# R3 Apple Valley

#### The standard is maximizing expected well-being. Prefer:

#### 1] Humans are hard-coded to follow pleasure and pain, comes before other ethics

Berridge et al 13 [Kent C Berridge, Morten L Kringelbach “*Neuroscience of affect: brain mechanisms of pleasure and displeasure*” Published: Current Opinion in Neurobiology, Vol. 23, Issue 3, June 2013] [<https://doi.org/10.1016/j.conb.2013.01.017>; Pg. 298-300] [PDF available upon request] [Berridge: James Olds Distinguished University Professor of Psychology and Neuroscience at University of Michigan. Ph.D. University of Pennsylvania] [Kringelbach: Professor of Neuroscience, Aarhus University. Senior Research Fellow, The Queen's College.] || SM

Subcortical brain machinery for actually generating or causing a ‘liking’ reaction to core pleasure can be probed more extensively via brain manipulations in animals. Studies in our laboratory have identified neural pleasure generators by focusing on the sensory pleasure of sweetness. Sweet ‘liking’ is useful because affective facial expressions of taste pleasure ‘liking’ exist in newborn humans and in some animals, aiding the objective measure of hedonic impact. For example, parents often know when their baby expresses a ‘liking’ judgment of the deliciousness of a meal. Sweet foods elicit a contented licking of the lips, but bitter tastes instead elicit disgust gapes and headshakes. Homologous ‘liking’ orofacial expressions are elicited also in apes and monkeys, and even in rats and mice [47]. We have used brain manipulations of ‘liking’ reactions to identify brain mechanisms that generate and enhance such pleasures as sweetness (Figure 3).

One surprising finding has been that neural generators of intense pleasure are much more restricted neurochemically than was previously envisioned. For instance, mesolimbic dopamine, probably the most popular brain neurotransmitter candidate for pleasure two decades ago, turns out not to cause pleasure or ‘liking’ at all. Rather dopamine more selectively mediates a motivational process of incentive salience, which is a mechanism for ‘wanting’ rewards but not for ‘liking’ them. When amplified by addictive drugs or by endogenous factors, dopamine helps generate intense levels of ‘wanting’, characteristic of drug addiction, eating disorders, and related compulsive pursuits. Why, then, are dopamine-promoting drugs such as cocaine or methamphetamine reportedly so pleasant? One possibility is that some psychostimulant euphoria comes from the ‘wanting’ component of reward: a world that seems more attractive may well carry an aura of euphoria. Another potential mechanism is that, distinct from raising dopamine in the synapse, such drugs might also induce secondary recruitment of additional neurobiological mechanisms that more directly cause hedonic pleasure. For instance, there is evidence to suggest that elevation of endogenous opioid signals may be recruited in limbic structure [62,63]. Such opioid recruitment in accumbens-pallidal hotspots described below would plausibly generate pleasure ‘liking’ [64]. Conceivably, the secondary recruitment of hedonic mechanisms might become somewhat sluggish with continual drug-taking, therefore requiring higher doses for the sought-after pleasurable high, even if dopamine-related sensitization enhanced circuit reactivity to produce more and more intense ‘wanting’ [60].

Hedonic hotspot network

Another surprising finding has been that pleasures generators are much more anatomically restricted than previously envisioned, localized to particular subregions. We have identified several pleasure generators as small hedonic hotspots, nestled in subcortical structures. Opioid and endocannabinoid neurochemical signals do more effectively generate intense pleasures than dopamine — but only within the boundaries of such hotspots. For example, mu opioid stimulation by DAMGO microinjection within a hotspot of NAc (localized in the rostrodorsal quadrant of medial shell), or in another hotspot of ventral pallidum (in the posterior half of ventral pallidum), more than doubles the intensity of ‘liking’ reactions elicited by sweetness. But the same DAMGO microinjections elsewhere in the remaining 90% of NAc outside the hotspot generate only ‘wanting’ without enhancing ‘liking’ — much like dopamine (i.e. remaining 60% of medial shell and probably entire lateral shell and core; and even regions of dorsal striatum) (Figures 1 and 3). In addition, in the anterior half of ventral pallidum, DAMGO microinjection actually causes opposite suppression of ‘liking’ reactions. So far, no hedonic hotspots have yet been found in neocortex (though the search continues), but rather only in these subcortical structures. Continued failure to find a hedonic-enhancing hotspot in prefrontal cortex would be another reason to distinguish between cortical representation and subcortical causation of pleasure as different functions.

Each accumbens-pallidum hotspot is only a cubic-millimeter in volume in rats (a human hotspot equivalent hould be approximately a cubic-centimeter, if scaled to whole-brain size). Functionally, hedonic hotspots seem quite specialized for intense pleasure generation compared to regions around them. Neurobiologically, hotspots may have unique anatomical or neurobiological features that distinguish them from the rest of their containing structure, and which perhaps permit the functional specialization for pleasure causation (Figure 1).

Integrating neurochemical and anatomical findings, what makes opioid neurotransmitters more hedonic than dopamine is not that limbic opioid signals always generate ‘liking’. In most of NAc, neither does. Rather opioid stimulation has the special capacity to enhance ‘liking’ only if the stimulation occurs within an anatomical hotspot— whereas dopamine never does anywhere. Beyond NAc and ventral pallidum, opioid stimulation in all regions tested so far for other structures, such as neostriatum, amygdala, and so on, at best generate enhancement only of motivation ‘wanting’ without enhancing hedonic ‘liking’. Overall, the pattern indicates not only strong localization of hedonic function, but also neurochemical specificity of pleasure neurotransmitters.

Functionally, hotspots in NAc and ventral pallidum interact together in a single integrated circuit. The two sites act as a functional unit for mediating pleasure enhancements. Each hotspot seems able to recruit the other to unanimously generate amplification of ‘liking’. For example, a single opioid microinjection into the NAc hotspot enhances also responsiveness of ventral pallidum hotspot neurons, reflected in neuronal firing patterns elicited by a sweet taste or in gene activation, at the same time as enhancing behavioral ‘liking’ reactions. Unanimous recruitment of both hotspots further appears to be required to magnify pleasure. Blocking either hotspot with an opioid-antagonist microinjection completely prevents opioid stimulation of the other hotspot from producing any ‘liking’ enhancement [72].Finally, the ventral pallidum hotspot may be especially important for maintaining normal levels of pleasure. Damage to ventral pallidum can cause even sweet sucrose taste to elicit purely negative gapes and other disgust reactions for days or weeks afterwards (C-Y Ho, ‘The ventral pallidum as a limbic pleasure generator, PhD Dissertation, Ann Arbor, University of Michigan, 2010) [8,73]. No other brain lesion of a single site so potently transforms sensory pleasure into purely negative affect. Of course, other brain structures do help generate intense aversive emotions when manipulated in other ways

#### 2] Life has a priori value achieved through pleasure.

Amien Kacou 8 WHY EVEN MIND? On The A Priori Value Of “Life”, Cosmos and History: The Journal of Natural and Social Philosophy, Vol 4, No 1-2 (2008) cosmosandhistory.org/index.php/journal/article/view/92/184

Furthermore, that manner of finding things good that is in pleasure can certainly not exist in any world without consciousness (i.e., without “life,” as we now understand the word)—slight analogies put aside. In fact, we can begin to develop a more sophisticated definition of the concept of “pleasure,” in the broadest possible sense of the word, as follows: it is the common psychological element in all psychological experience of goodness (be it in joy, admiration, or whatever else). In this sense, pleasure can always be pictured to “mediate” all awareness or perception or judgment of goodness: **there is pleasure in all consciousness** of things good; pleasure is the common element of all conscious satisfaction. In short, **it is simply the very experience of liking things**, or the liking of experience, in general. In this sense, pleasure is, not only uniquely characteristic of life but also, the core expression of goodness in life—the most general sign or phenomenon for favorable conscious valuation, in other words. This does not mean that “good” is absolutely synonymous with “pleasant”—what we value may well go beyond pleasure. (The fact that we value things needs not be reduced to the experience of liking things.) However, what we value beyond pleasure remains a matter of speculation or theory. Moreover, we note that a variety of things that may seem otherwise unrelated are correlated with pleasure—some more strongly than others. In other words, **there are many things the experience of which we like**. For example: the admiration of others; sex; or rock-paper-scissors. But, again, **what they are is irrelevant** in an inquiry on **a priori value**—what gives us pleasure is a matter for empirical investigation. Thus, we can see now that, in general, something primitively valuable is attainable in living—that is, pleasure itself. And it seems equally clear that we have a priori logical reason to pay attention to the world in any world where pleasure exists. Moreover, we can now also articulate a foundation for a security interest in our life: since the good of pleasure can be found in living (to the extent pleasure remains attainable),[17] and **only in living**, therefore, **a priori**, life ought to be **continuously (and indefinitely) pursued** at least for the sake of preserving the possibility of finding that good. However, this platitude about the value that can be found in life turns out to be, at this point, insufficient for our purposes. It seems to amount to very little more than recognizing that our subjective desire for life in and of itself shows that **life has some objective value**. For what difference is there between saying, “living is unique in benefiting something I value (namely, my pleasure); therefore, I should desire to go on living,” and saying, “I have a unique desire to go on living; therefore I should have a desire to go on living,” whereas the latter proposition immediately seems senseless? In other words, “life gives me pleasure,” says little more than, “I like life.” Thus, we seem to have arrived at the conclusion that the fact that we already have some (**subjective) desire for life** shows life to have some (**objective) value**. But, if that is the most we can say, then it seems our enterprise of justification was quite superficial, and the subjective/objective distinction was useless—for all we have really done is highlight the correspondence between value and desire. Perhaps, our inquiry should be a bit more complex.

#### 3] Actor spec:

#### A] Governments must aggregate since every policy benefits some and harms others, which also means side constraints freeze action.

#### B] States lack wills or intentions since policies are collective actions. Actor-specificity comes first since different agents have different ethical standings. Link turns calc indites because the alt would be no action.

#### 4] No intent foresight distinction—If we foresee a consequence, then it becomes part of our deliberation which makes it intrinsic to our action since we intend it to happen – cross apply to aspec.

#### 5] No act-omission distinction—governments are responsible for everything in the public sphere so inaction is implicit authorization of action: they have to yes/no bills, which means everything collapse to aggregation.

#### 6] We debate to win and learn because we get pleasure out of winning, proves that you make decisions based on pleasure and pain, so they come first.

#### 7] Extinction first:

#### A] Forecloses future improvement – we can never improve society because our impact is irreversible

#### B] Turns suffering – mass death causes suffering because people can’t get access to resources and basic necessities

#### C] Moral obligation – allowing people to die is unethical and should be prevented because it creates ethics towards other people

#### D] Objectivity – body count is the most objective way to calculate impacts because comparing suffering is unethical

#### E] Moral uncertainty – if we’re unsure about which interpretation of the world is true – we ought to preserve the world to keep debating about it

#### 8] Nonideal theory is necessary—even Korsgaard concedes extinction justifies moral loopholes

Korsgaard PhD 02 [Christine, PhD in Philosophy, works at Harvard] “Internalism and the Sources of Normativity” RE

But actions are also events in the world (or correspond to events in the world, at least), and they too have consequences. There are a number of different ways in which one can deal with worries about what happens to the consequences in Kant’s ethical theory. It is worth pointing out that Kant himself not only did not ignore the consequences, but took the fact that good actions can have bad effects as the starting point for his religious philosophy. In his religious thought, Kant was concerned with the question how the moral agent has to envision the world, how he has to think of its metaphysics in order to cope with the fact that the actions morality demands may have terrible effects that we never intended, or may simply fail to have good ones. I myself see the development of what Rawls has called “nonideal theory” to be the right way of taking care of a certain class of cases, in which the consequences of doing the right thing just seem too appalling for us to simply wash our hands of. But I do not want to say that just having bad consequences is enough to put an action into the realm of nonideal theory. I think there is a range of bad consequences that a decent person has to be prepared to live with, out of respect for other people’s right to manage their own lives and actions, and to contribute to shared decisions. But I also think that there are cases where our actions go wrong in such a way that they turn out in a sense not to be the actions we intended to do, or to instantiate the values we meant them to instantiate. I think that some of these cases can be dealt with by introducing the kind of double-level structure into moral philosophy that I have described in the essay on “The Right to Lie: Kant on Dealing with Evil.”3 But I also think there are cases that cannot be domesticated even in this way, cases in which, to put it paradoxically, the good person will do something “wrong.” I have written about that sort of case too, in “Taking the Law into Our Own Hands: Kant on the Right to Revolution.”4

## Plan

#### Plan: A just government ought to recognize the unconditional right of healthcare workers to strike

#### Currently, conditions are leading to less health-care workers, Sovold et al., 21

(Lene Sovold, John Naslund, Antonis Kousoulis, Shekhar Saxena, M. Wali Qoronfleh, Christoffel Grobler, and Lars Munter, 3-10-2021, accessed on 10-14-2021, Frontiers, "Prioritizing the Mental Health and Well-Being of Healthcare Workers: An Urgent Global Public Health Priority", https://www.frontiersin.org/articles/10.3389/fpubh.2021.679397/full) [Lynbrook MD]

The COVID-19 pandemic has had an unprecedented impact on health systems in most countries, and in particular, on the mental health and well-being of health workers on the frontlines of pandemic response efforts. The purpose of this article is to provide an evidence-based overview of the adverse mental health impacts on healthcare workers during times of crisis and other challenging working conditions and to highlight the importance of prioritizing and protecting the mental health and well-being of the healthcare workforce, particularly in the context of the COVID-19 pandemic. First, we provide a broad overview of the elevated risk of stress, burnout, moral injury, depression, trauma, and other mental health challenges among healthcare workers. Second, we consider how public health emergencies exacerbate these concerns, as reflected in emerging research on the negative mental health impacts of the COVID-19 pandemic on healthcare workers. Further, we consider potential approaches for overcoming these threats to mental health by exploring the value of practicing self-care strategies, and implementing evidence based interventions and organizational measures to help protect and support the mental health and well-being of the healthcare workforce. Lastly, we highlight systemic changes to empower healthcare workers and protect their mental health and well-being in the long run, and propose policy recommendations to guide healthcare leaders and health systems in this endeavor. This paper acknowledges the stressors, burdens, and psychological needs of the healthcare workforce across health systems and disciplines, and calls for renewed efforts to mitigate these challenges among those working on the frontlines during public health emergencies such as the COVID-19 pandemic. With the emergence of the coronavirus disease (COVID-19) pandemic in late 2019, and the World Health Organization declaring it a global pandemic on 11th March 2020, health systems in many countries have been at times overwhelmed and stretched past their limits in terms of capacity and resources while striving toward continued delivery of quality care. The challenges for health systems, further complicated by the emergence of new more infectious variants of the virus, are likely to persist—even though infection rates have decreased in many parts of the world and the vaccine roll out progresses at a rapid pace at the time of writing this article—because we are now facing a second and equally serious pandemic of mental health challenges. The threats to mental health run deep within communities and are far reaching, affecting the millions of individuals who have been traumatized during national or regional lockdowns, left vulnerable to substance use or loneliness, those who have lost loved ones to the virus or face heightened anxieties of getting sick, or among those facing the dire economic consequences of the pandemic (1–3). In this challenging recovery phase of the pandemic, the mental health needs of healthcare workers and those on the frontlines of the pandemic response cannot be overlooked. During recent years, the mental health needs of healthcare providers have been gaining attention as a major public health concern and threat to quality care delivery. Healthcare professionals are exposed to multiple stress factors within their work, which may influence their physical, mental, and emotional well-being in negative ways (4–6). The World Health Organization estimates a projected shortfall of 18 million health workers by 2030, mostly in low- and lower-middle income countries. However, countries at all levels of socioeconomic development face, to varying degrees, difficulties in the education, employment, deployment, retention, and performance of their workforce (7). The COVID-19 pandemic is likely to exacerbate these issues among healthcare workers across the globe. In this article we reflect on the mental health impacts on healthcare professionals during times of crisis and other challenging working conditions against a backdrop of the current COVID-19 pandemic. First, we provide a broad overview of the elevated risk of stress, burnout, moral injury, and mental health challenges experienced among health workers. Next, we consider how public health emergencies, such as pandemics, can exacerbate these concerns and pose additional challenges to reaching and supporting health workers. Further, we consider promising approaches for protecting and promoting the mental health of health workers through self-care and other evidence-based interventions. Lastly, we highlight the need for organizational measures, policies, and systemic changes needed to address these challenges and empower healthcare workers going forwards. Numerous factors contribute to elevated stress among healthcare workers, including heavy workloads, long shifts, a high pace, lack of physical or psychological safety, chronicity of care, moral conflicts, perceived job security, and workplace related bullying or lack of social support. The resulting psychological distress can lead to burnout, depression, anxiety disorders, sleeping disorders, and other illnesses (5, 6, 8, 9). Work related stress can have a negative impact on health care providers' professionalism, quality of care delivery, efficiency, and overall quality of life. Therefore, it is critical to identify and mitigate these work-related risk factors to protect the mental health and well-being of healthcare workers. Working in a stressful or challenging environment for long periods with little recovery time is a risk factor for burnout. Burnout is defined as an occupational phenomenon in ICD-11: “Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: (1) feelings of energy depletion or exhaustion; (2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and (3) reduced professional efficacy. Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life” (10). Maslach et al. describe burnout as that point at which important, meaningful, and challenging work becomes unpleasant, unfulfilling, and meaningless. Energy turns into exhaustion, involvement (also referred to as engagement) becomes cynicism and efficacy is replaced by ineffectiveness (11). A study investigating burnout and work-life integration in physicians between 2011 and 2017 in the US, found that about 44% of physicians reported at least one symptom of burnout in 2017 compared with about 54% in 2014 and about 45% in 2011 (12). This indicates some fluctuation in physician burnout in the years before the COVID-19 pandemic, yet the levels of burnout among physicians remained significant. Even when adjusting for age, sex, relationship status, and hours worked per week, physicians were found to be at increased risk for burnout and less likely to be satisfied with work-life integration compared with other working US adults (12). Studies have shown that physicians in clinical practice can be at risk for burnout as a result of both work and structural issues. Work related risk factors include work overload (e.g., large patient volumes, insufficient resources, or feeling poorly managed), lack of control over one's work environment, having to spend time on tasks inconsistent with one's career goals and high levels of work-home interference (4, 13). Structural issues predisposing physicians to burnout include being female, working in a solo practice, being early in one's career, lacking a sense of personal control over events, and attributing success to chance instead of personal accomplishments (14, 15). Also, in many low and middle income countries the ratio between healthcare workers and the overall population is a major issue which adds to healthcare workers' work burden, stress, and burnout. Additionally, many frontline health workers in lower income countries are predominantly women, and are therefore typically at the bottom of health system hierarchies, leaving them with limited autonomy and at elevated risk of burnout (16)

#### There are 59 million healthcare workers worldwide

**Joseph and Joseph, 16** (Bobby Joseph and Merlyn Joseph, Community health and occupational health services, St. John's Medical College, Community health and occupational health services, St. John's Medical College, August 2016, accessed on 10-21-2021, PubMed Central (PMC), "The health of the healthcare workers", https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5299814/) [Lynbrook MD]

A healthcare worker is one who delivers care and services to the sick and ailing either directly as doctors and nurses or indirectly as aides, helpers, laboratory technicians, or even medical waste handlers. There are approximately 59 million healthcare workers worldwide. Recognizing the vital role played by health care workers as “the most valuable resource for health” the World Health Organization (WHO) had declared the years 2006 to 2015 as the “The decade of the human resources for health.” Do these millions of workers who toil every day to provide healthcare to the ailing population enjoy good health themselves? In other words, are the healthcare workers healthier than their patients? As those who care daily for the sick and injured, healthcare workers are often viewed to be immune to injury or illness. Ideally, the very fact that the health facility is within their reach would make one believe so. However, the picture is not as rosy as it seems.

#### Medical workers hurt due to conditions for striking, McNicholas and Poydock 20

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The coronavirus pandemic has revealed much about work in the United States: There have been countlessexamples of workers speaking out against unsafe work conditions and demandingpersonal protective equipment (PPE) to try and [stay healthy and safe on the job](https://www.huffpost.com/entry/mcdonalds-workers-strike-coronavirus_n_5ec57c58c5b622c412eb224e). We also have seen that [essential workers](https://www.epi.org/blog/who-are-essential-workers-a-comprehensive-look-at-their-wages-demographics-and-unionization-rates/) are often notpaid commensurate with the critical nature of their work. Few U.S. workers have [access to paid sick time or paid leave](https://www.epi.org/blog/amid-covid-19-outbreak-the-workers-who-need-paid-sick-days-the-most-have-the-least/) of any kind. And, when workers have advocated for health and safety protections or wage increase, they have often been retaliated against, and even fired for doing so. As a result, [many workers have decided to strike](https://www.thenation.com/article/economy/coronavirus-workers-strikes-labor/) in an effort to have their voices heard. fEven before the pandemic, data from the Bureau of Labor Statistics (BLS) showed an upsurge in [major strike activity in 2018 and 2019](https://www.epi.org/publication/continued-surge-in-strike-activity/), marking a 35-year high for the number of workers involved in a major work stoppage over a two-year period. Further, 2019 recorded the greatest number of work stoppages involving *20,000 or more* workers since at least 1993, when the BLS started providing data that made it possible to track work stoppages by size. In fact, after decades of decline, strike activity surged in 2018, with 485,200 workers involved in major work stoppages—a nearly twenty-fold increase from 25,300 workers in 2017. The surge in strike activity continued in 2019, with 425,500 workers involved in major work stoppages. On average in 2018 and in 2019, 455,400 workers were involved in major work stoppages—the largest two-year average in 35 years. What is the right to strike and who has it? Most private-sector workers in the United States are guaranteed the right to strike under Section 7 of the National Labor Relations Act (NLRA). Section 7 of the Act grants workers the right “to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection.” This allows private-sector workers to engage in concerted activities such as strikes, regardless of whether the worker is in a union or covered by a collective bargaining contract. However, those in a union are better situated to engage in a long-term strike through strike funds. There is no federal law that gives public-sector workers the right to strike, but [a dozen states grant public-sector workers the right to strike](https://www.onlabor.org/overview-how-different-states-respond-to-public-sector-labor-unrest/). In general, there are two types of strikes: economic strikes and unfair labor practice strikes. In an economic strike, workers withhold their labor as leverage when bargaining for better pay and working conditions. While workers in economic strikes retain their status as employees and cannot be discharged, their employer has the right to permanently replace them. In an unfair labor practice strike, workers withhold their labor to protest their employer engaging in activities that they regard as a violation of labor law. Workers in an unfair labor practice strike cannot legally be discharged or permanently replaced. However, not all strikes are protected under the law. For example, it is currently unlawful for workers to be involved in “secondary” strikes, which are strikes aimed at an employer other than the primary employer (for example, when workers from one company strike in solidarity with another company’s workers). If a strike is deemed an “intermittent strike”—when workers strike on**-**and**-**off over a period of time—it is not protected as a lawful strike by the NLRA. In general, a strike is also unlawful if the collective bargaining agreement between a union and the employer is in effect and has a “no-strike, no-lockout” clause. What data do we have on strikes? Unfortunately, there are major data limitations around strikes. As a result, it is impossible to know the full extent of strike activity throughout the U.S. The main government source for strike data is the [Bureau of Labor Statistics (BLS) data on major work stoppages](https://www.bls.gov/wsp/home.htm). However, BLS data only include information on work stoppages involving 1,000 or more workers that last at least one full shift. Unfortunately, comprehensive data on work stoppages that involve fewer than 1,000 workers, or that last less than one full shift, are not readily available from BLS or other sources. The BLS’s monthly data on work stoppages do not capture any strikes directly related to the coronavirus pandemic. However, it is evident essential workers are going on strike as seen in the recent [walkouts](https://www.vox.com/recode/2020/5/1/21244151/may-day-strike-amazon-instacart-target-success-turnout-fedex-protest-essential-workers-chris-smalls) organized by Amazon, Instacart, and Target workers as well as the [dozens of strikes organized by fast food and delivery workers](https://www.thecut.com/2020/05/whole-foods-amazon-mcdonalds-among-coronavirus-strikes.html). Consequently, there is a large gap in knowledge about the true extent of strikes that occur during the coronavirus pandemic and beyond. Based on the very limited data available, the resurgence of strike activity in recent years has given over a million workers an active role in demanding improvements in their pay and working conditions. Essential workers during the coronavirus pandemic are continuing this trend by demanding better pay and safer working conditions from their employers. However, withoutcomprehensive data, it’s impossible to understand the scope of how many workers are utilizing their fundamental right to strike. This knowledge gap makes it difficult for policymakers to adequately address the needs for workers in the United States, and the Bureau of Labor Statistics should be provided funding to gather comprehensive data on worker strikes. But even with the limited knowledge we have, it’s evident that strikes are an effective tool to improve the pay and working conditions of working people. Therefore, strengthening the right to strike for workers needs to be at the heart of labor law reform going forward**.**

#### Healthcare Workers Stop the Spread of Disease, Patti 20

(Redheaded Patti, 3-18-2020, accessed on 10-20-2021, RedHeaded Patti, "Real Life Superheros: Importance of Healthcare Workers", https://redheadedpatti.com/real-life-superheros-importance-of-healthcare-workers/) [Lynbrook MD]

When you’re sick with the flu or something else, a nurse can be your best advocate for treatment. Since they’re the ones who spend the most time addressing your medical care and monitoring your progress. Nurses are able to glean important information from patients through small talk than might be offered up by the patient talking with the doctor. This helps them be able to spot potential red flags and determine how well-prescribed treatments are working. They can use this information when communicating with your doctor to help improve the quality of your care. However, around 90% of healthcare organizations struggle to find high caliber nurses and healthcare workers because their marketers lack sufficient digital skills. Not having enough workers to meet the medical needs of the public can cause infectious diseases like the flu to spread. A noncustodial parent typically gets their child 88 days out of the year. They may not be able to distinguish the difference between the symptoms of a cold with something more serious like the coronavirus or flu. Having enough healthcare workers to meet these kinds of needs not only serves these patients directly but keeps the general public safer from getting sick as well. Nurses and healthcare workers understand the implications and complexities of various types of illness. They can provide compassionate emotional support by helping patients and their families understand the diagnosis and treatment of the illness. They can help soothe nerves and provide stability and comfort to struggling individuals and families. Nurses provide updates on a patient’s condition to their family members to provide the reassurance that everything is okay when they aren’t around. They sit at the bedsides of the dying and help family members with their grief. Nurses also help create a welcoming experience for patients who are admitted to the hospital. They keep a watchful eye on a patient’s mental health and report any troubling concerns immediately to their doctor. They can provide a cheerful distraction in an environment that can be scary for some patients. This positive interaction can boost a person’s health and help them recover faster. They also help a patient readjust to their normal life when it’s time for them to leave the hospital. Healthcare workers serve on the frontline when contagious diseases like the flu sweep an entire community. We are seeing the positive impact that they are having with the recent coronavirus outbreak. By providing critical health information to the public and serving those affected, they help keep these contagious diseases from spreading faster throughout the community. They make sure that protective gear is worn to avoid accidental transmission and educate on proper sanitizing and disinfecting methods. They help the public understand steps they can take to protect themselves and others when outbreaks happen. According to the U.S Bureau of Labor Statistics, the metal fabrication alone is expected to add 12,000 new jobs over the decade. As more businesses add more employees working in close quarters together, the need for more healthcare workers will be even more critical to keep these viruses at bay. Burnout also severely impacts the number of healthcare workers that are available. If the healthcare system isn’t able to keep up with the growing demand, public health can be put in jeopardy. This can be prevented with more education and improvements in our healthcare system. Nurses and other healthcare workers work to protect people’s health both inside and outside of the hospital. They provide many wellness strategies and education to the public in order to prevent illnesses like the flu. These services range from routine wellness visits to a patient’s home to community-based campaigns regarding specific health issues. They provide educational materials with ways individuals can improve their health and prevent illnesses and diseases from developing. This health education can help employees work safer and experience fewer injuries. It can help improve the nutritional habits of children and teens to reduce the effects of obesity and diabetes. It can also help seniors live longer in their own homes. Because of their close work with many community patients, nurses make excellent advocates for developments in public policy. Registered nurses help create necessary health policies in communities that don’t have them. They also speak out and help reform health policies that are ineffective or harmful. They also make sure good policies are properly implemented and enforced. As policies are improved, it positively impacts how efficient the healthcare system is in treating the patients they serve. Nurses help change health policies both personally and on a national level. They conduct quality improvement projects in the workplace to help keep us safer from potential medical errors. They also attend local public meetings to share their advice and expertise in our schools. Nurses also write to political representatives to give advice on health issues that impact the entire community, such as the flu and the coronavirus. They work to improve technological innovations that are integrated into the healthcare system to improve quality of care. Healthcare workers are your first line of defense against contagious diseases. When you’re sick with flu or any other medical condition, healthcare workers work tirelessly to bring you back to good health once again. While they are often not publicly recognized for the work they do, it doesn’t change the fact that they are the everyday superheroes we need to maintain good health.

#### Diseases cause extinction, new diseases are uniquely probable due to environmental changes, Mooney 21

(Tom Mooney, Senior Communications & Advocacy Manager for the Coalition for Epidemic Preparedness Innovations, “Preparing for the next “Disease X””, CEPI, 2-1-21, Available Online at <https://cepi.net/news_cepi/preparing-for-the-next-disease-x/>, accessed 9-10-21, HKR-AM)

Disease X represents the knowledge that a serious international pandemic could be caused by a pathogen currently unknown to cause human disease. It was first included in the WHO’s list of priority pathogens in 2018. COVID-19 represents the first occurrence of Disease X since its designation was established, emerging much sooner than anticipated. While the world battles to control COVID-19, we know that future outbreaks of Disease X are inevitable. Our interconnected world has made us more vulnerable than ever to the rapid spread of new emerging infectious diseases. Rapid urbanisation, deforestation, intensive agriculture, livestock rearing practices, climate change and globalisation are increasing opportunities for animal-to-human contacts and for human-to-human transmission of disease on a global scale. The threat of Disease X infecting the human population, and spreading quickly around the world, is greater than ever before.COVID-19: CEPI’s first Disease X When CEPI was established in 2017 we classed Disease X as a serious risk to global health security, for which the world needed to prepare. Prior to the COVID-19 pandemic, CEPI had initiated a rapid response programme—including mRNA vaccines—against novel pathogens. Our goal was to be able to start safety testing of vaccines within months of a new pathogen being genetically sequenced. In January 2020—within 2 weeks of the publication of the genome sequence of the COVID-19 virus, and with just 141 confirmed cases of COVID-19 globally—CEPI began work on developing vaccine candidates against the virus. CEPI was able to move with such agility because it had already identified coronaviruses as serious threats and invested over $140 million in the development of vaccines against MERS. Within a few weeks of the COVID-19 outbreak, most of CEPI’s MERS vaccine development partners had pivoted to work on the new virus. Just one year later, two CEPI-supported vaccine candidates are amongst the first in the world to be approved by regulatory authorities and deployed to protect people from the virus; and potentially over one billion doses of vaccine enabled by CEPI investment will be available to the COVAX Facility in 2021. The speed of the scientific progress has been astounding, compressing vaccine development—which typically takes a decade into the space of 12 months—yet over 2 million lives have been lost to COVID-19 already and economies the world over have been devastated. So, could we move even faster next time? What next for Disease X? We don’t know where or when the next Disease X will emerge, only that it will. As COVID-19 has demonstrated, diseases do not respect borders so we need to be prepared on a global scale to respond to future outbreaks of Disease X, and we need to do it fast. In many ways COVID-19 is a proof of concept for rapidly developing a vaccine against a new viral threat. Scientists were already working on vaccines against MERS and SARS—pathogens from the same virus family as COVID-19—which gave us a crucial head start this time around. 25 viral families are known to infect humans, and over 1.6 million yet-to-be-discovered viral species from these viral families are estimated to exist in mammal and bird hosts—the most important reservoirs for viral zoonoses. We cannot develop vaccines against all potential viral threats, but we could produce a library of prototype vaccines and other biological interventions against representative pathogens from each of these 25 viral families. Having such a library of prototype vaccines, which could be ‘pulled off the shelf’, and advanced into clinical testing as soon as a related threat emerges would dramatically accelerate the development of vaccines. We also know that beta coronaviruses that cause SARS and MERS are associated with case fatality rates of 10-35% (25-88 times worse than COVID-19) and that coronaviruses circulate widely in animal reservoirs. The emergence of a coronavirus variant combining the transmissibility of COVID-19 with the lethality of SARS or MERS would be utterly devastating. We must minimise this threat as a matter of urgency. One way to do this in the long-term would be to develop a vaccine that provides broad protection against coronaviruses in general. If we can produce vaccines against Disease X in a matter of months instead of a year or more, we could revolutionise the world’s ability to respond to epidemic and pandemic diseases. Disease X and other emerging infectious diseases pose an existential threat to humanity. But for the first time in history, with the right level of financial commitment and political will, we could credibly aim to eliminate the risk of epidemics and pandemics.

## Underview

#### [1] Theory:

#### [a] 1AR theory is DTD because 4 minutes is too short to call out an abusive NC and go for substance – 1AR time skew proves that affirming is already harder

#### [b] No neg RVIs because they can collapse to a 6 minute voter in the 2NR which aff can’t do

#### [c] Neg can only get DTA on bidirectional shells since the aff speaks in the dark in the 1AC, violating countless unpredictable interps

#### [d] All theory spikes violations are DTD, prevents moot of the 1AC offense and helps account for 1ar time skew

#### [e] No new 2n responses to u/v, destroys AC theory leverage and skews aff strategy, they have cross to know implications of my underview.

#### [f] And I get 1ar theory or the neg can be infinitely abusive in the 1nc

#### [2] Reasonability and drop the arg on T – a) competing interps means that affirming is impossible because neg can always give a counter-definition and get risk of offense, b) authors can’t agree on one definition, don’t hold me to their random interps, c) key to resolving time skew, justifying even a normal aff takes valuable 1ar time.