political tool—using CDC to rubber-stamp policies that do not reflect scientific consensus—my ethical obligation became clear: I had to speak out and, if necessary, step away. I could not continue to lead in good conscience and participate in a system that undermined both science and public trust. Enough was enough.

Policy Concerns: Immunization Schedules and Exclusion of Expertise

One of my deepest concerns as director of the National Center for Immunization and Respiratory Diseases was the overhaul of the COVID-19 immunization schedules in May 2025. These changes were made without transparency and are at odds with science that supports vaccinating pregnant people and healthy children under 24 months of age, placing the lives of our youngest and most vulnerable at risk.⁸ What troubled me most was that CDC was excluded from the decision-making process despite being the source of the accepted science on the topic.⁹ Our repeated requests for the data supporting these changes were denied. Instead, members of the press eventually sent us a “frequently asked questions” document that HHS had distributed to members of Congress without CDC's awareness.¹⁰ This document referenced studies that Kennedy claimed supported his decisions, but the evidence was misrepresented—key findings were taken out of context or selectively cited in ways that contradicted the actual conclusions of the scientists involved.¹¹

Effective public health policy demands robust data, expert input, and transparent processes. When these are set aside in favor of political expediency, the consequences become real: disease, suffering, and loss of trust in preventive medicine. I could not in good faith support such a direction.

When agency leaders began treating public health as a political tool, my ethical obligation became clear: I had to speak out.



Leadership and Communication Failures: The Advisory Committee of Immunization Practices

Leadership in public health must be courageous, transparent, and collaborative. Instead, I observed major policy changes and personnel changes announced via social media and new advisory committee members appointed without proper vetting. For example, the Advisory Committee on Immunization Practices included 17 respected scientists who brought decades of pediatric, public health, and immunization experience to the table to guide national vaccine policy. They were terminated by HHS via a social media post and an op-ed¹² and were replaced by people with little or no qualifications beyond ideological alignment against vaccines¹³—these new members described themselves as “rookies”¹⁴ yet were empowered to make policy recommendations for our nation.

Meanwhile, the voices of those with decades of expertise—myself and my colleagues—were routinely sidelined. It became clear that HHS leadership was interested in appeasing political interests and following its own whims, not serving the public or respecting the processes that made CDC a global leader in public health and implementation science.¹⁵

This approach not only damaged morale within the agency but also eroded the credibility of CDC. When leadership chose ideology over expertise and bypassed established channels of communication that help maintain transparency and accountability, it endangered both the mission of CDC and the public it serves.

Impact on Vulnerable Communities

My career has been and remains devoted to protecting those most at risk. Under Kennedy’s leadership, I saw firsthand how policy shifts driven by ideology rather than science disproportionately harm children, pregnant people, and LGBTQIA+ individuals—especially transgender communities.¹⁶ The deliberate undermining of proven vaccination programs, the abandonment of critical HIV initiatives, and the termination of equity-driven research are not just policy failures; they are direct threats to lives and well-being. HHS has gone so far as to insert itself into the patient-clinician relationship, using fearmongering and scare tactics to prevent lifesaving gender-affirming care.

For decades, I have been a trusted advocate for LGBTQIA+ health; I could not be complicit in efforts to erase transgender populations or halt lifesaving research and programming. The fight for public health is inseparable from the fight for equity and justice.

Scientific Integrity: Why It Matters

Science is not an accessory to public health—it is foundational. Policies must be rooted in the best available evidence, shaped by open debate, and executed with transparency. When CDC subject-matter experts



were excluded from key decisions and data were withheld, the result was policy by fiat, not science.

Kennedy himself stated that Americans should not take medical advice from him.¹⁷ In the climate that developed under his leadership, I was compelled to agree. Leadership that refuses to engage with scientific expertise cannot be trusted to provide accurate health guidance. I reject the trend toward touting “natural infection” and unproven remedies, and I reject the revival of the eugenic rhetoric that underlies the anti-science, anti-equity moment in which we live.¹⁸ Such ideas have no place in public health or medicine.

Personal Reflection: Family Legacy and the Cost of Silence

My grandfather, whose name I carry, stood up to fascism in Greece and lost his life for his convictions. I resigned to honor his legacy. Like my grandfather, I could not remain silent as I saw CDC weaponized to hurt the populations I had committed to serve. We medical professionals must not sit quietly as we see equity replaced with eugenics and authoritarian directives.

I also resigned to stand against the cowardice that now infects our leadership—a refusal to acknowledge how divisive rhetoric created an environment where violence became possible. The shooting attack on CDC on August 8, 2025, in which a police officer was killed, was motivated by the misinformation peddled by Kennedy and his colleagues. It was the cumulative effect of leadership that refused to take responsibility, even as the consequences of their choices became tragically clear. The ideological violence they waged on the agency and on public health was manifested in a physical attack, leaving CDC damaged and injured—and leaving three children without a father.¹⁹ In my view, Kennedy and his team only hastened their dismantling of CDC at the expense of our nation’s health.

CDC’s mission—to save lives and health—cannot survive where scientific integrity is routinely sacrificed.

The health of our nation depends on professionals who will not compromise on integrity or science.

Public health is not just about individual well-being; it encompasses the health of the entire community, the nation, and, indeed, the world. The reckless choices of those now in charge place our nation's health security at risk. CDC's mission—to save lives and protect health—cannot survive in an environment where scientific integrity is routinely sacrificed. The cost is being measured not only in trust but in lives lost and suffering unaddressed.

Since my resignation, I have seen many of the attacks on the health of the nation that I feared, and that led to my decision to leave federal service, grow in strength. The scientists and other civil servants who remain at CDC are being held hostage by Kennedy and his leadership team, who have hijacked the agency and continue to demonstrate their disregard for science and, more importantly, for its mission to protect health for all, not just some.²⁰ I took the risk to resign, but not all people at CDC have the luxury to do so. They have families and financial circumstances to consider, and some have made commitments that they are unable to walk away from.

The New CDC Manifesto: Partisan Ideology Supplants Public Health

On September 17, 2025, CDC revised its "About CDC" page, replacing the expression of its public health mission with a manifesto that confirmed my concern that ideology had supplanted science and best practice. CDC's revised priorities emphasize a shift toward policies rooted in partisan stances rather than a broad, science-driven public health mission. The agency asserts it will insulate its recommendations

from conflicts of interest but also deprioritize funding for programs that do not align with its expressed values, including those related to harm reduction, housing-first approaches, and DEI initiatives (which remain conflated with health equity).

In the area of social policy, CDC explicitly states it will not support programs perceived to encourage immigration by undocumented people, elective abortion, or gender-affirming care for minors, citing supposedly evidence-based (but in fact deeply flawed) reviews that question the safety and efficacy of such interventions. The agency's stance on gender is rooted in a binary, "biological" definition that ignores the incredible sexual diversity of the natural world,²¹ and it commits to recognizing sex as immutable. Parental rights are also elevated, with CDC prioritizing transparency and "parental choice" in educational settings and promoting curricula without content that could conflict with a certain narrow set of personal beliefs—curricula that may intentionally fail to reflect scientific, historical, and social truths.²²

These ideological commitments diverge from CDC's historic mission to protect the public's health through unbiased science, inclusivity, and evidence-based interventions. By deprioritizing programs that address systemic inequities, support marginalized populations, and employ harm-reduction strategies, CDC's new direction undermines its role as a trusted public health authority. The focus on ideology over scientific consensus and best practices is compromising the agency's capacity to effectively safeguard the health of all Americans. This manifesto is not just rhetoric. It is being weaponized to cut key funding and programs that do not comport to these ideologies or that demonstrate dissent against HHS leadership, programs that serve many of the most vulnerable populations in the country.²³ This is not public health.

Science Replaced by Conspiracy: Vaccines and Autism

November 19, 2025, will be remembered as a very dark day in the history of public health in the United States. With the revision of its "Autism and Vaccines" page, CDC betrayed science, American families and children, and its own mission. Under the direction of Kennedy, CDC deleted the accepted scientific rationale that underpinned the statement that vaccines do not cause autism²⁴ and replaced it with decades-old, anti-vaccine distortions promoted by the secretary.

This shift from a clear, evidence-based stance that vaccines do not cause autism—supported by decades of research and global clinical consensus—to a message that introduces doubt and highlights unproven theories threatens the lives of millions of children. Most importantly, this distortion harms autistic



children and preys upon their parents by both placing blame on them and offering false hope about a cause for autism that has no scientific justification. Parents want the best for their children—a fact that is being leveraged by the secretary for political gain. And these changes bypassed CDC’s scientific staff and peer review and created an official CDC source document for Kennedy and his colleagues to attack vaccines—likely for their own personal gain.²⁵

This hostile revision not only reframed settled science as uncertain but also undermined trust in CDC by circumventing established scientific processes. The updated page includes a prominent asterisked statement explaining why the heading “vaccines do not cause autism” was kept while the content of the page was rewritten to undermine that accepted truth.²⁶ This footnote clarified that the only reason this sentence remained on the page was that Kennedy had made a political agreement with a Senate leader to secure his confirmation as secretary. He lied to that leader and to the American public.

The destruction of the wall between ideology and public health science has destroyed the credibility of CDC and put clinicians in a position where official recommendations are no longer reliable. The broader consequence is increased public confusion, potential resurgence of preventable diseases, as we are seeing with measles,²⁷ and the deserved loss of trust in CDC and other federal public health agencies. If the secretary can so easily override scientific consensus and rewrite guidance to fit his ideology, the fundamental mission of CDC and federal public health has been irreparably damaged. Mistakes made in the COVID-19 pandemic in communications and transparency at all levels of government allowed for this transformation of CDC into a wolf in sheep’s clothing. Public health exists in a political system, but it should not be compromised by it.

The rewriting of CDC’s autism page is a cautionary signal about the dangers of bringing ideology and partisan politics into science and about the need for Congress to intervene to preserve evidence-based public health policy. With great sadness, I no longer believe that CDC can be regarded as a trusted source for health policy or guidance. It has been transformed into a propaganda machine that supports the personal, political, and financial aspirations of a scienceless leader and his allies.

A Call to Action

My decision to step down was not just a protest—it was a call to action. We need to restore transparency in decision-making about public health, hold leaders accountable, and recommit to the principles that built CDC’s reputation as a beacon of hope and progress. The health of our nation depends on professionals who will not compromise on integrity or science, and

on institutions that are willing to defend the common good above all else.

We must be humble and acknowledge that the progress that ended the scourge of vaccine-preventable diseases, reversed the death sentence of HIV, and helped us begin to turn the corner on the opioid overdose epidemic included missteps and errors that brought us to this moment. We must not pine for a moment when the pendulum “swings back” to recreate the system that was so easy to destroy. Instead, we should listen to our past and present and work to create a new public health system more responsive to the ground, more focused on regional needs, and less academic and disconnected from the people it serves and the politicians who must work to co-create its implementation.

While we continue to witness the dismantling of public health, we health professionals must carry the water for our patients. We must drown out the distortions of partisan politics with clear statements of truth for the patients we care for and the systems we support. We must fight for health equity. We must defend, not erase, the most vulnerable. We must magnify science and debunk misinformation. Resistance is an act of love, not of hate, and we must counter mistruths without creating victims and martyrs.

When rationality returns to government, the actions we take today will become the blueprint for the future. We must be on the right side of history for the health of the nation and the world. +

For the endnotes, see aft.org/hc/spring2026/daskalakis.

Where to Find Reliable Vaccine Guidance

Credible information, especially on vaccines, should be sought through professional organizations, including the following:

- **American Academy of Pediatrics** – go.aft.org/2vd
- **American Academy of Family Physicians** – go.aft.org/t2n
- **American College of Obstetricians and Gynecologists** – go.aft.org/njb
- **Infectious Diseases Society of America** – go.aft.org/91s

Deeper reviews into vaccine science, once provided by CDC’s Advisory Committee on Immunization Practices, can be accessed at the Vaccine Integrity Project (go.aft.org/q59). Surveillance data at CDC continue to be published without compromise but also often without expert interpretation. Additional sources for better understanding these data include the following:

- **Your Local Epidemiologist** – go.aft.org/xjm
- **PopHIVE** – go.aft.org/u92

Healthcare clinicians should familiarize themselves with these resources and connect with their local and state health departments, which have been key in navigating the complex vacuum created by the destabilization of federal resources.

–D. C. D.

Protecting Our Immigrant Patients and Communities—*and* Each Other



J.W. HENDRICKS / NURPHOTO

Across the country, healthcare workers are confronting an unsettling reality: escalating immigration enforcement without regard for the law or—as highlighted by the recent murder of Veterans Affairs nurse Alex Pretti—for the safety of healthcare professionals who are trying to fulfill their ethical duty of care.

How are these terrifying immigration operations impacting patient care, and how can we protect our immigrant patients and communities—including the immigrants who have been the backbone of the US healthcare workforce for decades? We spoke with four leaders and members from AFT affiliates that are at different stages in addressing these questions.

In New York, the threat of Immigration and Customs Enforcement (ICE) is felt, although not as urgently as in other parts of the country. Anne Goldman, RN, BSN, a vice president of the United Federation of Teachers (UFT) and former

ICU nurse, and Diana Williams, RN, a nurse and union delegate who is using a pseudonym because she fears retribution, share how the UFT is providing training and resources to meet the moment if ICE ramps up. Across the country in Washington, healthcare workers are already confronting the direct impact of accelerated immigration enforcement in their communities. David Keepnews, RN, PhD, JD, executive director of the Washington State Nurses Association (WSNA) and an AFT vice president, and Jared Richardson, RN and WSNA nurse representative, share how WSNA is organizing for equitable treatment of immigrant staff and advocating for human rights at the local, state, and federal levels.

Whether ICE has already descended on your community or you're marshaling resources in preparation, we hope you will find inspiration here to continue the essential work of keeping your patients and coworkers safe.

—EDITORS

EDITORS: What led you to nursing and to union activism?

ANNE GOLDMAN: I started out as an ICU nurse in 1973 at Lutheran Medical Center, which is now New York University Langone Hospital–Brooklyn. Nurses were not allowed to form unions separate from the state nursing associations until 1979, when the National Labor Relations Board gave nurses more freedom to organize. My colleagues and I jumped on the opportunity. We chose the UFT because it offered the autonomy, collective bargaining support, and political power we needed to be successful. For me, that led to work developing the Federation of Nurses division of the UFT and the AFT’s healthcare division, so I’ve been part of the labor movement for nurses in the UFT from its inception. Today, we have 27,000 nurses throughout the state of New York in private and public hospitals, in home care, and in schools.

My motivation to organize came first from my coworkers. When I was a new nurse, 19 or 20 years old, and working the evening shift, many of my colleagues were from the Caribbean, England, Jordan, the Philippines, and other places. They were much older, had children in their home countries, and were striving to make a better life for their families. They worked so hard, and they were so vulnerable. They could never do anything the hospital didn’t like or refuse shifts or assignments because they didn’t want to be sent back—and the hospital leveraged their fear. Seeing their disparate treatment and the unfair working conditions gave me the fire to fight for the union, and that earned the confidence of my colleagues. That’s how we got an overwhelming vote to join the union.

As I continued in union work, I saw the need to focus on our professional responsibilities and to create best practices for patient care. Starting out as a nurse, I thought my job was just to care for people and do good, but we had unhoused and uninsured patients the hospital didn’t want to give care to, and I had to stand up and say, “These are human beings who need care.” I began to realize that my job was also to advocate for people. We’re trying to have the strongest voice where it should be—in our hands—because we’re patient advocates.

DIANA WILLIAMS: I am one of those nurses who, like Anne’s early coworkers, came from another country to work in the United States. I grew up in an island nation. When I finished high school, I really wanted to study medicine, but a family member introduced me to a nursing program, and I decided to apply. After graduation, I went to work in the hospital closest to my hometown. I loved my work, but my coworkers and I were always hoping to earn more money. A few years later, recruiters from American hospitals came to my country and promised better-paying jobs in New York. I got two offers, and I chose to work in the emergency department in the hospital where I have now been for

more than 25 years, and where the nurses were already organized with the UFT. I remember the recruiter met me and three other nurses at the airport, and we started our orientation a few days later. I have worked in many parts of the hospital as a bedside nurse, and I am also very involved in the work of our union.

JARED RICHARDSON: I spent most of my early adult life in the US Army as a combat medic, and that experience led me to union activism. My time in Afghanistan really opened my eyes to a world that I wasn’t aware of growing up in rural Utah. I saw a lot of social inequity that needed to be addressed. Right after that deployment, I was shipped out to Thailand, where we built elementary schools in some of the poorest parts of the country. That really pushed me toward wanting to see more social justice in the world.

I knew I wanted to go into nursing when I got out of the military, and I wanted to be in a union job where I could push for better opportunities for everyone. I accomplished those goals five years ago when I moved to Washington and got heavily involved with WSNA. The next thing I knew, I was working for WSNA. Now I am a nurse representative, helping our bargaining units with contract negotiations, contract enforcement and grievances, and whatever else they need.

DAVID KEEPNEWS: My parents weren’t union members, but they raised me with an awareness of labor as a force for progress and for social justice. After nursing school, I was fortunate to find work in unionized facilities, and I saw firsthand what a dramatic difference union membership made, not only in terms of pay and working conditions but also in the ways my union siblings and I felt empowered. We had professional autonomy and were able to stand up for patients.



REUTERS / YOSEPH ANAYA

I eventually went back to school to get a law degree, and later a PhD, hoping to help nurses be more effective in influencing policy. I worked for nurses' associations and spent many years teaching nursing (including several years as a member of the Professional Staff Congress at the City University of New York, an AFT affiliate). When the position of executive director opened up at WSNA, it felt like a fantastic opportunity to bring my nursing, law, and policy backgrounds together to make nursing a better profession and to make a better world for everyone. That's one of the things I love about being part of the AFT—it unites people from many different backgrounds with the common goal of doing better for all those we serve.

EDITORS: Let's talk about immigration in the context of healthcare. How was immigration status a factor in your workplaces before 2025?

“While there are guidelines on what ICE can and can't do ... there are no assurances that they will follow the rules. We learned that from Minnesota.”

—DAVID KEEPNEWS

DAVID: Let's start with healthcare workers. In Washington, as is the case all over the country, nursing has long included high numbers of immigrants. Our hospital systems and recruitment agencies have brought nurses from the Philippines, India, and several African countries, among other places. Of course, it's not just nursing—there are many immigrants in all job classifications in healthcare. Some have profession-specific visas, and others have immigrated through other routes. We also have a lot of DACA (Deferred Action for Childhood Arrivals) recipients. People from all over the world have been our colleagues throughout the state for many, many years.

While most nurses who are recruited internationally become hospital employees and union members, with all the protections the union affords, some remain employees of the recruiting agency and get paid less, with far fewer rights in the workplace. This used to be a much worse problem than it is now, but it still happens in some hospitals. Even nurses who are hospital employees have experienced serious mistreatment, including inequitable pay that went undiscovered for a long time. (See “Bargaining for Pay Equity” on page 23 to learn about WSNA's successful campaign to pay internationally educated nurses fairly.) We also know of internationally recruited nurses in other states who were grossly underpaid and overworked, kept silent by threats of financial ruin and deportation.*

JARED: Immigrant nurses are an essential part of our healthcare workforce and of our bargaining units. As David said, most of our agency nurses become hospital employees right away, but some of our employers use third-party agencies to bring in international nurses and hold them on three- or four-year contracts. They're not allowed to join the union, which suppresses their pay—and that's both an equity issue and a union-busting issue. It's harder to engage in strategic actions like pickets or strikes when 10 or 20 percent of the nursing workforce is contractually held and has concerns about their visas. We had a major win in securing more equitable pay for immigrant nurses through bargaining at St. Joseph Medical Center in Tacoma (St. Joe's Tacoma), and we're pushing to include similar contract language at other healthcare facilities, but we don't have the same ability to help nurses who can't join the union in the first place.

DAVID: In terms of patients, Washington state has a lot of immigrant patients from all over the world. For example, the largely agricultural Yakima area has a sizable Mexican population, and there are big Ethiopian and Eritrean populations south of Seattle. But before 2025, we didn't have to deal with day-to-day issues of immigration enforcement in hospitals and clinics. Federal policy recognized these as sensitive locations, along with schools and religious institutions. That's the biggest difference now—that's no longer the case.

JARED: Before 2025, hospitals mostly felt safe—although the Northwest ICE Processing Center, one of the largest detention centers in the country, has been in Tacoma for more than 20 years. It's less than two miles from two of our biggest hospitals. One of them, St. Joe's Tacoma, has a longstanding contract to provide care for ICE detainees. The other big hospital

*To learn about how some healthcare employers are exploiting immigrant nurses, read “Trapped at Work: How Employers Snare Healthcare Workers in Debt” on page 37.



DAVE DECKER / ZUMA PRESS WIRE

in the area, Tacoma General, has had such contracts in the past.

Farther north, St. Joseph Medical Center in Bellingham (St. Joe's Bellingham) has a contract with the Department of Homeland Security to treat people who have been detained at the Canadian border crossing. So we have had regular immigration-enforcement presence in our hospitals, but it wasn't anything like the situation we have now.

Since we're a border state, another relevant immigration issue is that a lot of Canadian nurses commute to our northernmost hospitals for the higher wages. At St. Joe's Bellingham, which is in a somewhat geographically isolated city, about 30 to 35 percent of the current RN workforce is Canadian.

ANNE: We have the same situation with our clinics and hospitals near the Canadian border. Those facilities depend on Canadian nurses who cross the border every day to staff ICUs and acute care hospitals. They're an important part of our very eclectic workforce in New York state. We have also had waves of nurses recruited from the Caribbean, the Philippines, all over the world. That's the history of nursing and of healthcare: a mix of cultures and languages, and often different opinions about what's happening in the world, in their home countries, or in the United States. But we know we're on the same team, and we can only succeed if we recognize each other's strengths.

In general, immigration from the employer's view is intended to circumvent contractual wages, raises, and working conditions, as well as to undermine union voice and power because people on visas are not the first on a picket line. But fortunately, that has not been the case in my history. When now-AFT President Randi Weingarten joined us at the UFT, we were going out on our first strike. She secured letters of support on behalf of the nurses who were on work visas to say, "You will be safe, and you belong on the picket line." The UFT fought hard for our immigrant nurses so they would know they were safe. And we have always made sure our nurses who are on visas know their rights and know how the union can protect them. But many more nurses don't have that security, and that's why we keep organizing.

EDITORS: How has the Trump administration's aggressive approach to immigration affected your members and your patients? What concerns do you have?

DAVID: ICE has free rein now to enter hospitals, schools, and places of worship, and people are worried. In some clinics that work with large immigrant populations, patients just aren't coming in because they're afraid to seek care. Our public health nurses in Seattle/King County and other locations report lower participation in street medicine, primary care, and parent-child programs that serve undocumented

community members. And even before the murders of Renée Good and Alex Pretti in Minnesota, fear and anxiety were running through our hospital workforces. It's especially acute for people with fewer financial resources who may not have access to legal assistance if they get detained. And we've heard from several of our nursing units with DACA-recipient members who are very fearful about whether that status will change or what the administration may do with that program.

One of the biggest sources of fear is that, while there are guidelines on what ICE can and can't do—for example, needing to show a judicial warrant to enter a hospital for enforcement activity—there are no assurances that they will follow the rules. We learned that from Minnesota. That casts a pall for many people, not just immigrant nurses or patients, especially since the Supreme Court essentially allowed ICE to racially profile people.¹ Even our nurses who are natural-born US citizens aren't protected from that. How do they protect patients and themselves if ICE shows up?

What does ICE presence in our facilities, even if it's just to accompany a detainee, mean for other patients and community members? Unlike sheriff's deputies accompanying a patient in the criminal justice system, ICE could potentially look around to see if there are other people they want to detain. And if there's an ICE officer present, what else might they see and hear? How do our members carry out their duty to protect patient privacy under HIPAA? These are really big concerns.

JARED: I saw one change immediately when President Trump took office. We were coming off this major victory in our fight for pay equity for foreign-trained nurses and compiling a list of people with international experience who might be eligible for pay increases. Being on that list, which was a joyful thing in December of 2024, became terrifying in January 2025. Two nurses asked to have their names taken off the list because they didn't want any attention on their immigration status. It was heartbreaking.

And we've all been waiting for Trump to send ICE or the National Guard into Seattle to try to crush us like he's done with Chicago, Washington, DC, Los Angeles, Portland, and Minneapolis. That's a big source of anxiety.



“Access to healthcare, especially preventive care, is already a significant issue. Now, with more people avoiding care for longer, how much worse will things get?”

—JARED RICHARDSON

ety for the whole community. I've heard from several organizations that their community members are seeking alternative forms of healthcare from friends and family because they're concerned if they go to the ED, they'll get deported. Access to healthcare, especially preventive care, is already a significant issue. Now, with more people avoiding care for longer, how much worse will things get?

ICE agents also interfere with care more directly. We've been involved with the case of a Filipino patient we call Kuya G. (*Kuya* is an honorific that means "older brother" or "respected elder.") He had been in detention for a while and had serious health issues, including a bone infection that resulted in the amputation of one toe and part of his foot. He asked for medical care but didn't get it until he was very sick. They brought him to St. Joe's Tacoma, and he was admitted to the ICU—but they removed him after two days to receive medical care at the detention center, which is beyond sub-

standard.² Eventually, they tried to deport him, but the plane they chartered wouldn't take him because he was medically unfit to make the trip. WSNA got involved because we believe that every person has the right to timely healthcare. Thanks to the efforts of many activists, Kuya G has finally been released, but the larger problem remains.

There was also a situation in which an ICE officer left their loaded service weapon in the communal bathroom on one of our units. Luckily, it was found by a nurse after the officer went home. Workplace violence is a constant issue in healthcare facilities, and we had worked so hard in our contract negotiations to secure better protections, including weapons detectors and screening processes

for every patient who comes into the ED. Nurses had begun to report feeling safer, with fewer instances of weapons being found in rooms. Then an ICE officer bypassed that system, putting all of us in danger.

DIANA: We haven't had that kind of ICE presence in my hospital, but I have certainly felt the chilling effect. My niece's husband was recently pulled over by the police because he resembled someone they were looking for. He showed them his green card, and they let him go. But what happens next time? I have copied my US passport, and I carry it with me every day because I've seen videos of people being stopped. If I get stopped, will I be safe with my passport or REAL ID? Will my documents mean anything to them?

Sometimes I talk quietly with my colleagues at work, especially since the two murders in Minneapolis. We don't all have the same political affiliations, but we agree that this should not be happening. What about the families being broken up and the trauma of children who are living in the prison camps? But I hesitate to publicly express my feelings because I don't want the employer to say I'm trying to have a political influence on other nurses. I have no problem influencing nurses when it comes to union negotiations, the benefits they're entitled to, and what the union can do for them. But when it comes to ICE and immigration, I'm very cautious.

No one from the hospital administration has said anything to us about what's happening with ICE. I haven't even seen an email acknowledging Alex Pretti's murder: A nurse was murdered by ICE while trying to provide assistance—that silence is very loud. Sometimes we nurses wonder how much we can trust or rely on nursing management because of how they treat us and how they have dealt with the union. I don't think they value the union's perspectives.

I think there are a lot of people like me with internal turmoil about what's happening to the country. So many of our nurses, nurse aides, patient care technicians, and other technicians are immigrants. We go about our work, we do what we must do, while deep down we are scared about what the future holds.

ANNE: We are fortunate that we haven't yet had issues with ICE officers trying to enter our facilities. But we see some consequences of the increasing national volatility around immigration that began during the first Trump administration. I used to take groups of nurses on rescue missions around the United States and in other countries. We were very proud of that work. But now I don't have confidence that I can bring everyone back safely, even from a US territory like Puerto Rico. We also used to have union meetings and classes for immigrants, but we stopped during COVID-19 because it just made people targets, especially our nurses from the Philippines. We have had to become more strategic and private about how we provide support.

"I think there are a lot of people like me, with internal turmoil about what's happening to the country.... Deep down we are scared about what the future holds."

—DIANA WILLIAMS



MICHAEL NIGRO / PACIFIC PRESS VIA ZUMA PRESS WIRE

One of the biggest patient impacts we've seen is that people are avoiding maternity care. Pregnant people are more easily targeted by ICE because pregnancy is hard to hide. So they're very scared, and more of them avoid coming in until they're delivering, which increases the risk of complications and other health issues. And they don't even want to come in when they're delivering because they don't want to be separated from their babies. We are also seeing delays in routine care and other treatment for children, where parents don't bring in their child until the fever is high and their kid is really sick. They're scared that they'll be separated.

Among the bigger workforce issues I'm concerned about are Trump's proposal to charge \$100,000 for a work visa³ and the change in the professional degree designation that will make it much harder for people to pursue nursing and other healthcare-related degrees.⁴ Both would significantly affect our ability to maintain our nursing workforce, let alone grow it. Our clinics and hospitals near the Canadian border wouldn't be able to operate. And nationwide, these policies would make it more likely that hospitals would pay the visa fees or sponsor the education, and then the workforce would be beholden to the employer. That would crush the labor movement and allow the employer to decide best practices, which is what all of us fight against every day. So these two changes have the power to entirely reshape the healthcare workforce. Some people might think these are just other people's visa or paperwork issues, but they're all of our unions' issues and, ultimately, all of our healthcare issues because we're all patients, too.

EDITORS: How are you organizing in your unions and in your communities to protect patients and each other?

DIANA: At my hospital, we are hoping the management team will give us additional support and preparation because we are not ready to answer questions if ICE tries to come through the door. Will hospital administrators let them in, or will they at least ask for a judicial warrant? All healthcare institutions are required to follow HIPAA—will administrators continue to protect patients and workers from HIPAA violations if ICE comes in?

We also need to know what the hospital will do to protect us as employees. President Trump claimed that he was going to deport people committing terrible crimes, but ICE is picking up people with misdemeanors—or nothing at all—and profiling and arresting random people on the street. People who have lived here all their lives, who are trying to earn a living and support their families, are being deported to countries they've never lived in. It seems only a matter of time until it happens at my workplace. ICE could pick up one of my colleagues who has a minor traffic violation on their record, or they might see someone who doesn't "look" American and



handcuff them and throw them to the ground. We need to know what our employer will do. We are asking them to at least tell us what their plan is or to work with us to develop one. We have to be prepared.

ANNE: Our employers may not have protocols in place, but the UFT has protocols with a chain of communication and chapter action teams to support our members. We have Know Your Rights cards and toolkits in many languages, and attorneys are available to address legal questions or needs. We also help members make sure their visas, immigration records, and licensing are all up to date so they can travel as needed to visit their families, and the employers often work with us on that because they have a lot of money invested in the stability of the workforce.

The UFT is also working to address these issues on a broader scale. We passed an emergency resolution supporting the national day of action on January 23 and encouraged members to take part in demonstrations and lobby their representatives to protect immigrant communities.⁵ We also offer workshops to help members organize committees in their workplaces to support and defend immigrant families. We want members who feel vulnerable to know they can trust the union, and we work to build that trust.

At the hospital I'm on release from for the UFT, NYU Langone-Brooklyn, we have excellent security and training because we frequently deal with unwanted visitors. We have a huge volume of patients in the ED, and there are so many ways that chaos can be introduced, so no one gets in but the patients—not

“Some people might think these are other people’s visa or paperwork issues, but they’re ... all of our healthcare issues because we’re all patients, too.”

—ANNE GOLDMAN

the police or anyone else. ICE cannot hang out in the lobby or even outside. We have cameras, audio, and other alerts, and our rooms are secured by buttons and locks as well as by guards to protect patients and staff. And everyone gets de-escalation training, no matter who they are. Everyone needs to know how to function in an emergency setting to mitigate harm and keep people as safe as possible.

In the event of a safety violation or other emergency, we also have a team that comes in to help with de-escalation so we don't end up with a shooting or something even worse. It's not an infallible system, but it's pretty strong. We'd like every hospital to feel that secure so that people won't be afraid to come to work or to get care. But in the meantime, we arm people with information, and we protect them while they're with us.


DAVID: As Jared mentioned, we in Washington have expected that our cities will be targets of ICE occupation from the beginning. We put out an advisory early on so our nurses would know what to do and what to expect from the Trump administration and its policies.⁶ So far, the hospital association has been a partner in this. We fight with them on a lot of things, but we all share concern about raids happening in healthcare facilities. WSNA has continued to advocate for nurses and for our responsibility to our immigrant communities. The

Code of Ethics for Nurses tells us that we have an ethical responsibility to stand up against human rights violations, and we take that responsibility very seriously.⁷

We're also working with our labor partners in the Washington State Labor Council, which is our AFL-CIO state federation, as well as with other community organizations. We know it's important to be prepared for a potential occupation, so we're organizing now. We don't want to be caught off guard. And we are tracking policy related to immigrant rights and protections and asking members to engage with their legislators on these issues. We're working on multiple fronts at the local, state, and federal levels.

JARED: At the hospital level, we're also focusing on prevention, preparation, and organization, looking at what works and trying to replicate it. At St. Joe's Tacoma, we have a fantastic racial justice committee that has been a great avenue to talk about ICE presence in the hospital and what to do. The committee began through a pilot program negotiated in a previous bargaining cycle that we made permanent in 2025 negotiations. The committee, which meets monthly, sends people to conferences and offers an annual training on diversity, equity, inclusion, and accessibility. It also has an internal portal where staff can report racist incidents; the portal is a safe place to bring concerns because the staff member doesn't have to deal with their direct manager. This committee has created so much more conversation and collaboration on addressing these issues at St. Joe's Tacoma, and that has translated into strength for organizing on important issues, like addressing inequitable treatment of immigrant staff. So we're trying to introduce something similar at Tacoma General and elsewhere.

As a union, I think one of the most important things we've been doing is being visible. WSNA is a comparatively small organization in the state, with only 18,000 members, but we're lending help where we can. I'm so proud to work for an organization that doesn't back down from a fight. From the rank and file to the top, we're taking action, and we're showing up. We've gotten a little pushback, as our membership spans the spectrum of political affiliations and beliefs. But we know that this is the right thing to do, and what we've sworn to do as nurses. Immigration, human rights, and social justice are nursing issues. We're coordinating with other unions in the area, especially within hospitals and healthcare systems, and we're facilitating member-led interunion collaboration so we can share experiences and strategies.

As unions and professional organizations, this is our time. If your organization has stuck to professional issues in the past, this is our job now. We can't stay siloed or silent any longer. 

For the endnotes, see aft.org/hc/spring2026/goldman_keepnews_richardson_williams.



BOSTON GLOBE / CONTRIBUTOR / GETTY IMAGES

Bargaining for Pay Equity

Pay inequity for nurses trained outside of the United States has been an issue for a very long time,* but it can be hard to address because many nurses simply aren't aware they're being paid less than they should be. It only came to the forefront for the Washington State Nurses Association (WSNA) at St. Joseph Medical Center in Tacoma (St. Joe's Tacoma) as a bargaining issue in 2024, with two Filipino nurses who were brought to the United States by an agency and were roommates. One was working at St. Joe's Tacoma, and the other was at another hospital in the same health system. They were on the same wage scale, both represented by WSNA, but the nurse at St. Joe's Tacoma started at a lower rate than her roommate. She came to me wanting to know why.

HR told me that it was the health system's practice to give nurses with experience in countries other than the United States or Canada—which means primarily people of color from Asia, Africa, or the Caribbean—only 50 percent credit for that experience. It wasn't an official policy; it was just the practice they had followed for decades, through several mergers and ownership changes. When confronted, HR's response wasn't *Let's take a look at this practice so we can ensure our nurses are compensated equitably*; it was *Tell us who the other nurse is so we can bring their pay down*. I was shocked.

Our contract language had no carve-outs for nurses with international experience, so we started digging. First, we sent a survey to members asking how their international experience was credited. We got a range of responses. Some received full credit, but most people received 50 percent credit, and some received no credit. With that information in hand, we filed an association grievance on behalf of WSNA. There were 13 named nurses in that first grievance; when I got their hiring documents, I saw that there was always a note on their credit experience sheet: "Philippine nurse, half credit." There was no further explanation.



COURTESY OF THE AUTHOR

When I asked administrators about the reasoning behind the half credit, I was basically told "They're not doing the same work 'over there,' so the experience isn't the same." That's ridiculous, particularly in the Philippines, where nurses are trained in English in American-style hospitals for the specific purpose of coming to work in the United States. Employers know it's untrue, too. If they really thought nurses trained elsewhere weren't ready to work in US hospitals, they wouldn't send them straight to the floor after orientation—they would have to offer additional training. But this pay inequity is not about experience. It's about profit.

When we filed the grievance, we were preparing to go into bargaining, so the employer and WSNA agreed to put the grievance in abeyance to see if we could work it out in negotiations. We were fortunate to have Kathleen Jabasa, a Filipino nurse, as one of our bargaining team members. She fought hard at the table to get the employer to understand how racist and xenophobic this practice was, and she told her story and the stories of her coworkers in a very powerful way. She was a huge help in convincing the employer to end this practice.

Our agreement included a six-month period for affected nurses who came forward to be re-stepped, but we could not get the employer to agree to full back pay. They said it would be too difficult, and they weren't willing to put in that effort. That was disappointing, but getting people to the appropriate step and making sure this process won't happen moving forward is still a huge win for our international nurses.

Of the 37 affected nurses at St. Joe's Tacoma, more than 30 were from the Philippines, but nurses from Ghana, Saudi Arabia, South Korea, and India were also affected. Four of the nurses were already at the maximum wage scale because they had been at St. Joe's Tacoma for so long, so they couldn't be re-stepped. We were able to come to a settlement agreement with the employer for one-time payments of \$5,000 each.

That isn't anywhere close to what they are owed, but it's all the employer was willing to pay out.

Since then, we've gotten the same deal for a sister facility from the same company, St. Clare Hospital in Lakewood, Washington. That's a much smaller hospital—200 nurses, compared to 1,100 at St. Joe's—but we got 15 nurses there re-stepped. We're also heading into negotiations at Virginia Mason Medical Center, our third hospital from that parent company, and we expect to get the same deal there. And it's been a key part of our negotiations for units at other health systems. Tacoma General has already stopped this practice, and we've secured contract language prohibiting them from reinstating it. They're also going to open an experience review period for anyone who thinks they may not be at the correct wage scale. We're proud of the progress we're making, but we also know we'll continue to see the effects of this unfair practice, so we'll keep fighting for as long as it takes. +

If employers really thought nurses educated elsewhere weren't ready for US hospitals, they'd offer additional training. This pay inequity isn't about experience. It's about profit.

BY JARED RICHARDSON

Jared Richardson, RN, is a Washington State Nurses Association nurse representative and a former combat medic.

*See, for example, [go.aft.org/pfu](https://www.aft.org/pfu).

A Better Future for All

How Our Public Colleges and Universities Save Lives, Power the Economy, and Strengthen Democracy



MARCO POSTIGO STOREL / THE NEW YORK TIMES / REDUX

By **Randi Weingarten** and **Todd Wolfson**

Randi Weingarten, JD, is the president of the AFT and the author of *Why Fascists Fear Teachers*. Prior to her election in 2008, she served for 11 years as president of the United Federation of Teachers, AFT Local 2. Her commendations include being named to *Washingtonian's* 2023 Most Influential People in Washington and *City & State New York's* 2021 New York City Labor Power 100. Todd Wolfson, PhD, is the president of the American Association of University Professors (AAUP) and has been in leadership of Rutgers AAUP-AFT. Wolfson is an associate professor in the Department of Journalism and Media Studies at Rutgers University and codirector of the Media, Inequality and Change Center; his most recent book is *The Gig Economy: Workers and Media in the Age of Convergence*.

Since Donald Trump returned to the White House, he has led an assault on established science, ongoing research, and higher education. While other articles in this issue address the damage being done to healthcare and public health, it is important to also consider the impact on higher education. All professionals are dependent on higher education to start our careers—and all of our communities benefit from the many ways colleges and universities drive local and national economic growth, engage in lifesaving research, prepare young people to be responsible voters, and more. And many of our healthcare professionals work for employers that are also universities or other institutions of learning. So while this article may be more meaningful to you as a voter or parent than as a healthcare professional, we hope you find it useful at this precarious moment in our nation's history.

—EDITORS

Our unions together represent the largest and most powerful force of faculty and staff in America's colleges, universities, and community colleges. These campuses are where students go to gain knowledge and advance their lives and where breakthroughs that benefit humankind are discovered. These campuses are also cultural and economic hubs that enliven and enrich the communities around them. By any measure, American higher education is an essential public good. But after more than a half century of disinvestment and ideological attacks, it is under even more ferocious assault from forces seeking to weaponize political power to control how these institutions operate and even what can be taught.

President Donald Trump has declared war on higher education. His administration has cut or withheld billions in federal grant funding,¹ arrested student activists,² targeted diversity initiatives,³ and sought to undermine academic freedom and university independence by tying funding and preferential treatment to adherence to a coercive compact.⁴

These attacks on higher education threaten instructors' freedom to teach, students' freedom to learn, and the foundations that have made America a global leader in research, innovation, and democratic governance. We must understand what is at stake, how we arrived at this moment, and what we must do to protect the independence of institutions of higher education and the right of all students to learn. In this moment of profound crisis, we must not only defend our institutions from sustained political and economic attacks, but advance our vision of what higher education can and must be: a democratic, accessible, and transformative public good.

Our colleges and universities benefit not just individual students, but society as a whole, our democracy, local communities, and the broader economy. Colleges and universities serve multiple essential functions that no other institutions can replicate.

Research and innovation: America's colleges and universities are drivers of discovery. Federal funding for university research—totaling \$60 billion in fiscal year 2023⁵—has produced breakthroughs that have transformed human life. From the development of COVID-19 vaccines⁶ to advances in cancer treatment,⁷ and from

artificial intelligence⁸ to clean energy technologies,⁹ university researchers have been at the forefront of scientific progress. Universities perform 48 percent of all basic research in the United States, laying the groundwork for innovations that can then be broadly disseminated.¹⁰

These institutions have contributed to virtually every major medical breakthrough of the modern era. Research at Harvard Medical School alone led to the development of the smallpox vaccine, anesthesia, insulin, and pioneering work in genetics and cancer treatment.¹¹ Recent university research has yielded treatments for Alzheimer's disease¹² and rare cancers,¹³ and stem cell therapies¹⁴ that were once thought impossible. From 2020 to 2024, universities contributed patents underpinning 50 percent of the drugs approved by the Food and Drug Administration.¹⁵

Complex, costly, and protracted work such as this is made possible with the substantial and sustained financial support that only the federal government can provide.

But the Trump administration is deliberately undermining America's world leadership in science, technology, and innovation. It has slashed billions from the National Institutes of Health,¹⁶ the Centers for Disease Control and Prevention,¹⁷ and other agencies,¹⁸ dismantling the greatest biomedical research infrastructure in the world, bar none. As these budgets are cut and staff are fired, fewer grants are being made to university researchers, and existing grants have been stopped.

The funding cuts and freezes ordered by the Trump administration set us backward, toward an era of less innovation, fewer cures, and a shrinking economy. They result in very real harm to the public—to all of us.

Economic impact: Higher education has economic benefits both for graduates and for the greater society. Students who have completed any level of college generate an estimated \$73.4 billion in additional annual earnings relative to those with only a high school education.¹⁹ These earnings ripple through local economies, supporting businesses, generating tax revenue, and reducing expenditures on public health, criminal justice, and public assistance programs.

Whether a community college or a four-year university, institutions of higher education anchor communities, often serving as the largest employer in the region.²⁰ Businesses are built around them. Colleges and universities expand opportunities for students and are engines of our local and national economies. States' public higher education systems also often run hospitals that are major providers of healthcare for local residents and of training for the next generation of clinicians, and our state regional universities—many of which started as “normal schools”—train the educators who teach preK–12.

The State University of New York (SUNY) system is the largest system of public colleges and universities in the country. For every \$1 the state of New York invests in SUNY, the SUNY system returns \$8.67 to the state in terms of economic growth.²¹ This pattern repeats across the country. Higher education institutions in Washington,

DC, contribute more than \$15 billion to the local economy and employ more than 100,000 workers.²² Community colleges in Southwest Virginia collectively benefit regional economic growth by making education accessible and affordable while preparing students for higher-paying jobs.²³ Historically Black colleges and universities generate \$16.5 billion in economic impact across local and regional economies, generating more than 136,000 jobs and preparing graduates to earn more than \$1 million in additional income throughout their working lives.²⁴

Democratic vitality: Higher education serves as a crucial bulwark for democracy. Research shows that the link between increased levels of higher education (particularly studying liberal arts) and decreased levels of authoritarian attitudes is particularly strong in the United States. Education promotes independent thought, respect for diversity, and rigorous assessment of evidence—competencies essential for democratic citizenship and for countering unquestioning deference to authority.²⁵

As one of us (Weingarten) wrote in *Why Fascists Fear Teachers*,* and as both of us frequently argue, authoritarians fear a well-educated citizenry. They fear what educators do—the teaching of critical thinking, of honest history, of pluralism—because their brand of greed, power, and privilege cannot survive in a democracy of diverse, educated citizens. An educated public is essential to a free and fair America. Educators are under siege not for anything we do wrong, but for all the things we do right.

A History of Disinvestment Rooted in Backlash

The current crisis in higher education did not emerge overnight or as a result of the Trump administration's assaults, although those have exacerbated the crisis. It is the culmination of decades of systematic disinvestment and political attacks that began as backlash to the civil rights movement and campus activism of the 1960s.²⁶

As student bodies started to become more diverse in the 1960s, and as students and faculty demanded reforms in admissions policies, faculty representation, and the development of race-conscious policies, a powerful backlash coalesced. Conservative politicians and business leaders viewed demands by civil rights activists, educators, and students for greater access to higher education as threats to the existing social and economic order.

Ronald Reagan's successful 1966 gubernatorial campaign in California explicitly targeted the Berkeley Free Speech Movement. Politicians across the country followed suit, enacting punitive measures against student activists. The financial sanctions imposed on public higher education were devastating and long-lasting, with state legislatures cutting college and university budgets even as enrollments grew, beginning a pattern of austerity that persists today.

*To read an excerpt, see “Why Do Fascists Fear Teachers?” in the Fall 2025 issue of *American Educator*. aft.org/ae/fall2025/weingarten_book.



Institutions of higher education have contributed to virtually every major medical breakthrough of the modern era.



The funding cuts and freezes ordered by the Trump administration set us backward, toward an era of less innovation, fewer cures, and a shrinking economy.



Ellen Schrecker, a professor emerita of American history at Yeshiva University and a longtime AAUP leader, documents this troubling development in her book *The Lost Promise: American Universities in the 1960s*.²⁷ The promise of free or nearly free access to public higher education gradually disappeared as a result of this backlash. The neoliberal restructuring of higher education that began in the 1970s transformed colleges and universities from institutions prioritizing education as a public good into entities forced to operate like businesses.

A pivotal moment came in 1971 when Lewis F. Powell Jr., shortly before his nomination to the Supreme Court, wrote a confidential memo to the US Chamber of Commerce titled “Attack on American Free Enterprise System,” in which he crafted a blueprint for corporate political and economic dominance. Powell identified college campuses as “the single most dynamic source” of attacks on the American economic system and called for a comprehensive, coordinated counteroffensive by the business community.²⁸

The Powell memo laid out a strategic plan that included developing scholars to be placed on college campuses, demanding “balance” on college faculties, influencing curriculum, and ensuring that think tanks and media outlets promoted pro-corporate perspectives. Inspired by Powell, in 1978 former Treasury Secretary William E. Simon explicitly called for using economic pressure to reshape higher education, suggesting that businesses should “cease the mindless subsidizing of colleges and universities whose departments of economics, government, politics, and history are hostile to capitalism.”²⁹

In the decade following its publication, the number of corporations with public affairs offices in Washington grew from 100 to more than 500, registered lobbyists increased from 175 to nearly 2,500, and corporate political action committees multiplied from under 300 to more than 1,200. Conservative think tanks proliferated, lavishly funded to produce research attacking higher education as a public good and supporting free-market ideology.³⁰

Today, the Trump administration is following a modern-day successor to the Powell memo’s blueprint to capture higher education for ideological purposes: the Heritage Foundation’s *Mandate for Leadership*, commonly called “Project 2025.”

Project 2025 is a 900-page document meant to serve as a road map for a far-right presidential administration. The Trump administration swiftly began enacting its sweeping policy proposals, which are designed to give anti-democratic politicians, judges, and oligarchs more control over Americans’ lives. Among its sweeping provisions is a radical plan to transform American colleges and universities by cutting funding, stifling ideas, silencing debate, and destroying autonomy.

Project 2025 details the intent to roll back decades of progress on access to higher education, eliminate protections for LGBTQIA+ students and sexual assault survivors, privatize student loans, end loan forgiveness, attack programs like TRIO and GEAR UP that provide a real pathway

to a college education for low-income students, and, as we are seeing, abolish the US Department of Education.

The document baselessly claims that institutions of higher education are “hostile to free expression, open academic inquiry, and American exceptionalism.”³¹ That is a central myth promoted by those attacking higher education: that colleges and universities are centers of indoctrination rather than education. This claim inverts reality.

Education Is the Antithesis of Indoctrination

Contrary to claims by some that universities are bastions of indoctrination, the goal of education is not to get all students on the same page politically or ideologically.³² It is to develop their ability to reason through complex problems, to separate fact from fiction and information from disinformation, to apply reasoning, and to form their own opinions. Critical thinking is the most important muscle in the exercise of democracy.

Higher education prioritizes students’ freedom to learn by creating open environments for inquiry and engagement. Students learn to evaluate evidence, consider multiple perspectives, engage in civil dialogue, and form independent judgments. We want ideological diversity on campuses and an open environment that challenges assumptions, beliefs, and ideas—without it, the intellectual environment dies.

Campuses should be places of free speech, with the exception of speech not protected by the First Amendment, such as defamation, incitement, and true threats. The proper response to controversial or offensive speech is not censorship but more speech—open and vigorous contestation of ideas through reasoned argument and evidence. Universities and colleges fulfill their mission not by shielding students from challenging concepts but by equipping them to grapple with complexity, ambiguity, and disagreement.

Our campuses must be places where all are safe to learn, speak, and question. Protecting free expression and ensuring safety are not competing goals, they are inseparable: Students need to feel safe enough to speak freely. And they are especially vital given the growing divisions in the United States and the efforts to limit constitutionally protected freedoms since the October 7, 2023, Hamas attacks.³³

We will continue to combat antisemitism on our campuses and in our society because all students and staff must feel and be safe and welcome on campus. We are especially concerned, however, about the Trump administration’s cynical weaponization of antisemitism as a pretext for censoring scientific research as well as targeting immigrants and free speech on campuses. Instead of addressing the legitimate concerns of students, faculty, and staff about antisemitism, the Trump administration is exploiting the issue to attack colleges and universities and to undermine democratic norms and rights.³⁴

The Corporatization of Higher Education

The shift away from viewing higher education as a public good has had devastating consequences for how colleges and universities operate. As government appropriations dwindled, institutions increasingly turned to raising revenue through tuition, private donors, and federal and corporate research grants. Between 2003 and 2020, state and federal appropriations fell from 68.5 percent to just 56.1 percent of total revenue for public universities.³⁵

This financial pressure led to the erosion of shared governance—the principle that faculty, administrators, and boards should work together on institutional decisions. As colleges and universities adopted top-down managerial practices borrowed from business, they sidelined faculty input in favor of institutional efficiency. The traditional role of faculty in determining curriculum, hiring, and institutional priorities gave way to a corporate model focused on cost-cutting and revenue generation—often without regard to the impact on students' opportunities to learn.³⁶

Decades of public disinvestment in our public colleges and universities has led to higher tuition and fees for students, cuts in academic programs, institutional closures, and the decline of stable, full-time positions in academia.

Average tuition at public four-year universities has increased by 213 percent since the late 1980s.³⁷ Meanwhile, average student loan debt (for all students, not just those at public colleges) rose from \$27,260 in 2007 to \$37,850 in 2024 (with both figures in 2024 dollars).³⁸ For many students, particularly those from low-income families and communities of color, this debt burden is a crushing obstacle to economic mobility and wealth-building.³⁹

Simultaneously, the academic workforce has been radically changed. Forty years ago, 70 percent of academic employees were tenured or tenure-track. Today, that figure has flipped: 68 percent of faculty are contingent workers who are not eligible for tenure and 48 percent hold part-time positions.⁴⁰ Academics increasingly are joining the ranks of gig workers and temps, working part time for low pay, often without benefits or job security. This lack of job security makes colleagues in contingent positions especially vulnerable in this current environment of censorship and attacks on freedom to teach.

More than one-quarter of adjunct faculty respondents in an AFT survey reported earning less than \$26,500 annually, and only 22.5 percent reported having contracts providing continuous employment.⁴¹ Many adjuncts teach at multiple institutions simultaneously, rushing between campuses with little time for the engagement with students that effective teaching requires.

One of us (Wolfson), as president of the Rutgers AAUP-AFT local in 2023, helped lead the first strike of academic workers at Rutgers in the institution's then-257-year history. Our strike brought together 9,000 workers across three unions representing faculty, graduate workers, postdocs, librarians, healthcare workers, and

counselors. We won more control over our work, contractual rights around academic freedom, and raises of 14 to 44 percent over four years, as well as a \$600,000 fund to support housing for workers living near the university.⁴² Key to our demands were the needs of the more vulnerable parts of our unit—the adjunct faculty and graduate workers. In an important victory, we won job security for full-time nontenure-track faculty, adjunct faculty, postdocs, and grad workers.

How did we do this? By rallying the support of the community and reminding the administration that a university is more than a business.

The Trump Administration's Authoritarian Assault

From Project 2025 to the broadsides on higher education from both Trump and Vice President JD Vance, the administration's hostility toward higher education has not been whispered but blared.

Trump has declared that “our colleges [have] become dominated by Marxist maniacs and lunatics” and vowed to “get this anti-American insanity out of our institutions once and for all.”⁴³ We cannot help but wonder how the “radical Left” that Trump rails about manages to indoctrinate students in their physics labs, accounting courses, and Chaucer lectures. Even in courses about the 20th-century rise of fascism, students are expected to think for themselves and to debate each other (only a fascist would tell them what to think).

With the ascension of Vance to the vice presidency, far-right forces have succeeded in elevating an extremist who vows to “aggressively attack universities in this country”⁴⁴ to within striking distance of their goal: the annihilation of American higher education as we know it.

Vance's labeling of professors as “the enemy” and his praise of Hungarian dictator Viktor Orbán's seizure of state universities as “the closest conservatives have ever gotten to successfully dealing with left-wing domination of universities” are unambiguous.⁴⁵ This administration aims to take control of higher education and bend it to their will.

The Trump administration set out almost immediately to freeze or threaten billions in federal funding to coerce universities into compliance with ideological demands that violate institutional autonomy or the First Amendment. By April 2025, the administration had frozen or paused federal funding to numerous universities, including more than \$400 million to Columbia University, \$2.3 billion to Harvard, \$1 billion to Cornell, and \$790 million to Northwestern.⁴⁶ The administration justified these actions by claiming universities had not adequately addressed antisemitism, but federal judges have found that the government was actually engaged in ideologically motivated retaliation against institutions that refused to surrender their independence.⁴⁷

Trump's so-called Compact for Academic Excellence in Higher Education is essentially a loyalty oath.⁴⁸



KYLE HANDOLIO

The Trump administration set out to freeze or threaten billions in funding to coerce universities into compliance with ideological demands.



We must refuse to choose between academic freedom and safety, between excellence and equity, between free inquiry and community.

The compact would force colleges and universities to adopt Trump’s priorities in exchange for favorable treatment, including access to federal funding. Trump’s corrupt bribery attempt would usher in a new draconian era of thought policing in American higher education, damage our capacity for technological innovation, and assault our very democracy. No amount of federal inducement is worth surrendering the freedom to question, explore, and dissent.

Trump’s compact is not just wrong, it’s unconstitutional. It violates the First Amendment by forcing universities to surrender their right of free speech and academic freedom in exchange for federal funds. It risks America’s world leadership in science, technology, innovation, and healthcare, creating opportunities for our competitors and our enemies to take the lead. It sets us backward toward an era of less innovation, fewer cures for diseases, and a shrinking economy.

The AAUP and AFT, as well as others, have sued to halt the administration’s abuses of power and illegal actions targeting higher education. We have prevailed in several important cases.

The Trump administration has systematically targeted diversity, equity, and inclusion initiatives across higher education. On the first full day of his second administration, Trump issued an executive order requiring all federal agencies to end what it describes as “illegal discrimination” and directing agencies to identify potential investigations of institutions with endowments over \$1 billion.⁴⁹ The US Department of Education responded by sending “Dear Colleague” memos to colleges and universities ordering them to end all “race-based decision-making” or face penalties, including loss of federal funding.⁵⁰

In August 2025, federal Judge Stephanie Gallagher agreed with a lawsuit filed by the AFT that the government was enforcing “unclear and highly subjective” restrictions that forced educators to “choose between chilling their constitutionally protected speech and association or risk losing federal funds and being subject to prosecution.”⁵¹ And that victory was affirmed on appeal and became final in January 2026 when the Trump administration withdrew its appeal.

In September 2025, a federal district court issued a scathing decision blocking the Trump administration from withholding federal funds from Harvard. Judge Allison D. Burroughs found that the administration “impermissibly imposed unconstitutional conditions on Harvard’s receipt of federal funds”⁵² and engaged in First Amendment retaliation after Harvard refused to comply with demands that would violate its constitutional rights.

And in the *AAUP v. Rubio* case, the AAUP took on the Trump administration’s attempt to deny international students and scholars First Amendment rights and to use participation in constitutionally protected speech as a pretext to purge these academics from the country. In late September, Judge William G. Young found that the Trump administration had violated these individuals’ constitu-

tional rights, writing that, “This case—perhaps the most important ever to fall within the jurisdiction of this district court—squarely presents the issue whether non-citizens lawfully present here in [the] United States actually have the same free speech rights as the rest of us. The Court answers this Constitutional question unequivocally ‘yes, they do.’ ‘No law’ means ‘no law.’ The First Amendment does not draw President Trump’s invidious distinction and it is not to be found in our history or jurisprudence.”⁵³

And in November, the AAUP and AFT were granted a preliminary injunction that will stop the Trump-Vance administration’s attempt to unlawfully stifle free speech and academic freedom across the University of California system’s 10 campuses and medical centers. The judge wrote that our wall-to-wall labor union lawsuit submitted “overwhelming evidence” that the administration has engaged in a concerted campaign to purge certain viewpoints in violation of the First Amendment.⁵⁴

But our most successful response to the Trump compact has been the organizing work undertaken by our members and the students at Brown, Dartmouth, the University of Virginia, Vanderbilt, the University of Texas at Austin, MIT, the University of Pennsylvania, the University of Southern California, and the University of Arizona. Their successful organizing and protesting—coupled with our unions’ national petition—created the momentum for seven of the nine administrations to reject the compact.⁵⁵ None of the original nine have signed on, and even after Trump opened the compact up to all colleges and universities, we are seeing very little appetite from institutions of higher education to sign on.

We must continue to forge and strengthen alliances with students at our universities and colleges because the fight to save higher education is a fight for their futures. They should have a right to higher education that is debt-free and that provides them with education and skills they need not only to thrive but also to meaningfully engage in their communities. That is why we joined with student groups on November 7 for a day of action, with our members participating in rallies, teach-ins, and protests in over 100 locations nationwide, including a large, multi-union rally outside the Apollo Global Management headquarters in New York City to protest CEO Marc Rowan’s involvement in the drafting of the Trump compact for higher education and protests outside Senator Dave McCormick’s offices across Pennsylvania to call for more federal funding for higher education.⁵⁶ And that is why we continue to work in coalition with student groups to push back on Trump’s agenda for higher education and to push for higher education that truly serves our students and our communities.

The Assaults on Academic Freedom and Free Speech

Historian Ellen Schrecker observes that the crackdown today within higher education is “worse than McCarthyism—much worse.” Then, individual academics were

scrutinized and fired for Communist ties. But today, she notes, the country is experiencing a “frontal attack on everything that has to do with universities and colleges.”⁵⁷

The Trump administration is demanding institutional neutrality all the way down in clear violation of constitutional rights. It follows authoritarian regimes across the world,* restricting speech, abducting our students in broad daylight for writing editorials they don’t like, and outlawing protests on our campuses,⁵⁸ which we believe is a prelude to trying to crush dissent in society writ large.

Even before the burst of terminations related to commentary on the assassination of conservative activist Charlie Kirk⁵⁹—political violence that we as a union have unequivocally condemned—faculty members reported being increasingly afraid to express political views or engage with controversial topics, knowing that a single social media post, even on their personal accounts, could cost them their jobs and livelihoods. Surveys show that more than half of faculty report self-censoring in response to perceived threats to their academic freedom.⁶⁰

The University of Chicago’s “Chicago Principles” on free expression make clear that “it is not the proper role of the University to attempt to shield individuals from ideas and opinions they find unwelcome, disagreeable, or even deeply offensive.”⁶¹ Indeed, a core purpose of higher education is to provide a forum to wrestle with difficult ideas and engage with people across differences.

The September 2025 assassination of Kirk led to an unprecedented wave of faculty and staff terminations that has further intensified the climate of fear in higher education. In the month following that terrible event, at least 40 faculty were fired or threatened with termination for comments related to the killing—half the number of faculty who were fired during the entire McCarthy era.⁶²

The Trump administration is putting the vise on wholesale institutions—demanding changes to how departments operate and ordering universities to eliminate departments that it says create violence against conservative ideology.

In Orwellian doublespeak, they are using fear, misinformation, and intimidation to turn colleges and universities into what the far right has for years falsely accused them of being: indoctrination centers.

The Struggle for Higher Education’s Soul and Survival

The convergence of decades of disinvestment, corporatization, attacks on shared governance, the affordability

*For more on how the Trump administration is following the lead of other authoritarian rulers, see “The Trump Administration Is Trying to Wreck Our Democracy” in the Fall 2025 issue of *AFT Health Care*: aft.org/hc/fall2025/ben-ghiat.

crisis, and now an openly authoritarian assault from the federal government poses grave threats to higher education in America.

In this moment of profound crisis, we have a responsibility—not only to defend our institutions from sustained political and economic attacks, but to advance a bold, collective vision of higher education as a democratic, accessible, and transformative public good.

That is the purpose of the joint higher education campaign launched in September 2025 by the AAUP and AFT: *Saving Lives, Building Futures, Powering the Economy*. We want workers on our campuses to have dignity and security. We want to expand opportunity, make college more affordable for anyone who wants to pursue postsecondary education, and end crushing student debt. We want to ensure that all those who work in our colleges and universities have jobs that provide them with dignity and economic security. And we want to uphold academic freedom and students’ freedom to learn.

It is a simple proposition: Any person who wants to avail themselves of postsecondary education should be able to do so—in a manner that is affordable and accessible.

That is part of the American dream—and America can achieve its role in the world as that engine of opportunity and innovation and hope and freedom when its universities are muscular, dynamic campuses full of vibrancy and aspiration.

To bring this to fruition, higher education faculty and staff, students, parents, unions, businesses, policymakers, and others with an interest in not just preserving but strengthening and improving higher education must unite. We must forge a political force that can respond to the threats, offer a counter vision, and fight for a policy agenda that enacts that vision.

We must become a social and political force with footholds on every campus, in every state, and at the national level to resist authoritarian control and to advocate for reinvestment in our colleges and universities so that they are truly a public good.

We must tell the truth about higher education—acknowledging genuine problems that need addressing while rejecting false narratives designed to justify ideological control. And we must refuse to choose between academic freedom and safety, between excellence and equity, between free inquiry and community. These are false choices designed to divide us. The path forward requires embracing all of these values, recognizing that they are complementary and mutually reinforcing.

We write this not only as a warning but as a vision of what can be. The fight for higher education in America is a fight for the common good, for democracy, and for the American dream. +

For the endnotes, see aft.org/hc/spring2026/weingarten_wolfson.

We have a responsibility to advance a bold, collective vision of higher education as a democratic, accessible, and transformative public good.





The Fight to SAVE SUNY DOWNSTATE

SUNY Downstate, one of the State University of New York's three teaching hospitals, has been at the center of a yearslong battle to protect access to healthcare in central Brooklyn. Despite decades of underfunding, SUNY Downstate is a crucial academic medical center and safety-net hospital that delivers quality care to a primarily Black and Latinx community with disproportionately high rates of chronic illness. When SUNY Chancellor John King announced plans to shut the hospital down in January 2024, Downstate's unions and a broad community coalition fought back. Unified and vocal, they won a resounding victory in June 2025, when they secured \$1.1 billion to upgrade and expand SUNY Downstate's facilities and services. But with the Trump administration's cuts of nearly \$1 trillion to Medicaid over the coming decade, the fight is far from over.

To learn more about this incredible victory and the ongoing community campaign to protect healthcare in central Brooklyn, we spoke with affiliate leaders from the Public Employees Federation (PEF) and United University Professions (UUP). Redetha Abrahams-Nichols, DNP, MPA, RN, has worked as a nurse at SUNY Downstate for 25 years, including more than a decade as the assistant director of nursing in the emergency department; she is also the president of UUP's Downstate chapter and serves on the UUP Executive Board and the AFT Nurses and Health Professionals Program and Policy Council. Deb Egel, RN, JD, is a longtime nurse and attorney and serves PEF as an interim director of regional field services. Fred Kowal, PhD, is the president of UUP and an AFT vice president; he is a member of the New York State United Teachers Board of Directors and Executive Committee and serves on the New York State AFL-CIO Executive Council. Wayne Spence is a parole officer and the president of PEF; a vice president of the AFT, he also serves on the AFT Nurses and Health Professionals Program and Policy Council and on the executive councils of the New York State AFL-CIO and the Service Employees International Union.

—EDITORS

EDITORS: What can you tell us about the history of SUNY Downstate and the long fight to save it?

REDETHA ABRAHAMS-NICHOLS: I am a member of the SUNY Downstate community. My mom, my grandmother, and my family—we're all from here. When I graduated from nursing school in 2001, I came to Downstate because of its mission and because I wanted to serve the Black and Latinx communities. The hospital was struggling, and Percy Allen, who was in charge at that time, had a vision for a new emergency department (ED) that would incorporate the community and save the hospital. So I came with a passion to support Downstate and started in the ED, and I saw it grow in numbers. Within two years we became 911-receiving, and we eventually saw 75,000 visits a year. The hospital received accolades, with cardiothoracic surgery, radiology, oncology, and psychiatry as our pillars. I have been here through big wins but also through services closing and downsizing. I know what Downstate can do, and it's important to me that it stays open for the next generation.

SUNY Downstate isn't just a hospital—it's an academic medical center that combines higher education and clinical practice. It's the only medical school in Brooklyn, and a lot of people of color get their training here.¹ We know that cultural competency and concordance are essential in healthcare, and SUNY Downstate does a good job of hiring clinicians with the same backgrounds as the patient population they

serve, which is predominantly Black and Latinx with 53 percent first-generation immigrants, primarily from Caribbean nations.² With our five schools (the colleges of medicine and nursing and the schools of public health, health professions, and graduate studies), we create the whole healthcare team at the bedside in one place and train the next generation of clinicians. One in four doctors working in New York state has practiced in some way at Downstate. Kings County Hospital is across the street, but it's overloaded—when its ED is full, it uses our facility. Perhaps more importantly, it doesn't have the teaching component or the same specialized departments, and it doesn't serve the same purpose in the community.

Downstate provides so much care to the people of central Brooklyn. The median income in our area is lower than the city average, and 42.6 percent of people in the neighborhood are insured by Medicaid and/or Medicare³—but more than 80 percent of our revenue comes from Medicaid, Medicare, and state supplements to help us care for people who are less fortunate. On top of that, Downstate has done a lot of humanitarian work, with clinicians traveling to other countries to provide care and the hospital also bringing people from other countries to train here. The value of Downstate is that it's so big and multilayered, supporting our community and creating the kind of melting pot that New York City is known for.

WAYNE SPENCE: SUNY Downstate has a really special history. In addition to training clinicians, it has been a center of medical innovation. The first MRI machine was built there in 1977,⁴ and it has been home to many medical discoveries, including research that resulted in a Nobel Prize.⁵ The hospital also provides advanced care in its Level 4 NICU, its kidney transplant center, and other areas.

My part in the fight to save Downstate began in 2012, when I was a vice president of PEF. A panel appointed by the then-governor of New York, Andrew Cuomo, recommended that the hospital campus be closed and its operations consolidated with University Hospital of Brooklyn at Long Island College Hospital (LICH), which was in a wealthier, predominantly white neighborhood.⁶ We brought in a medical and economics expert, Dr. Fred Hyde, to help us and got the New York state comptroller involved. The comptroller's audit found that Downstate had been in good financial health until the SUNY system acquired Victory Memorial Hospital in 2008 and LICH in 2011⁷ (moves that the Downstate unions had opposed).

By the time I got involved, the folks on the ground already had a campaign that was building momentum through a community coalition that included local religious leaders. We learned very quickly that we wouldn't be successful if our message was just about saving union members' jobs. The focus had to be on patients saving their hospital, and the roots had to be in the community.

FRED KOWAL: When I became president of UJUP in 2013, Downstate was in the middle of this campaign. Attending a rally at Downstate, I felt the energy of our members and PEF's members. They were doing such incredible work in a hospital that had been underfunded for so long, and it was clear that then-Governor Cuomo was trying to starve the institution or close it down. In the early aughts, the state made a deal to provide a subsidy covering the significant costs of the fringe benefits we negotiated for UJUP's 2,200 members, in recognition of Downstate's heavy Medicaid patient load. But Cuomo zeroed out that subsidy, and we had to fight to get some of that money put back in the budget.

We decided that we would go on the offensive. We all felt, including the community, that we needed to do more than stop Cuomo from closing the hospital. We needed to make the hospital stronger in providing healthcare for the community as well as education and training for the medical school. This became one of the hallmarks of the campaign then and now: Don't just save Downstate, improve it. It's a vital institution in an under-served, under-resourced community that needs this hospital to be the best it can be. That's where I started, and even though we prevailed in 2014, it's still been nonstop since then, including the last two years.

EDITORS: Will you tell us more about what led to the threat of closure in 2024?

DEB EGEL: Part of the problem was that Downstate was designated as a COVID-19-only hospital during the most intense period of 2020.⁸ Downstate couldn't take non-COVID patients, which meant no other money coming in, and relief funding was slow to materialize.⁹ It's estimated that Downstate lost more than \$100 million in revenue during that time.¹⁰ But a bigger underlying problem is that the Medicaid reimbursement for Downstate is less than that of other hospitals in the area, although Downstate provides the same care in higher numbers. That creates financial problems, which of course leads to less reinvestment.

As a side note, one of the things I find most amazing about Downstate is that the doctors who work there and teach in the medical school don't get paid extra. Many



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Right from the start, we focused on a very simple message: **'If you close this hospital, people will die.'**

—FRED KOWAL



of them graduated from SUNY and are still working and teaching there 50 years later. It's an incredible testimony to the dedication the school inspires and the commitment to educating the people who will care for the community. That kind of loyalty is hard to find, and it's here at SUNY Downstate.

FRED: From 2014 on, every year the fight to hold onto the state subsidies got tougher and the subsidies got smaller, but the care model didn't change. If Brooklyn were a city on its own, it would be the third largest in the United States. We're talking incredible population density. But Downstate is the only state hospital and the only teaching hospital in the area, and it has to take every patient that comes through the door. The hospital has taken a lot of financial hits, so it's no wonder that SUNY eventually claimed it couldn't afford to keep Downstate open—but that's because the state had broken its part of the deal.

WAYNE: Cuomo kept dismantling Downstate by cutting departments. By 2024, the hospital was limping along after so many years of neglect. In 2012, PEF had close to 1,000 members at Downstate, and now we're down to about 400 because Downstate hasn't gotten the crucial support it needs.

REDETHA: One consequence of chronic underfunding is that our facilities and equipment are aging. Very little has been done to upgrade the hospital since it was built in the 1960s. We were getting money to maintain the hospital but not to actually fix it. Many clinicians have left because they can't get the right supplies and because services are being closed as funding is cut, so they fear they won't be able to give good care to our community. Our hearts are in this work, but we don't have the resources.

Many hospitals rely on patients with private insurance to provide revenue that balances the costs of care for uninsured patients. That's not the case with Downstate because people who have private insurance believe they can get better care across the bridge in Manhattan. Meanwhile, their community suffers and the hospital is financially overburdened.

EDITORS: Tell us about the last two years. What happened, and how did you organize and strategize for the campaign to save Downstate?

WAYNE: On Martin Luther King Jr. Day in 2024, we were informed that SUNY Chancellor John King planned to make Downstate basically an oversized urgent care, shifting most staff and operations to other hospitals. He and his team tried to pit PEF against UUP, promising that while UUP might have some cuts, PEF members would be safe, but we didn't fall for that. We knew what the hospital means to our members and to the community they live and work in. Fred and I immediately started coordinating our strategy.

FRED: John King had come in as the new chancellor about a year earlier. In my monthly meetings with him, we talked about Downstate, and I repeatedly asked him to bring in all the stakeholders for a conversation, but that never happened. Then this plan was announced to relocate services, build a new campus center, and provide some outpatient care. I think the chancellor expected that we wouldn't fight it, but he was wrong. I talked to Wayne and to Redetha, and we got a campaign going. Right from the start, we focused on a very simple message: "If you close this hospital, people will die." Community members, people who had been treated at Downstate for a long time with serious illnesses, were saying it, too. No matter what the chancellor tried to throw at us, claiming it was just the unions trying to save their jobs, we stuck with our simple message.

REDETHA: The first thing we did was drop a letter telling the membership what was going to happen, before the president of the hospital did. We had everyone on our side because we were the ones giving the information. Our first meeting was January 26, which was the birthday of Rowena Blackman-Stroud, a longtime chapter president. That was meaningful because this struggle started for me 12 years ago, when I used to walk with her around the hospital. It's been a relay race, with the baton being passed from one set of union leaders to another, and that's what this campaign felt like. Two weeks later, we had another meeting where members of other UUP chapters toured the hospital to see the conditions, and that helped fuel the fire.

We started with building the groundwork: finding our trusted and respected people in the community, having these natural leaders do outreach and build

awareness, developing existing relationships, and forging new ones. We made our priorities clear. We wanted everyone in the community to know what was happening to their hospital and what we were asking them to do. I felt like I was on a press junket. I went with a couple of members to different community organizations every night to talk about Downstate and what we were fighting for. Every community board member, every NAACP member, every small grassroots organization—we knew that we would need all those people to make this fight real.

DEB: We built alliances by showing up at these meetings, talking to people, and listening to them. And we had to be patient. Finding common ground takes time, but once you land on it, whole communities can bring their energy to fight for your shared goal. We also had to learn the real meaning of union solidarity, going beyond the “Solidarity Forever” song we sing. Redetha and I would get on calls in the middle of the night and early in the morning, sharing information and talking through ideas. We didn’t always see everything eye to eye, but we always yielded to the right mission, which was to keep SUNY Downstate open. We worked in solidarity across union lines and learned how to truly live that value.

FRED: We followed our usual strategy of gradual escalation, always considering how to continue to build momentum and keep the other side on the defensive. Even we were surprised by the response to that first membership meeting. AFT President Randi Weingarten attended, as did Melinda Person, the president of New York State United Teachers, and more than 300 people crammed into that meeting room eager to learn what was next and to take action. So many said, “We’ve got friends in the community who can do this task or help out with that.” It was a resounding response.

Then Wayne and I got together again to figure out the next steps. We decided the pressure point had to be state legislators in Albany, so we planned a big press conference and rally at the state capitol to kick off our advocacy and our media campaign. All the labor leaders—Randi, Melinda, Wayne, and me—as well as people from Downstate, including medical students, and legislators joined in. That was the first escalation. Then we planned a big rally at SUNY Downstate for February 29. It was freezing cold, but it was a big success. Everything just kept escalating from there.

At every event, PEF and UUP asked people, “Would you be willing to tell your story at a public hearing?” We accumulated all these contacts, so when we lobbied in Albany and held public meetings and hearings, we didn’t have to speak. Wayne and I just stood at the back of the room and listened to the community speak to elected officials and SUNY leadership. But always, we were asking ourselves, “What’s the next step? How can we escalate this and increase pressure?”

WAYNE: We found some natural allies in the legislators because many of them live in the Downstate area. As hard as COVID-19 was, it was a gift in the sense that three elected officials—a state senator and two state Assembly members—received treatment there. They said, “Downstate saved my life. If not for this hospital, I wouldn’t be alive” or “My family wouldn’t be alive.” But we knew we needed to keep building support. So we kept holding community meetings, lobbying, keeping up pressure in the media, and working to build momentum.

Going into the end of the 2023–24 budget year (at the end of March 2024), we brought in Fred Hyde again to do financial analysis and figure out how much money we needed to save Downstate. His calculations came close to \$1 billion. Governor Kathy Hochul gave us a gift in that she had recently committed \$850 million in public funds to build a new stadium for the Buffalo Bills.¹¹ We kept asking how they could come up with that money for a football team but not for healthcare.

An important part of our strategy was to let community members lead the way. Fred and I recognized that legislators could easily write us off as union leaders, but they couldn’t do that with, say, members of the clergy. Redetha had been holding meetings in schools and churches, and the community saw for themselves which politicians were lukewarm and started giving them heat. We brought a group of local leaders, including Bishop Orlando Findlayter, to Albany, and we sat behind them in support, but we didn’t have to say anything in those meetings. We knew we were all on the same page, and we were all speaking with one voice.

The value of Downstate is that it’s so big and multilayered, supporting our community and creating the kind of melting pot that New York City is known for.

—REDETHA ABRAHAMS-NICHOLS

FRED: In the state’s 2024–25 budget, we won a commitment to keep the hospital open with an additional \$750 million to \$850 million for capital expenses. The governor also agreed to form the Downstate Community Advisory Board with members appointed from the legislature, SUNY, the community, and the unions. Since UUP is the largest union at Downstate, I was asked to serve on the board.

The board was supposed to come up with a plan, but SUNY consultants (who seemed to be part of the initial plan to close Downstate) were providing the majority of the information. Thanks to the coalition we had formed, we were well organized for public hearings, and the community was loud and persistent



NEW YORK STATE UNITED TEACHERS



Finding common ground takes time, but once you land on it, whole communities can bring their energy to fight for your shared goal.

—DEB EGEL



DEB EGEL

about what needed to be done. We also did our own research to provide information to the board, lobby board members, and extend the process so we could keep fighting for a better outcome.

We had crucial support in this stage from Downstate’s clinicians and medical students. The clinicians analyzed SUNY’s plan from their dual perspectives as faculty and clinical care providers. SUNY claimed the medical school would be fine and the only real change would be getting rid of the building, but our physicians and nurses gave detailed explanations why a medical school of Downstate’s size needs an attached hospital to succeed. As far as the medical students, their schedules and Downstate’s location have made advocacy in Albany difficult in the past, but they stepped up. It was so powerful for many of my colleagues on the board to hear the students say, “We don’t want a campus center. We want a hospital and we want *this* hospital so we can get the best education.”

REDETHA: That was one of our biggest strengths in the grassroots campaign: Everyone owned this fight as theirs. We had so many ambassadors wearing our Brooklyn Needs Downstate T-shirts. I saw them everywhere I went, and I still see them, because the community still has that fire, and they carried that energy throughout the campaign.

WAYNE: The community wasn’t just a prop for us. It was a true partnership. Instead of taking over, say, design and printing of materials (which we could have handled in our Albany headquarters), we asked our community partners, “Who can take on this responsibility?” When we held meetings at churches, we covered the costs of electricity and other expenses because it was important to be clear that we didn’t expect the clergy to foot the bill. We were all sharing the burden.

FRED: I think the chancellor and others behind closing Downstate believed it was a done deal and were shocked at the organized resistance. I heard the chancellor say in Downstate advisory board meetings that our campaign was based on lies and politics, but it was based on the truth: Without that hospital, people wouldn’t get healthcare and people would die. Making it about the community wasn’t merely a political strategy. We knew we were on the right side, and that’s why we had so much support. And eventually

we convinced the governor, which is how we got to the planning stage last year and to where we are today.

The advisory board’s official recommendation in June 2025 was that New York state invest \$1 billion to keep the hospital open and fully renovate and expand the facilities,¹² and on June 17, the governor announced a \$1.1 billion funding commitment.¹³ The funds will go toward supporting existing services, expanding the ED, building a new annex with an ambulatory care center, upgrading building infrastructure, and educating the next generation of clinicians. It’s a great win for the community.

EDITORS: What were some of the keys to success for this campaign? What would you tell other affiliates that are facing similar fights?

WAYNE: We coordinated with UUP from the beginning and strategized about how we could play off each other. There were certain actions that Fred would take or projects that UUP would fund, and there were others that PEF would fund. We considered our existing relationships with legislators and community leaders and focused on playing to those strengths. It reminded me of the biopic about Bayard Rustin, which showed how politicians and communities came together during the civil rights movement to plan the March on Washington, building on commonalities instead of harping on differences. Here, unions were powering a movement that was about more than just jobs. It really was about healthcare and the community. And that got us crucial support from Hochul and the Democratic majorities in the Senate and Assembly to secure the funding we needed.

The huge challenges we faced at Downstate were a blessing because of the volumes they spoke about our health professionals. We could point to COVID-19 as evidence of how essential Downstate is to the community and how the hospital rose to the occasion in spite of so many obstacles. For people who pretended they didn’t understand Downstate’s worth, we only needed to go back to the news footage to remind them that in a time of fear, the community relied on Downstate.

DEB: Consistency was one of the biggest keys. We continued to push even when the odds were against us. And we had to not only find our allies and build coalitions but also maintain and grow them. We had to ask, “Who are all the stakeholders? Who else can we involve in this fight? And how do we find common ground?” We didn’t always get along with every organization, but we looked at everything strategically and tried not to take differences of opinion personally. We reminded ourselves to focus on the shared goals.

Earlier, Redetha mentioned finding our trusted people, and I would add that it was important for us to find champions who would stay and fight no matter what. We had several—Redetha, Wayne, and Fred, as well as

Bishop Findlayter, to name a few. Their perseverance and leadership made it possible for us to keep pushing. But it's a balancing act because you also need to give space for passionate people who aren't necessarily leaders to speak from the heart.

REDETHA: In creating this campaign, we considered what happened at Kingsbrook Jewish Medical Center, which stopped inpatient admissions in 2021 and closed for good in November 2023.¹⁴ The Kingsbrook staff was unionized but the physicians weren't, and that made it easier for the administration to divide the employees. The administration promised that if the physicians backed down about the closure, they'd reopen the ED and open an outpatient center. But none of that happened, and now Kingsbrook is going to be apartments. When former Kingsbrook staff heard what was happening at Downstate, they joined our fight. Our physicians are unionized and live in the community, so they had just as much at stake as the rest of us. That made a big difference.

FRED: I don't want to understate how much work this has been. I've never worked so hard in my life, and I saw the hours UUP and PEF folks put in handling administrative work and logistics, in addition to constantly building our coalition and supporting community engagement. So many people worked so hard for many, many months. But we were also effective because we had a simple message. When the chancellor got on television, he would talk in circles trying to explain how they weren't really closing a hospital. He missed the central lesson of politics, which is if you have to keep explaining your plan, you're not going to win. Our plan was clear as day: The hospital cured people and saved people's lives; without it, people would die. We had the facts on our side, and we had a broad coalition—that's why we were successful in the end.

EDITORS: **This victory isn't the end of the battle for Downstate, especially with Trump's Big Ugly Bill cutting nearly a trillion dollars from Medicaid. How are you continuing the fight to protect healthcare in central Brooklyn?**

FRED: I'm afraid the cuts will be devastating. Estimates on the budget hits that the state will take starting in the 2027 fiscal year are as high as \$15 billion a year,¹⁵ and more than 70 hospitals in the state will be in danger of closing.¹⁶ That includes all three SUNY hospitals. Our challenge is twofold: One, we need to make sure the promised capital funding comes through and construction gets going. Two, New York has the opportunity to counteract what Trump is doing by raising state taxes on the billionaires and ultra-wealthy who are getting a federal break and using that money to make New York state the envy of the country in terms



We need to keep fighting to see the chancellor sign contracts and break ground for the hospital this community deserves.

—WAYNE SPENCE



of healthcare. Fund these hospitals, keep them going strong, and show that there's a better, more compassionate way to run a society than what Trump and his authoritarian buddies are doing. That's the challenge I hope we can rise to.

WAYNE: When Hochul announced the \$1.1 billion investment in Downstate, we already had the state comptroller's report on how the Big Ugly Bill would affect New York state's agencies, so we knew we'd have to stay vigilant. We have the promises, and now we need to see the action. We know we have the support of Hochul, but the chancellor is controlling the process, and he didn't want this project to begin with. It would be far too easy to delay and then say, "Downstate had all this money and didn't spend it, so they must not have really needed it. Let's give it to someone else." So this coalition will be needed for quite some time to come. Hochul announced the beginning of the design stage in December,¹⁷ and that's a good start, but we need to keep fighting to see the chancellor sign contracts and break ground for the hospital this community deserves.

DEB: In that vein, we recently were approved for an AFT MOVE (Mobilize, Organize, Vote, Empower) grant to continue our collaboration and build a stronger coalition in Brooklyn. Longer term, if Downstate is going to survive whatever cuts are coming down the line, it needs to actively work to bring in more private insurance dollars, which the renovations should help

with, and to negotiate a fair reimbursement rate for Medicaid. And Downstate can learn from SUNY Stony Brook, which has foundations that support facilities, medical equipment, and scholarships. Those are three places to start.

REDETHA: The members on the ground own the facility because we're also part of the community, and we haven't stopped the campaign. We continue to march

for the construction to start now, and we're not going to stop. The passion is here, and the members are here and want to be part of sustaining healthcare in our community for Black and Latinx people. We want to be a case study for others to see that when people come together around an issue, anything is possible. +

For the endnotes, see aft.org/hc/spring2026/abrahams-nichols_egel_kowal_spence.

Fired Up and Ready to Fight

This most recent fight to save Downstate has been part of a much longer struggle for my colleagues and me to be treated fairly—and I know struggle. I'm from Trinidad, and before I came to the United States I worked for a company called Metal Box Trinidad Limited and was a member of the Oilfields Workers' Trade Union. Protesting our working conditions and wages, we saw bitter struggle, even sleeping outside in tents to show our commitment and that we knew what our labor was worth. That's the knowledge and the fire that I have brought to this fight for healthcare in central Brooklyn.



MIKE LISI / UNITED UNIVERSITY PROFESSIONS

Brooklyn needs Downstate. It's not just about a fancy new building—it's about our survival.

I first worked at SUNY Downstate in 1995 as an employee of a moving company. Then I joined the hospital staff in 1997 as a cleaner. In the decades since, I've had many roles. I have been in the IT department for many years and was promoted to IT supervisor in 2016, but I'm still fighting to get paid as a supervisor. And I'm doing the work of two or three people on a regular basis. Instead of hiring enough staff, the hospital gave me a phone to carry around. If someone calls the IT office and no one is available, it comes to my phone. I'm supposed to take the call, wherever I am in the building. But how can I help someone who is calling from home when I'm on another assignment?

Beyond insufficient staff, another ongoing IT issue is our need to upgrade our electronic health record system. All of the health facilities around us use

Epic, which allows hospitals to centralize patient information across multiple sites. But we don't have it—and even if we did, we don't have the IT staff to support it. That makes everyone's work more difficult and makes it harder to provide the best care to our patients.

Administrators have made bad financial decisions over the years, and the employees have paid the price. Before SUNY acquired Victory Memorial Hospital in 2008 and University Hospital of Brooklyn at Long Island College Hospital in 2011, our hospital was more profitable, but around 2012 administrators started telling us that they were losing money. We have been told repeatedly that there's not enough money to pay us fairly; every time, we have had to put our foot down and march around the hospital so they would hear us. There have also been other kinds of financial mismanagement, including the former chairman of emergency medicine stealing more than \$1.4 million from the hospital.¹ We have a lot of reasons not to trust management when they tell us what the hospital can and can't afford while we're working so hard to keep the hospital going for our community.

When they said in 2024 they were closing the hospital, we weren't going

to sit there and take it. We were fired up and ready to fight. We rallied in the cold and traveled to Albany for public hearings to stand up for our hospital. Downstate is not only our workplace, it's an essential part of this community. Central Brooklyn was my first home in the United States, and Downstate is still the hospital where I receive care. The SUNY chancellor tried to say that Downstate's patients could just shift to Kings County Hospital across the street, but Kings County is already overwhelmed. I recently went there because I had a hip problem and they had a specific kind of equipment that could help, but I waited in the emergency room for 24 hours without being seen. Finally, I went home. When I still had pain a couple of days later, I came to Downstate and was taken care of in a few hours.

This community is behind SUNY Downstate. Even though we won the funding we need, we know the struggle is ongoing. We're going to be relentless until they renovate the hospital properly. Brooklyn needs Downstate. It's not just about a fancy new building—it's about our survival. +

For the endnote, see aft.org/hc/spring2026/holder.

BY ANTHONY HOLDER

Anthony Holder is an IT supervisor who has worked at SUNY Downstate for more than 25 years. He is also a United University Professions Downstate Medical Center Chapter delegate.

Trapped at Work

How Employers Snare Healthcare Workers in Debt



In May of 2022, 34-year-old Jhane Engnan started working as a nurse at a skilled nursing facility in Petersburg, Virginia. Engnan had come to the United States from the Philippines in pursuit of her “American dreams”—but at Petersburg Healthcare Center, part of the CommuniCare Family of Companies, she found a reality that was anything but dreamy. She was assigned 20 to 25 patients at a time and spent each shift praying that she wouldn’t make mistakes.¹

After five months, Engnan decided that the toll chronic understaffing was taking on her mental health was too great, and she gave her notice. Two days after her final shift, she was informed that she owed CommuniCare \$14,222.24.² A week later, CommuniCare sued her for \$100,000, claiming breach of contract, fraud, and other costs. “I feel like a criminal for quitting my job,” Engnan said.³

Stories like Engnan’s have become increasingly common across the country, particularly in healthcare. Today, employers in a wide range of fields rely on predatory “stay-or-pay” contracts that charge workers a fee for quitting, often ranging from thousands to tens of thousands of dollars.⁴ Among those are industries

like healthcare, transportation, and retail, in which jobs are disproportionately held by women, workers of color, and early career workers.⁵

Stay-or-pay contract terms are especially harmful in healthcare because they can prevent nurses from speaking out about poor working conditions and unsafe nurse-patient staffing ratios, or from coming together with their colleagues to form a union and advocate for better pay and workplace environments. This article discusses the rise of restrictive contract language and the dangers it poses for healthcare workers, especially those who are just entering the workforce; it also outlines what unions and advocacy groups can do to fight back and protect healthcare professionals.

“Stay-or-Pay” Contracts: Modern-Day Indentured Servitude

Employers’ use of restrictive contract terms has grown increasingly common since the 1990s.⁶ The most common type of stay-or-pay contract is a *training repayment agreement provision* (TRAP).⁷ TRAPs are often forced on workers as a condition of employment and require workers who receive on-the-job

By **Chris Hicks**

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TRAPs allow employers to lock workers in place, limiting their mobility and bargaining power.



training—regardless of the quality or necessity of that training—to pay back the supposed cost if they leave their job before the end of a specified term.

Researchers found that the use of TRAPs rose from 4.1 percent in 2014 to as much as 8.7 percent in 2020, including a sharp rise among younger workers.⁸ This would mean that today, millions of workers are unable to leave their jobs without triggering tens of thousands of dollars of contingent loan obligations. This should raise an alarm.

TRAPs and other stay-or-pay contracts allow employers to use the threat of debt collection or litigation to lock workers in place, limiting their mobility and bargaining power, and imposing crushing financial penalties when a worker dares to leave. And even if the contract is not enforced, its presence has the intended effect of pressuring workers into staying.

This scheme may sound familiar. Because TRAPs are often structured to prevent workers from transitioning to competing employers, they substitute for traditional noncompete clauses, which have come under growing scrutiny from federal government agencies and state lawmakers. But TRAPs may be even more effective at limiting or blocking workers from leaving their jobs than traditional noncompetes, particularly for low-wage workers who can't afford to pay their employer a substantial sum to quit.⁹ And while traditional noncompetes aim to limit workers from departing for a competitor or starting a competing business, TRAPs may be enforced against a departing worker no matter what they do after their job. Even if a worker leaves to take care of a sick family member or changes careers or industries completely, they still have to pay.

The debt created by TRAPs also poses a unique, unavoidable danger to workers because at the moment the worker is required to sign the contract, the debt is already inextricably linked to their employment. According to workers who shared their experiences with the Consumer Financial Protection Bureau, in many instances by the time they learned they would have to sign a TRAP in order to start a job, they had already left their previous employment; the result was a deeper imbalance of power and decreased ability to negotiate the terms.¹⁰ And once these workers began employment, their ability to afford to quit and repay the TRAP debt was controlled by the issuer of the debt. For the vast majority of workers with TRAPs, the threat of debt or debt collection litigation brought by employers amounts to a form of modern-day indentured servitude, keeping them trapped in jobs with low wages and bad working conditions.

Stay-or-Pay Innovations

As regulatory and media scrutiny of TRAPs has increased (see “Putting the Spotlight on TRAPs”), some employers have turned to contracts that use

different language but are often functionally equivalent. They may require employees to pay either a flat fee (called “liquidated damages”) or an unspecified (and therefore unlimited) amount of money to recoup what the employer characterizes as expenses related to employee training, finding and training a replacement employee, or vague harms like “loss of goodwill.”

One such example occurred in California. With a workload that was upward of 40 patients a day and breaks that lasted only a few minutes, one doctor working for Concentra considered quitting. But when he spoke with his boss, he was told that Concentra would enforce the stay-or-pay provisions of his contract. The contract requires employees to give 120 days' notice when quitting or pay a fee equivalent to their salary for the remainder of that period. The doctor found a way to stick it out for another four months, but during that time he turned down multiple job offers from companies that simply could not hold a position open that long.¹¹

Filipino nurse Benzor Shem Vidal found himself in a similar situation when he accepted a job with Advanced Care Staffing (ACS), a nursing agency based in Brooklyn, New York. Vidal had left a job to work for ACS, so when he was asked to sign a stay-or-pay contract, he felt like he “had no choice.”¹² The contract required him to work for the nursing agency for at least three years or pay \$20,000 plus the company's future profits, attorneys' fees, and arbitration costs.¹³ After four months of ACS failing to address his concerns, which included being assigned more patients than he felt he could responsibly care for and working under grueling conditions, Vidal resigned. The company sued him for more than \$24,000, including \$9,000 for future profits. This was more than he had been paid by the company during his employment. Vidal sued ACS, and the US Department of Labor later joined the case. Because the penalty was greater than the amount Vidal had earned, the Department of Labor argued that the company had violated federal minimum wage requirements.¹⁴

Deepening the Healthcare Staffing Crisis

While the use of TRAPs has generally increased across the economy, they are particularly prevalent in the healthcare industry. The COVID-19 pandemic revealed a healthcare system that was unprepared for a global health crisis, and hospitals and healthcare facilities experienced large staffing turnover; nearly one in five healthcare workers quit or otherwise left their jobs.¹⁵ Workers have continued to grapple with the ongoing staffing crisis as working conditions remain challenging and worker burnout has worsened. More than 138,000 registered nurses have left the workforce since 2022.¹⁶ Instead of offering competitive jobs that retain highly skilled, qualified nurses

and healthcare workers with increased salaries, better benefits, reasonable patient loads, and meaningful training opportunities, hospitals and healthcare companies are turning to TRAPs and other stay-or-pay contracts to coerce nurses to stay.

This looming threat of debt is real: in July 2020, while much of the country was banging pots and pans on their doorsteps to cheer on healthcare workers, it was reported that Parkland Memorial Hospital in Dallas was suing nearly two dozen nurses who had left the hospital before completing their two-year agreements, including one who had agonized before deciding to leave in 2015. In her exit survey, she wrote, “As a single working mom, I found it increasingly difficult to work long hours & weekends away from my daughter. My absence was negatively impacting her well-being so I made a hard choice to leave a job & facility I love. I loved working @ Parkland & the skill & their staff is the absolute best!” Parkland sued her for \$19,248.¹⁷

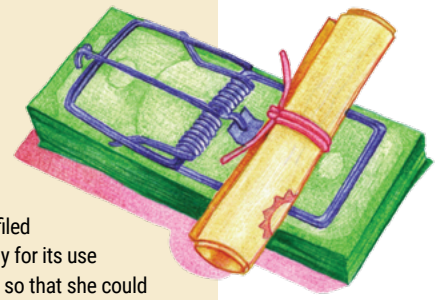
Parkland Memorial Hospital is far from the only hospital or healthcare staffing company to use TRAPs to prevent nurses from departing or to punish those who do. When the Consumer Financial Protection Bureau launched the first-ever public inquiry into the harmful effects of TRAPs and other stay-or-pay contracts in 2022, one healthcare union surveyed more than 1,100 union and nonunion nurses about their experiences with these contracts. Among registered nurses in hospitals with one to five years of experience, *nearly 45 percent* reported having been in a TRAP. In contrast, of registered nurses with 11 to 20 years of experience, only 24 percent had ever been in a TRAP.¹⁸ Given the broader labor analysis indicating that early career workers, women, and workers of color are more likely to have a TRAP, it is not surprising that TRAPs in healthcare are most common among new nurses and foreign-educated nurses, both of which are more likely to be women or workers of color.¹⁹

The Scarring Effect of TRAPs on New Nurses

Despite being fully licensed, all new graduate nurses at Mission Hospital in Asheville, North Carolina, were required to complete the \$10,000 StaRN “training” program as a condition of employment, and to repay up to the full cost if they left Mission Hospital within two years. In October 2020, nurses in the StaRN program earned a rate of \$24 an hour, more than \$8 lower than the hourly median wage for RNs in the state. In addition, they were classified as temporary employees, making them ineligible for benefits.²⁰

Nurses just entering the profession often lack the bargaining power to negotiate for higher wages or better benefits; healthcare employers exploit this even further by locking these workers into employment contracts meant to prevent them from leaving for better opportunities. In recent years, multiple nurses who have had a TRAP enforced against them,

Putting the Spotlight on TRAPs



TRAPs gained national attention in July 2022 when former PetSmart groomer BreAnn Scally filed a groundbreaking lawsuit against the company for its use of TRAPs. Scally had taken a job at PetSmart so that she could follow her passion of working with animals. It seemed like a good deal: PetSmart offered her a “free” training that was “worth \$6,000” so that she could learn how to groom pets. For months, she struggled to support herself on her minimum wage salary while dealing with a grueling workload and very little one-on-one training from her supervisors, often teaching herself or learning by watching other employees do their jobs. She kept working for PetSmart for as long as she could manage the stress of the job but ended up quitting after seven months. Despite never getting any communications from the company about her TRAP, Scally noticed the derogatory mark on her credit report three months later: the company claimed she owed \$5,500 for her training.¹

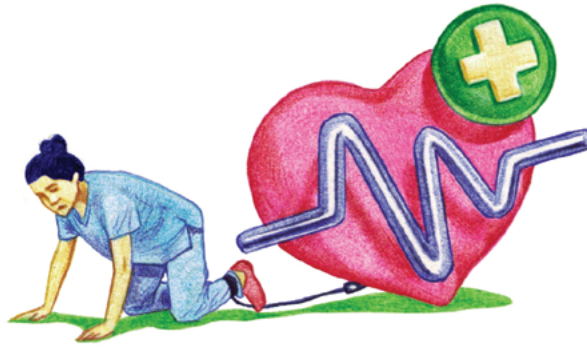
In the months that followed Scally’s lawsuit, workers from numerous industries—including healthcare, aviation,² computer programming,³ and more—filed lawsuits challenging the use of TRAPs. These lawsuits led to federal attempts to address the growing problem of TRAPs. In response, then-National Labor Relations Board (NLRB) General Counsel Jennifer Abruzzo issued a memo (since rescinded by the Trump administration⁴) explaining that TRAPs violate federal worker protections. According to Abruzzo, TRAPs pose “serious potential for suppressing union organizing and other concerted activity for mutual aid or protection, including by impairing job mobility.”⁵ Other government agencies also took notice of the growing use of TRAPs and the threat they pose to workers: the US Department of Labor sued multiple companies for their use of TRAPs, stating that they violate federal worker protections;⁶ the Consumer Financial Protection Bureau issued a report highlighting how TRAPs and other types of stay-or-pay contracts could violate federal consumer protections;⁷ and the Federal Trade Commission (FTC) proposed a ban on TRAPs through federal rulemaking due to how they unfairly limit competition and may violate antitrust protections.⁸ (The FTC, under the Trump administration, withdrew from defending this rule in September 2025.⁹)

Former US Senator Sherrod Brown (D-OH) held a listening session in 2022 during which workers harmed by TRAPs and other stay-or-pay contracts testified about their experiences. One of those workers was Cassie Pennings, a former registered nurse at University of Colorado Health and a union member. Pennings detailed her experience as a new nurse: she quickly experienced poor working conditions, such as unsafe staffing ratios and inadequate resources, after signing an employment contract with a TRAP. After she made the difficult decision to resign, the hospital informed her by email that she needed to pay \$7,500 immediately. “That’s two months of my salary. That’s more than six months’ rent,” Pennings told Congress. “Suffice it to say, we certainly did not receive \$7,500 worth of benefits through the program. Hospitals have demonstrated they would rather trap their employees with the threat of debt than incentivize them to stay.” University of Colorado Health withheld half of her final paycheck as a first payment toward the TRAP debt.¹⁰

The Trump administration has halted or reversed much of the progress made in the last few years. In addition to rescinding the NLRB memo and vacating the FTC noncompete rules, it is apparently deprioritizing Consumer Financial Protection Bureau and US Department of Labor investigations and lawsuits related to TRAPs.¹¹

—C. H.

For the endnotes, see aft.org/hc/spring2026/hicks.



TRAPs are becoming more common in healthcare, especially for new nurses and nurses trained outside the United States.

or were threatened with one, have testified before regulatory agencies investigating their use.²¹ Their experiences suggest that less desirable hospitals with unsafe working or patient care conditions utilize TRAPs because they are unwilling to compete on wages and benefits.²² Nurse unions and advocacy organizations have highlighted how workers laboring under TRAPs and noncompetes routinely receive lower wages than employees who are free to depart and work for competitors.²³

While TRAPs present an immediate threat to inexperienced nurses, the downstream effects may also harm them for years to come. In the aftermath of the Great Recession, research found that young workers who entered the labor market during times of depressed wages and salaries experienced a “scarring” effect that could lead to a lifetime loss in earnings.²⁴ Nurses who enter the workforce without a TRAP are able to pursue higher-paying jobs as they become available, while nurses with TRAPs may remain stuck in lower-paying positions for years. This can be exacerbated if future employers base their salary offers to newly hired healthcare professionals on previous earnings.

Hospitals in some instances advertise employer-required TRAPs as a form of enhanced training and education for new graduate nurses, going as far as calling them “residency” programs for RNs.²⁵ This advertising allows hospitals to take advantage of new nurses’ desire to receive mentorship and hands-on training. Unfortunately, few of these programs deliver on their promise to provide these benefits.

Targeting Nurses from Abroad

Eager for the opportunities that a move to the United States might bring, Filipina ED nurse Novie Dale Carmen accepted an offer from staffing agency Health Carousel to work at a hospital in Pennsylvania. She soon found herself working long hours in a chronically understaffed unit where she had to provide intensive care for up to six patients at once. She learned that her pay of \$25.50 an hour was far below the more than \$35 an hour that the other nurses in her hospital received and less than half of the \$52 an hour that Health Carousel was being paid for her contract. The staffing agency also exerted an unusual amount of control over Carmen, prohibiting

her from discussing her working conditions with other staff or even leaving town without permission.

Depressed and feeling trapped, Carmen decided to leave her job. When Health Carousel demanded \$20,000 in “liquidated damages,” she paid them with money her boyfriend had been saving for years to buy a house. In 2021, Carmen and several of her former colleagues sued Health Carousel for its abusive employment practices.²⁶ Last year, the company agreed to a \$6 million settlement with the nurses.²⁷

Many hospitals attempt to address the shortage of nurses willing to work under unsafe conditions by recruiting foreign-educated nurses. The largest group is Filipino exchange nurses, who are especially desirable because they’re trained in English in programs modeled on the American medical system.* Just 1 percent of the US population, Filipinos make up a much larger proportion of the nursing workforce, with 1 in 20 nurses in the United States trained in the Philippines as of 2019.²⁸ Foreign-trained nurses typically come on EB-2 or EB-3 visas, which are employment-based “preference immigrant” visas for skilled workers and professionals in a range of fields.²⁹

One reason hospitals are more aggressively turning to foreign-educated nurses is cheap labor. American registered nurses earned a median annual wage of \$93,000 in 2024, according to the US Bureau of Labor Statistics.³⁰ But, as Novie Dale Carmen and her fellow Health Carousel nurses learned, Filipino nurses might be paid much less:† according to their lawsuit, they earned roughly \$60,000 a year, less than two-thirds the national median.³¹ Lawyers representing nurses working on EB-3 visas in other cases have claimed that some employers use deceptive practices in determining wages for nurses, including basing their pay on more rural, low-cost areas rather than where the nurses are actually employed.³²

Foreign-educated nurses may also face threats regarding their immigration status if they speak up about patient-staffing ratios, pay, benefits, or other concerns with the hospital. Nurses in multiple lawsuits claim their employer threatened to report them to immigration authorities if they left their job and failed to repay the TRAP debt immediately, despite the fact that these nurses’ EB-3 visas permit them to work elsewhere.³³

In the current political climate, the threat of involving immigration authorities or taking legal

*To learn more about the history of recruiting Filipino nurses to work in the US healthcare system, see “Investing in Our Future” in the Fall 2021 issue of *AFT Health Care*: aft.org/hc/fall2021/bailey_moon.

†To learn how an AFT affiliate is bargaining to secure fair wages for nurses trained outside the United States, see “Bargaining for Pay Equity” on page 23.

action presents a severely heightened risk for nurses. Nurses whose employers are using their immigration status to force them to stay in the job or to otherwise silence them may be able to file claims for violations of the Fair Labor Standards Act and the Trafficking Victims Protection Act, as well as other federal and state protections. In 2022, New York Attorney General Letitia James announced a settlement with Albany Med Health System after finding that it required foreign-educated nurses to pay up to \$20,000 if they resigned or were fired within the first three years of employment at the hospital. If a nurse failed to pay the fee, the contract provision threatened legal action and reporting to immigration authorities.³⁴ James also found that the stay-or-pay provisions in these contracts violated the Trafficking Victims Protection Act because of their threat of serious legal and financial harm to coerce the nurses to continue working.³⁵

Fighting Debt TRAPs

After they were sued for more than \$100,000 by CommuniCare, Jhane Engnan and four of her former colleagues worked with the Asian American Legal Defense and Education Fund and two law firms to file an unfair labor practice charge with the National Labor Relations Board (NLRB).³⁶ It was one of the first challenges to a stay-or-pay contract. The AFT supported the effort, working to ensure all nurses are protected and know their rights as workers.

The NLRB took administrative action against CommuniCare, arguing that the employer was coercing employees to stay by making an example of the nurses.³⁷ Afterward, the company agreed to drop its lawsuits against the five nurses. It also agreed to rescind its use of stay-or-pay contracts nationwide, to remove them from their employee handbooks, to make current or former employees whole for lost wages or other benefits and for the costs of defending against the lawsuits, and to pay damages to current or former employees who were deprived of better employment opportunities.³⁸

Under the Biden administration, workers across the country saw new protections developed to address the growing use of TRAPs and other stay-or-pay contracts. Now, these federal protections are in grave danger as the second Trump administration is implementing its blatantly anti-worker agenda. But as federal protections erode, unions and advocates have continued to successfully challenge these harmful practices.

The AFT has been working alongside its partners to eliminate stay-or-pay contracts. Together, they are supporting nurses as they file unfair labor practice charges with the NLRB and file lawsuits against hospitals and staffing companies that use them. As a result, numerous hospitals and healthcare companies have agreed to end the use of these contracts.³⁹

Unions and advocacy organizations are also protecting workers from stay-or-pay contracts at the state level. In 2025, multiple states passed legislation that would restrict the use of these contracts. Republican and Democratic state lawmakers in Indiana worked together to prohibit hospitals from imposing stay-or-pay provisions in physician employment contracts if the terms require the workers to remain at a facility for more than three years.⁴⁰ And Colorado prohibited hospitals and healthcare staffing companies from charging medical professionals any damages for departing their jobs.⁴¹

Other states have gone beyond limiting TRAPs and other stay-or-pay contracts to just certain types of workers, with three states passing important bills in 2025. Wyoming voided noncompete clauses and prohibited any employer from imposing stay-or-pay contracts lasting longer than four years; it also required employers to prorate the amount that can be collected every year of employment.⁴² California and New York banned the use of nearly every type of stay-or-pay contract, creating the most sweeping prohibition of these contracts in the country.⁴³ (California's new law built on its 2020 legislation that barred employers from requiring direct care workers, including nurses, to pay for employer-mandated training.⁴⁴)

In Massachusetts,⁴⁵ Minnesota,⁴⁶ and Pennsylvania,⁴⁷ bills that aim to ban employers from using TRAPs across all workforces and industries are building momentum, moving through committee hearings and picking up bipartisan support (as of the end of January 2026). These bills, and others like them that protect workers' voice and their ability to organize and improve working conditions, are important targets for union advocacy.

Unions can focus on education and advocacy efforts to make sure that healthcare workers are aware of the protections available to them. They can also monitor to ensure that restrictive contracts are not being used to suppress union organizing or other efforts to improve working conditions.

Unchecked, TRAPs and other stay-or-pay contracts can leave healthcare workers buried in debt just for escaping intolerable working conditions, taking a better opportunity, or having to quit a job to navigate personal hardships. But while workers may feel powerless under these circumstances, they don't have to stay trapped. Union members can—and do—play a unique role in bringing awareness to this form of worker coercion and exploitation and holding employers accountable. +

For the endnotes, see aft.org/hc/spring2026/hicks.

Unions can play a central role in challenging these harmful practices and holding employers accountable.



Protecting Our Patients and Communities

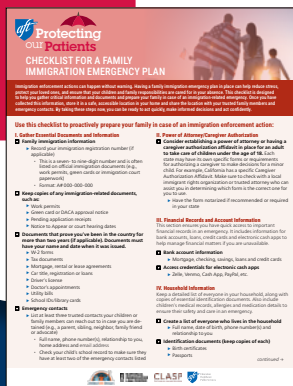
Practical Tools for Uncertain Times

Immigration enforcement actions can happen without warning. Patients, healthcare workers and community members deserve clear information and practical steps—not panic. The AFT has developed straightforward resources to help people prepare, stay safe and support one another.

Checklist for a Family Immigration Emergency Plan
Preparation reduces fear. Planning protects families. This step-by-step checklist helps families gather critical documents, organize emergency contacts and make clear plans in case of an immigration-related emergency. It includes guidance on:

- Immigration documents and registration details
- Trusted emergency contacts
- Power of attorney or caregiver authorization for minors
- Financial records and account access
- Medical information and identification documents
- School, employer and union contacts
- Attorney and consular contacts
- Personal, community and character records

Download the “Checklist for a Family Immigration Emergency Plan” at go.aft.org/ovy.



Protecting Our Patients Emergency Kit: Whistle + Know Your Rights Card

Hospitals, schools, colleges, houses of worship and community spaces must remain places of care—not fear. The “Protecting Our Patients Emergency Kit” is designed to help you assemble materials to share in your communities, including instructions on how to use a whistle as a nonverbal alert when immigration enforcement agents are visibly present. These tools are about awareness, preparation and protecting one another while respecting the law.



Access the “Protecting Our Patients Emergency Kit” at go.aft.org/j9l and download Know Your Rights cards at go.aft.org/8e1.



Know Your Rights When Encountering ICE or Other Agents Conducting Immigration Enforcement Actions

This new resource gives practical guidance for how to respond lawfully and calmly during enforcement encounters in public, in healthcare facilities, in schools and at home.

Download the “Know Your Rights When Encountering ICE” resource at go.aft.org/8fy.



Stand Together. Be Prepared. Protect Each Other.

The AFT is committed to supporting healthcare workers, educators, public employees, students and families with practical resources that promote safety, dignity and community care.

For more immigration resources and toolkits: go.aft.org/hcw