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## Case

#### The right to strike for health care workers is blocked by NLRA Section 8g, which requires 10 days’ notice for strikes, making strikes a conditional right

NLRB [The National Labor Relations Board (NLRB) is comprised of a team of professionals who work to assure fair labor practices and workplace democracy nationwide. Since its creation by Congress in 1935, this small, highly respected, independent Federal agency has had daily impact on the way America's companies, industries and unions conduct business. Agency staff members investigate and remedy unfair labor practices by unions and employers. No date. “The right to strike” <https://www.nlrb.gov/strikes> Accessed 10/27 //gord0]

Strikes unlawful because of misconduct of strikers. Strikers who engage in serious misconduct in the course of a strike may be refused reinstatement to their former jobs. This applies to both economic strikers and unfair labor practice strikers. Serious misconduct has been held to include, among other things, violence and threats of violence. The U.S. Supreme Court has ruled that a “sitdown” strike, when employees simply stay in the plant and refuse to work, thus depriving the owner of property, is not protected by the law. Examples of serious misconduct that could cause the employees involved to lose their right to reinstatement are: Strikers physically blocking persons from entering or leaving a struck plant.Strikers threatening violence against nonstriking employees. Strikers attacking management representatives.

Section 8(g)—Striking or Picketing a Health Care Institution Without Notice. Section 8(g) prohibits a labor organization from engaging in a strike, picketing, or other concerted refusal to work at any health care institution without first giving at least 10 days’ notice in writing to the institution and the Federal Mediation and Conciliation Service.

#### Hospitals are agreeing to no-strike clauses now, and have huge staffing shortages, while simultaneously ruining patient care.

Pappas et al 10/23 [Mike Pappas is an activist and medical doctor working in New York City. Luigi Morris is a freelance photographer, socialist journalist and videographer. He is an activist for immigrants' rights. Olivia Wood is a writer and editor at Left Voice and an adjunct English lecturer in the NYC metropolitan area. October 23, 2021. “Buffalo Healthcare Workers Strike for Better Patient Care and Fair Wages” <https://www.leftvoice.org/buffalo-healthcare-workers-strike-for-better-patient-care-and-fair-wages/> Accessed 10/28 //gord0]

<https://www.leftvoice.org/buffalo-healthcare-workers-strike-for-better-patient-care-and-fair-wages/>

More than 2,000 healthcare workers — including nurses, technicians, clerical workers, and custodians — at Mercy Hospital in Buffalo, New York have been on strike since October 1. Similar to other [healthcare workers around the country](https://www.leftvoice.org/healthcare-workers-are-fed-up-and-hitting-the-picket-lines/), the striking workers’ main demand is improved staffing ratios to allow for safer care for patients. In addition, workers are fighting for better wages to attract more qualified staff, to prevent their health insurance plan from being converted to a high deductible plan, and to prevent their pension plans being converted to a 401(k).

Mercy Hospital is owned by Catholic Health System (CHS), which also owns other hospitals in the area. The striking workers at Mercy Hospital are part of the Communications Workers of America (CWA) union and were originally supposed to strike with two other hospitals, the Sisters of Charity Hospital and Kenmore Mercy Hospital. However, as reported by[Labor Notes](https://labornotes.org/2021/10/two-thousand-hospital-workers-strike-buffalo), “recognizing the potential strength of bargaining together against the chain, Locals 1133 and 1168 sought to coordinate the expiration dates of their contracts and force a master agreement in the last round of negotiations in 2019.” CHS tried to push back against this tactic, and a no-strike clause was eventually agreed to for two out of three of the hospitals, leaving Mercy Hospital as the one location able to strike on behalf of all three.

Although negotiations were supposed to begin in the middle of last year, healthcare workers agreed to delay bargaining during Covid-19 as the hospital claimed to be struggling financially — despite the CEO’s $2 million per year salary. The union healthcare workers agreed to continue working and accepted a temporary contract extension with a raise of just half a percent for the year. But despite these sacrifices, the hospital continues to refuse to give healthcare workers what they need. Hospital management’s proposals do not go nearly far enough: they proposed to add 250 new positions, similar to a proposal made back in 2016, which did nothing to resolve staffing crises.

Management Lies

It is clear that CHS management is trying to frame the ongoing lack of a contract as the fault of the workers and the union itself. In a [recent interview with local press](https://www.wivb.com/catholic-health-hospital-strike/live-catholic-health-ceo-addresses-contract-negotiations-amid-strike/), CHS CEO Mark Sullivan stated he was optimistic a deal would be reached, but “only CWA can end the strike.” Nurses Left Voice spoke with say that when they initially announced the plan to strike, the hospital tried to frame it as workers abandoning patients, putting press releases out to the community.

But healthcare workers know how hypocritical this rhetoric is, and they know they care about their patients more than anyone. Workers put their lives on line throughout the pandemic — the striking healthcare workers created Covid-19 Memorial Walls around each of the picket areas commemorating both those who became ill and those who lost their lives during the pandemic’s peaks — and were called “heroes” when the label could be used as propaganda by management. Workers were even given “healthcare heroes” shirts from CHS, but now, they say they’re seen as “zeroes” and are told they are “abandoning” patients. These claims of abandoning patients are especially ironic because, as one nurse pointed out, not only are these striking healthcare workers the ones who actually care about patient well-being — hence their resistance to the continual drive to cut staffing and costs to increase profits — but the hospital’s CEO, Mark Sullivan, who makes between $1.5-2 million a year, was planning on abandoning contract negotiations midway for vacation to Europe.

It appears the hospital’s rhetoric backfired, as there has been an outpouring of community support, with many residents of the neighborhoods around the hospital putting union signs in their front lawns. Healthcare workers from the two other hospitals not currently striking have been working in solidarity, raising money at Buffalo Bills games and other community events for the union strike fund. Healthcare workers want to get back to work, but they refuse to accept horrible working conditions that lead to poor patient outcomes. Contrary to CHS’s claims, healthcare workers actually care so much about patients that they are willing to strike to see their demands met. They refuse to let the hospital force them into a poor contract that will ultimately threaten the health of patients.

The Hospital System’s Response: Scabs and Security Firms

Those who run hospital firms like CHS know what the threat of striking and winning demands could mean for other hospital systems in the area or the country, so instead of simply meeting the healthcare workers’ demands, they continue to resist. CHS has hired the global parasitic, blood-sucking, anti-strike firm Huffmaster to not just provide scabs, but also provide security. Per their [website](https://huffmaster.com/), “Huffmaster is a master staffing agency for healthcare, security, and other industries. Specializing in rapid strike staffing, we keep business in business.” Huffmaster advertises for job fulfillment and provides housing, travel, and meals for scabs in order to break strikes. As [WNYLaborToday.com reported](https://www.wnylabortoday.com/news/2021/10/04/buffalo-and-western-new-york-labor-news/as-striking-cwa-represented-nurses-continue-to-walk-the-picket-line-outside-south-buffalo-s-mercy-hospital-in-a-battle-over-patient-care-how-can-catholic-health-not-pay-them-but-bring-in-nearly-200-out-of-town-caregivers-at-150-an-hour/), CHS is paying Huffmaster to pay these scabs between $100 and $150 an hour, plus $45 per day for their meals, but they are not willing to pay their regular unionized employees anywhere near as much. Even the pay for the X-ray technicians, one of the higher-paid positions among the striking workers, only reaches $80 per hour — far less than the scabs are being paid.

In their effort to claim the title for one of the worst companies in the world, not only does Huffmaster provide scab healthcare workers, but also violent security personnel. Healthcare workers at Mercy Hospital showed Left Voice reporters video footage and photos of how the security personnel at Mercy are the same security that were hired to help break the [Nabisco strike](https://www.leftvoice.org/nabisco-workers-face-pay-cuts-while-the-company-doubles-its-profits/) and brutally attacked workers. Now there is an injunction from New York State Attorney General Letitia James claiming the company is not licensed to do work in New York State, but as of October 21, Left Voice observed Huffmaster security personnel still on the hospital property, protecting scabs and using fake badges to hide their company logo. In addition to the hired security, Buffalo police were also present and coordinated with the drivers of the scab vehicles.

CHS CEO Trying to Deflect: CEOs Gonna CEO

In the early days of the strike, [CEO Mark Sullivan said](https://www.wivb.com/catholic-health-hospital-strike/live-catholic-health-ceo-addresses-contract-negotiations-amid-strike/) healthcare staffing is a struggle across the nation, not just at Catholic Health: “One in five healthcare workers, since the pandemic has started, has left healthcare. This is not a Mercy Hospital staffing crisis, this is not a Catholic Health staffing crisis, this is a national staffing crisis. Healthcare, overall, is broken.” And he’s right: Healthcare is “broken,” but not because of the workers. Rather, healthcare is broken because under capitalist healthcare, the primary goal is to maximize profit from people’s bodies. Everything else, [including patient care](https://www.leftvoice.org/capitalist-healthcare-killed-my-grandparent-and-hurts-all-elderly/), is secondary. Therefore, under this model, it becomes logical to cut costs whenever possible — for example, by decreasing staffing ratios. Healthcare workers have left the industry because they are tired of working in a system that does not care about patient well-being and continues to put money over lives. They joined their workplaces hoping to help others, but many workers soon find out that the system itself does not hold this priority.

Healthcare is “broken” because the system as it stands was never meant for the maintenance of health for health’s sake — instead, its origins lie in [racism](https://www.leftvoice.org/the-racist-history-of-medical-research/), white supremacy, and [maintaining worker wellbeing just enough to be tools of labor](https://books.google.com/books?id=2MYwMb9hApQC&printsec=frontcover#v=onepage&q&f=false). In some respects it isn’t “broken” but functions just how CEOs like Sullivan — along with the heads of other sectors of the medical industrial complex such as insurance companies, device manufacturers, and pharmaceutical companies — want it to, as they have the main same goal: profit maximization at all cost. This leads them to constantly work to uphold a destructive healthcare system, while the actual maintenance of health and well being remains secondary. Since a CEO like Sullivan can’t say “I am horrible and part of upholding a horrible system,” he must resort to a refrain like “healthcare is broken” to misdirect the public gaze. Executives like to pretend everyone is “on the same team” wanting to care for patients, but this is not the case. It is the healthcare workers who actually care for patients and communities, and CEOs like Sullivan who are a barrier to providing adequate care.

#### Staff shortages are high, and pay inequality among temporary and permanent staff only exacerbates the issue

Hwang 10/19 [Kristen Hwang reports on health care and policy for CalMatters. She is passionate about humanizing data-driven stories and examining the intersection of public health and social justice. Prior to joining CalMatters, Kristen earned a master’s degree in journalism and a master’s degree in public health from UC Berkeley, where she researched water quality in the Central Valley. She has previously worked as a beat reporter for The Desert Sun and a stringer for the New York Times California COVID-19 team. October 19, 2021. “Hospitals brace for strikes as California workers protest staff shortages” [https://www.ivpressonline.com/news/state/hospitals-brace-for-strikes-as-california-workers-protest-staff-shortages/article\_e8023a82-3094-11ec-a2f2-230b2ba54887.html Accessed 10/28](https://www.ivpressonline.com/news/state/hospitals-brace-for-strikes-as-california-workers-protest-staff-shortages/article_e8023a82-3094-11ec-a2f2-230b2ba54887.html%20Accessed%2010/28) //gord0]

Labor advocates are calling it “Striketober.”

As weary health care workers across California enter the 19th month of the pandemic, thousands are walking off the job and onto the picket line, demanding more staffing.

The strikes and rallies threaten to cripple hospital operations that have been inundated by the COVID-19 Delta surge as well as patients seeking long-delayed care.

More than two dozen hospitals across the state — including some Kaiser Permanente and Sutter Health facilities and USC Keck Medicine — have experienced strikes by engineers, janitorial staff, respiratory therapists, nurses, midwives, physical therapists and technicians over the past four months.

This week, nearly a third of all California hospitals reported “critical staffing shortages” to the federal government, with more predicting shortages in the coming week. Hospitals are unable to meet the state’s required staff-to-patient ratios for nurses or schedule adequate numbers of other critical personnel.

In the Central Valley, the region hit hardest by the Delta surge, National Guard medics have been deployed since September to assist area hospitals.

The reason for the shortages? Record patient volumes at the same time that many workers have been driven away from the bedside by burnout, early retirement and the seemingly unending stress of the pandemic.

SEIU-United Healthcare Workers West estimates that about 10 percent of its members — close to 10,000 people — have retired, left the profession, or taken extended leaves of absence during the pandemic.

“What’s really important is that 10 percent doesn’t turn into 15 percent, does not turn into 20 percent. There’s not enough temporary staff out there to fix what’s going on,” said Dave Regan, president of SEIU-UHW.

The shortages are an untenable scenario, unions say — one that has persisted for many years brought to a boiling point by the pandemic.

Since the pandemic began, union grievances with hospitals are increasingly about inadequate staffing, although bargaining over pay remains a key issue.

Money matters when it comes to holding onto workers, they say, especially because temporary staff brought on for pandemic response often make more than regular employees. In some instances, traveling nurses have been paid $10,000 per week at California hospitals with severe staffing needs.

“You’re paying exorbitant amounts for travelers while the existing workforce makes exactly the same amount (as before the pandemic),” Regan said.

**Striking to 'stop the bleeding'**

Early in the pandemic, Gov. Gavin Newsom announced efforts to expand the healthcare workforce through a volunteer health corps. Although tens of thousands signed up, most people didn’t have the necessary medical skills, and only 14 volunteers worked out.

The California Department of Public Health also signed a $500 million contract to help hospitals pay for emergency health care workers like traveling nurses. That contract expired in June.

Unions say those efforts are a Band-aid on a larger problem. Instead, they say policymakers should get hospitals to try harder to retain their current employees.

“Right now, hospitals, the health industry, the state of California, you need to do a lot more so that it doesn’t get worse,” Regan said. “We’re doing very little as a state to support this workforce that has been under a really unique set of pressures.”

In an early attempt to stop the churn, SEIU-UHW sponsored a bill that would have provided hazard pay retention bonuses to health workers. Opposed by the hospital association. the bill stalled before it was voted upon by the Assembly and did not make it to the Senate.

Assemblymember Al Muratsuchi, a Democrat from Torrance who introduced the bill, said the hospitals’ claims that they couldn’t afford hazard pay were unfounded since they received billions in federal pandemic funds, some “specifically earmarked for hazard pay and bonuses for frontline workers.”

“The state made a decision that they were not going to provide financial incentives to recognize and retain healthcare workers, and we think that’s shortsighted,” Regan said.

Over the summer, hundreds of nurses at hospitals, including USC’s Keck Medicine, San Francisco’s Chinese Hospital and Riverside Community Hospital, staged strikes over inadequate staffing and safety concerns.

Now more than 700 hospital engineers employed by Kaiser Permanente facilities in Northern California have been striking for four weeks, demanding higher wages.

In Antioch, more than 350 workers at Sutter Delta ended a week-long strike over inadequate staffing Friday but have yet to reach a contract agreement with their employer.

In the Victor Valley and Roseville, hundreds of workers staged recent rallies and vigils to highlight what they’re calling a “worker crisis.” Advocates say their upcoming schedules are packed with pickets planned in solidarity with other unions.

And perhaps the strongest flexing of union muscle has come in Southern California, where members of the United Nurses Associations of California/Union of Health Care Professionals, or UNAC/UHCP, voted overwhelmingly to approve a strike against Kaiser Permanente if negotiations remain at a standstill. Should a strike materialize in the coming weeks, more than 24,000 members would walk out of the health care giant’s medical centers and clinics in more than a dozen cities.

Although the dollars and cents of bargaining vary from union to union, the common thread is clear: They want employers to “stop the bleeding” of health care workers fleeing the profession and invest more in recruiting and retaining staff.

The union found 72 percent of its members — which includes nurses, occupational and physical therapists, midwives and other medical staff — were struggling with anxiety and burnout, and between 42 percent and 45 percent reported depression and insomnia. About 74 percent said staffing was a primary concern.

#### Not just the US – Afghanistan is experiencing shortages combined with economic crisis that makes sufficient care impossible

Peshimam 10/26 [Gibran Naiyyar Peshimam, writer for Reuters. October 26, 2021. “In Kabul Children's Hospital, Medics Struggle With Staff Shortages” [https://www.usnews.com/news/world/articles/2021-10-26/in-kabul-childrens-hospital-medics-struggle-with-staff-shortages Accessed 10/28](https://www.usnews.com/news/world/articles/2021-10-26/in-kabul-childrens-hospital-medics-struggle-with-staff-shortages%20Accessed%2010/28) //gord0]

KABUL (Reuters) - In Kabul's main children's hospital, the crumbling of Afghanistan's health system is reflected in the eyes of exhausted staff as they eke out fast-diminishing stocks of medicines.

As crowds of mothers and sick children fill waiting rooms in the Indira Gandhi Children's Hospital, medical staff are squeezing three babies into a single incubator and doubling them up in cot-like infant warmer beds.

Nurses who once took care of three or four babies each are now having to look after 20 or more to make up for the absence of staff who fled the country when the Taliban seized power in August.

"We tell each other that we have do this work, if we don't do it, these problems will become big, it's a loss for ourselves, our society and for our country," said Dr Saifullah Abassin as he moved from bed to bed in the crowded intensive care unit.

Although the number of blast victims and war wounded have fallen since the fighting ended, Afghanistan's hospitals are grappling with the fallout of a rapidly spreading economic crisis that has threatened millions with hunger.

U.N. agencies say as much as 95% of the population does not regularly have enough to eat and last month, the head of the World Health Organisation warned the health system was on the brink of collapse as international aid has dried up.

Lack of support for the $600 million Sehatmandi health service project administered by World Bank, has left thousands of facilities unable to buy supplies and pay salaries, threatening health services at all levels from village clinics to hospitals offering caesarian sections.

STAFF NOT PAID IN MONTHS

For the medical team, it is the acute staff shortage that is causing the heaviest strain. They have not been paid in months and often struggle even to pay their car fare to work.

"We only ask from the government firstly that, they should increase our staff," says Marwa, the nursing supervisor in the nursery ward. "Because of the changes, most of our colleagues left the country."

Nurses who would normally be taking care of three or four babies for each nurse are now handling 23. "It is a lot of load on us," she said.

Mohammad Latif Baher, assistant director of the Indira Gandhi Children's Hospital, said officials from the U.N. children's agency UNICEF have given some help but more is needed quickly to fill the shortage of medicines and supplies to treat malnourished children.

"They (international organisations) have promised more aid. And we hope that they will keep their promises," Baher says.

The hospital, built during the Soviet era in 1985 and financed by Indian aid money, has 360 beds but is operating well over capacity because of the lack of functioning clinics in the provinces around Kabul.

With a heavy flow of families coming in, the hospital has admitted 450 children and turned others away, he said.

Arzoo, who brought her eight-month-old daughter Sofia in for treatment, already lost one of her five children to malnourishment-related illness and is desperate not to lose another.

"We had a water tank at home – we sold that and used that for treatment," she said, even though the cost means Sofia's four siblings at home do not have much to eat.

"Their father came in the morning and told me the kids don't have anything. When they (hospital) provide some food, I portion it out and send some home to the kids."

#### South Africa too – their HRH strategy shows worsening leadership which re-affirms staff shortage concerns

Cleary 20 [Kathryn Cleary is a finalist for the 2020 Isu Elihle Awards for child-centred journalism, and is currently working on a series on child hunger and how the Covid-19 pandemic has affected the nutritional status of children in South Africa. September 24, 2020. “South Africa is facing a healthcare worker crisis – thousands more nurses will be needed” <https://www.dailymaverick.co.za/article/2020-09-24-south-africa-is-facing-a-healthcare-worker-crisis-thousands-more-nurses-will-be-needed/> Accessed 10/28 //gord0 \*Brackets in original]

Healthcare workers on the frontlines face many challenges, including a lack of personal protective equipment (PPE), essential medicines and, at times, poor leadership, and governance.

However, South Africa’s new 2030 Human Resources for Health (HRH) strategy, obtained by *Spotlight* and *Maverick Citizen*, reveals that South Africa’s healthcare workforce also faces worsening staff shortages, which will require billions of rands in additional investment to prevent.

Need for more support

“For me, what [the pandemic] revealed in a very stark way, are the failures of leadership and management and adequate support to frontline healthcare workers,” says Professor Helen Schneider, a public health expert from the University of the Western Cape.

“There needs to be a recognition of [systems that support] health workers in dealing with immense challenges in their work; so preventing burnout, debriefing, psychological and social support.”

Health workers experience the system around them, explains Schneider, and if a facility or province has poor managers and leadership, it directly impacts the morale of workers – she points to the Eastern Cape’s infamous Livingstone “hospital of horrors” as an example of this.

“You can see that where there is a really good manager at a facility – with a stable team that has public interest orientation, service oriented and people oriented – the frontline players are motivated, their absenteeism levels are low, they experience job fulfilment.

“It depends a lot on the nature of immediate support to frontline health professionals, but also the extent to which the system as a whole is supportive.”

Adding to this, Schneider says the crisis of access to PPE highlights pre-existing issues with supply chains. “That is just an indicator of a wider set of issues, like chronic shortages of drugs or other kinds of equipment and supplies.”

Speaking to *Spotlight*, Simon Hlungwani, president of the Democratic Nursing Organisation of South Africa (DENOSA), says support for health workers is very poor and stems from both systemic and leadership issues. Questions sent to the national department of about these issues were not responded to by the time of publication.

#### Understaffing harms patient safety and increases mortality rates. Also causes further staff absence because of mental and physical health issues, which results in cyclical staffing shortages.

EMU 19 [Eastern Michigan University. October 10, 2019. “How Nurse Staffing Affects Patient Safety and Satisfaction” <https://online.emich.edu/articles/rnbsn/nurse-staffing-affects-patient-safety-satisfaction.aspx#:~:text=This%20lack%20of%20focus%20can%20lead%20to%20medical,postoperative%20complications%2C%20and%20a%20greater%20number%20of%20falls>. Accessed 10/28 //gord0]

When healthcare facilities have insufficient nurses on staff, the welfare of patients can be compromised. Moreover, overwhelmed nurses could overlook details or not fully engage with patients. This can leave patients feeling dissatisfied with nurse performance.

Why Does Understaffing Occur?

Budget cuts, nurses reaching retirement age and a shortage of nurse faculty to prepare new nurses are just a few reasons for understaffing.

Is There a Link Between Understaffing and Negative Patient Outcomes?

Healthcare facilities that do not keep an adequate number of nurses on duty can jeopardize the safety of their patients. Overworked nurses may suffer from fatigue or burnout which can impair their ability to focus on tasks. This lack of focus can lead to medical errors, a lack of engagement and missed nursing care. Patients in understaffed facilities face an increased rate of in-hospital mortality, a higher risk of infection, a rise in postoperative complications, and a greater number of falls.

How Does Understaffing Affect Nurses?

When a healthcare facility is understaffed, the same amount of work falls to fewer nurses who typically end up working longer hours. Doing so with little to no relief can cause a breakdown in mental, emotional and physical health. Nurses who are sick or injured may be absent from work, which can also compound the staffing problem. In addition, nurses who face constant stress can develop a number of health issues, including anxiety, exhaustion, depression, heart disease, hypertension and musculoskeletal disorders.

Does Inadequate Nurse Staffing Affect Patient Satisfaction?

A scarcity of available nurses can affect patient satisfaction. In a [study](https://bmjopen.bmj.com/content/8/1/e019189) cited by the British Medical Journal, negative patient perceptions of nursing care relate to missed care, which can be a result of a shortage of nursing staff. Patients can also lose confidence in the care they receive when RNs are too rushed to explain medications or coordinate care with other team members.

Why Is Patient Satisfaction Important to the Healthcare Industry?

The healthcare industry is moving toward patient-centered care, so good satisfaction ratings are important. As consumers, patients can boost or damage the reputation of a facility with their opinions. Satisfied patients could become loyal patrons, contributing to the financial stability of a healthcare organization.

What Can Healthcare Organizations Do to Improve Nurse Staffing?

Healthcare organizations need to focus on retaining nurses by maintaining an effective and supportive work environment. The [American Nurses Association](https://www.nursingworld.org/practice-policy/work-environment/nurse-staffing) (ANA) recommends that employers allow RNs to work together to create flexible staffing schedules for their units. ANA suggests that employers should consider these factors when determining nurse staffing:

Condition of patients based on complexity, acuity or stability

Number of discharges, admissions or transfers to the unit

The staff's level of nursing preparation, expertise and skills

Size of the nursing unit

Technical support and additional resources

Given that nurses provide care and safeguard the well-being of patients, it is imperative for employers to keep qualified nurses from exiting the workforce. Nurses who not only have proper nursing preparation but are also empathetic, dedicated and vigilant can help improve patient outcomes and ensure that patients are satisfied with their care.

#### Causes burnout for nurses and prevents effective pandemic response – covid proves

Lasater et al 20 [Karen B Lasater Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Linda H Aiken Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Douglas M Sloane Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Rachel French Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Brendan Martin National Council of State Boards of Nursing, Chicago, Illinois, USA. Kyrani Reneau National Council of State Boards of Nursing, Chicago, Illinois, USA. Maryann Alexander National Council of State Boards of Nursing, Chicago, Illinois, USA. Matthew D McHugh Center for Health Outcomes and Policy Research, School of Nursing, University of Pennsylvania, Philadelphia, Pennsylvania, USA. Published August 18, 2020. “Chronic hospital nurse understaffing meets COVID-19: an observational study” <https://qualitysafety.bmj.com/content/30/8/639> Accessed 10/28 //gord0]

**Introduction** Efforts to enact nurse staffing legislation often lack timely, local evidence about how specific policies could directly impact the public’s health. Despite numerous studies indicating better staffing is associated with more favourable patient outcomes, only one US state (California) sets patient-to-nurse staffing standards. To inform staffing legislation actively under consideration in two other US states (New York, Illinois), we sought to determine whether staffing varies across hospitals and the consequences for patient outcomes. Coincidentally, data collection occurred just prior to the COVID-19 outbreak; thus, these data also provide a real-time example of the public health implications of chronic hospital nurse understaffing.

**Methods** Survey data from nurses and patients in 254 hospitals in New York and Illinois between December 2019 and February 2020 document associations of nurse staffing with care quality, patient experiences and nurse burnout.

**Results** Mean staffing in medical-surgical units varied from 3.3 to 9.7 patients per nurse, with the worst mean staffing in New York City. Over half the nurses in both states experienced high burnout. Half gave their hospitals unfavourable safety grades and two-thirds would not definitely recommend their hospitals. One-third of patients rated their hospitals less than excellent and would not definitely recommend it to others. After adjusting for confounding factors, each additional patient per nurse increased odds of nurses and per cent of patients giving unfavourable reports; ORs ranged from 1.15 to 1.52 for nurses on medical-surgical units and from 1.32 to 3.63 for nurses on intensive care units.

**Conclusions** Hospital nurses were burned out and working in understaffed conditions in the weeks prior to the first wave of COVID-19 cases, posing risks to the public’s health. Such risks could be addressed by safe nurse staffing policies currently under consideration.

#### COVID and future pandemics will reproduce untenable working conditions and racialized and classed life outcomes.

Sell 20 – Susan K. Sell is a Professor of Political Science and International Affairs at George Washington University. (“What COVID‑19 Reveals About Twenty‑First Century Capitalism: Adversity and Opportunity,” pg. 152-153) julian

The COVID-19 pandemic has revealed the lethal consequences of the sharp rise in economic inequality, the concentration of wealth in fewer and fewer hands and the increasing precarity of labour. For example, as COVID-19 slammed Manhattan, members of the top 1% flocked to their beach retreats in the Hamptons to ride out the contagion (Sellinger 2020). Meanwhile, ‘essential workers’ at the bottom of the contemporary economic hierarchy had no options but to continue to show up for work and face exposure to the deadly virus. First responders, bus drivers, nursing home workers, janitors, postal workers, grocery stockers, agricultural workers, Wal-Mart employees, Amazon warehouse workers, delivery drivers, and meat packers—many earning minimum wage and most without employer-subsidized health insurance or other benefits—had to keep working. As Bertha Bradley, a food service worker in North Carolina stated, ‘I don’t get health benefits, I don’t get sick time, I don’t get paid vacations, I don’t get a living wage’ (Jaffe and Chen 2020: 126). Katie Pine and Kate Henne refer to them as ‘new risk workers’, many of whom are given mandates for minimizing risk but few resources to implement them (Pine and Henne 2020). For example, in the John H. Stroger Hospital in Chicago, nurses were being told to reuse N95 masks, ‘sometimes up to forty-five days’ (Jaffe and Chen 2020: 138). By contrast, knowledge workers could work from the safety of their own homes and reduce their risks of becoming infected.

COVID-19 has disproportionately attacked communities of colour, compounding economic inequality and systemic racism. It is clear that ‘race matters for the way that markets have been built historically and function today’ (McNamara and Newman 2020: 6). As Presidential candidate Joe Biden pointed out during the presidential debate in September 2020, 1 out of every one-thousand African Americans in the US has died from COVID-19. In Chicago about 70% of the COVID deaths were African Americans (Jaffe and Chen 2020: 140). The UN Secretary-General António Guterres pointed out that COVID-19 ‘is exposing fallacies and falsehoods everywhere … the delusion that we live in a post-racist world, the myth that we are all in the same boat’ (Guterres 2020). In September, Citigroup released a report that systemic racism, discrimination against African Americans, has cost the economy $16 trillion (Akala 2020).

Many of the precariat are people of colour, recent immigrants and undocumented workers. By May 2020 slaughterhouses around the world became virus hot spots and exposed multiple layers of dysfunction. The meat processing industry is highly consolidated, dominated by global multinational corporations including Cargill, JBS, Smithfield and Tyson. Since the 1980s this industry has pursued the financialized model of consolidation and vertical integration, ‘aimed at increasing profits through efficiency and low wages’ (van der Zee et al. 2020). Many migrant workers in these plants live in communal housing; crowded working conditions, large plants and cramped housing, and lack of paid sick leave all exacerbate the spread of coronavirus in these environments. Indeed, Tyson was even offering workers $500 bonuses to keep working in the midst of plant outbreaks (van der Zee et al. 2020). Workers are shouldering all of the risk as slaughterhouse companies get the rewards. Structures of the global economy, including financialization and monopoly capitalism have amplified the dangers of the pandemic and pushed people further ‘into unequal groups that are not only divided by money but by matters of life and death’ (McNamara and Newman 2020: 11; Sell and Williams 2019).

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

#### The plan is effective – emergency duty workers stay and organizers will reveal flexibility and organization

Świątkowski 17 [Andrzej Marian Świątkowski. Polish lawyer, professor of legal sciences, full professor at the Jagiellonian University and the Ignatianum Academy in Krakow, specialist in the field of labor law. Pronounced “Swat-cow-ski”. December 20, 2017. “The Right To Strike in Health Service” [https://www.humanitas.edu.pl/resources/upload/dokumenty/Wydawnictwo/Roczniki%20AiP%20-%20pliki/Podzielone/Roczniki%20AiP%202017%20z2/RAiP\_2\_2017-303-314.pdf Accessed 10/28](https://www.humanitas.edu.pl/resources/upload/dokumenty/Wydawnictwo/Roczniki%20AiP%20-%20pliki/Podzielone/Roczniki%20AiP%202017%20z2/RAiP_2_2017-303-314.pdf%20Accessed%2010/28) //gord0]

SPECIFIC SITUATION OF THE MEDICAL PERSONNEL DURING A STRIKE The discussion on the ban on strike expressed in Art. 19 section 1 of the Act of 23.5.1991 should be illustrated by an example concerning a specific substantive strike of hospital staff - medical staff: doctors, nurses, laboratory technicians.8 In order to assess the situation about the compliance or unlawfulness of a specific strike organized in a hospital, the number of people striking in each of the three mentioned substantive groups of medical personnel is significant. Certainly, the general participation in the strike of all employees belonging to the hospital medical staff would pose a threat to the health or life of patients, because there would not be a single employee in the hospital who would be able to take and carry out the necessary medical activities in the case of an emergency situation. The common practice used by trade unions organizing strikes of medical staff in hospitals is to refrain from performing the work of medical personnel except those who perform “emergency duty” – they are on standby to take the necessary rescue procedures in sudden and unexpected situations. “Emergency duty” is a commonly used technique of caring for health and life of hospital patients on days and hours non-working for medical personnel. Then pre-planned medical procedures are not performed. A hospital is an institution which should guarantee its patients that the obligation of the treatment will be carried out. With reference to the above the organizer of the strike is under the obligation to decide how many employees who belong to the substantive medical staff must be excluded from the planned strike in each of the three above mentioned occupational categories (doctors, nurses, lab technicians) so that the intended strike could be carried out according to the law without endangering the health and life of those treated. The evaluation of this situation may change. The organizer of the strike must reveal flexibility, involving the exclusion from the category of strikers and including in the group a certain number of employees of the medical personnel necessary to enable the management to carry out both scheduled and emergency activities related to the protection of health and life of patients. Most likely for these reasons in the Act of 5.12. 1996 on the professions of a doctor and a dentist9did not include the provisions on the right of doctors to strike. The Code of Medical Ethics passed in 1993, a set of ethical norms not recognized as the provisions of applicable law10 requires the striking doctor to provide the patient with professional assistance in a situation where failure to comply with a moral obligation could endanger health or life. Each physician, both strikers and those who perform work, have a moral duty to care for the well-being of the patient under their care. Doctors, nurses, laboratory technicians, staying with a hospital in an employment relationship or employed there on a different basis than a contract of employment, participating in a legal strike, are obliged to provide the employer with all necessary information about the patient’s situation, so that during their absence at work because of the strike, it was possible to ensure continuity of treatment without undue delay. According to labor law, the employee’s participation in a legal strike is a justified reason for the absence of an employee at work. Only few criminal lawyers share the above view of specialists in the field of labor law11. A different approach to the strike of medical staff is made by other lawyers dealing with criminal law. According to some of them, the striking doctor may be released from responsibility for deterioration of health, serious damage to health, death of the patient under his care after finding that the hospital manager had a real opportunity to provide proper care to patients12. Thus, it is not clear whether the participation of medical staff in a strike organized in accordance with the law is only treated as a case of exercising the right guaranteeing the strikers a release from the obligation to perform work, or also acts as an immunity that protects the doctor from criminal liability.

#### \*Strikes have already gotten off the ground in certain areas because they’re recognizing leverage, but are prohibited or conditioned in others, making the plan essential.

Al-Arshani 10/23 [Sarah Al-Arshani is a breaking news reporter for Insider. Before joining Insider, Sarah was an editorial intern with The Jordan Times. She graduated from the University of Connecticut in May 2019. October 23, 2021. “Over 500,000 healthcare workers quit in August and thousands more have gone on strike as the industry deals with burnout and staff shortages” [https://www.businessinsider.com/thousands-healthcare-workers-quitting-striking-burnout-grows-staff-shortages2021-10 Accessed 10/28](https://www.businessinsider.com/thousands-healthcare-workers-quitting-striking-burnout-grows-staff-shortages2021-10%20Accessed%2010/28) //gord0]

Over [500,000 healthcare workers quit in August](https://www.bls.gov/news.release/pdf/jolts.pdf), the most recent month figures are available for, and more than two dozen strikes amongst healthcare workers have taken place since the start of the year, according to reports.

A tracker from [Cornell University's School of Industrial and Labor Relations](https://striketracker.ilr.cornell.edu/) found there have been 35 strikes in the Healthcare and Social Assistance industry as of Friday.

Over the past four months, t[housands of workers at more than two dozen hospitals](https://www.businessinsider.com/california-hospital-workers-strike-over-critical-staffing-shortages-2021-10) in California have gone on strike. Earlier this month, close to 31,000 healthcare workers at [Kaiser Permanente voted to authorize a strike over wages.](https://www.businessinsider.com/kaiser-permanente-health-care-workers-vote-to-authorize-strike-2021-10)

Nurses at one hospital in Massachusetts have been on strike since March, [Masslive reported.](https://www.masslive.com/worcester/2021/10/striking-saint-vincent-hospital-nurses-no-longer-entitled-to-unemployment-some-may-have-to-repay-benefits-state-rules.html)

The strikes are occurring during a time of increased demand for patient care and a shortage of workers. In addition to the Delta variant, the US is also facing a rise in chronically ill patients who delayed care during the pandemic, [Politico](https://www.politico.com/news/2021/10/20/hospitals-labor-shortage-covid-delta-516303) reported.

Healthcare workers told Politico that while they know walking out may garner "scorn" from some, they wanted to use the attention they've recieved throughout the pandemic to demand better conditions.

"We're drowning here," Mike Pineda, a senior transport technician at Sutter Delta Medical Center in Antioch, California, told Politico. "The wear and tear on everyone got to the point where people became frustrated."

Jamie Lucas, the Executive Director of the Wisconsin Federation of Nurses and Health Professionals, told the outlet that the reasons to strike have always been there but that some healthcare workers, like many other industries [demanding better conditions across the country](https://www.businessinsider.com/what-is-striketober-kelloggs-john-deere-iatse-strike-labor-2021-10), are realizing they have some leverage.

Throughout the pandemic, healthcare workers have said they're burnt out. In May, Nikki Motta, a travel nurse who spent a year working with COVID-19 patients in understaffed hospitals across the East Coast [told Insider she was experiencing hair loss from the stress.](https://www.businessinsider.com/nurses-are-considering-leaving-the-profession-after-covid-19-pandemic-2021-5)

Liz Evans, another travel nurse, told Insider she was taking care of six patients at a time when in normal times, she might have two at most.

 A March 2021 [Trusted Health online survey](https://uploads-ssl.webflow.com/5c5b66e10b42f155662a8e9e/608304f3b9897b1589b14bee_mental-health-survey-2021.pdf) of over 1,000 travel nurses found that almost half said they were considering leaving the profession. Seven months, later a [ShiftMed survey found 49% of US nurses](https://www.businessinsider.com/nurse-shortage-labor-quit-healthcare-hospital-jobs-employment-shiftmed-survey-2021-10) said they may leave the profession within the next two years. More than 90% of respondents in the ShiftMed survey said staffing shortages were negatively impacting them.

Some of the other factors that have pushed healthcare professionals to consider leaving include the pandemic, low wages, and an increase in workload.

"I really started looking away from bedside over the last year, because the weight was really heavy of what I was doing, and I didn't feel like I was doing the job that I initially signed up for, which is to help people and make people feel better," Motta told Insider in May. "I feel like there are even more and more expectations for nurses, and nurses are the type of people who want to help and who want to do what is asked of them, but I think that is being taken advantage of in a lot of ways."

#### Disease causes extinction — the risk is categorically underestimated.

Dennis Pamlin & Stuart Armstrong 15. \*Executive Project Manager Global Risks, Global Challenges Foundation. \*\*James Martin Research Fellow, Future of Humanity Institute, Oxford Martin School, University of Oxford. February 2015, “Global Challenges: 12 Risks that threaten human civilization: The case for a new risk category,” Global Challenges Foundation, p.30-93. https://api.globalchallenges.org/static/wp-content/uploads/12-Risks-with-infinite-impact.pdf

A pandemic (from Greek πᾶν, pan, “all”, and δῆμος demos, “people”) is an epidemic of infectious disease that has spread through human populations across a large region; for instance several continents, or even worldwide. Here only worldwide events are included. A widespread endemic disease that is stable in terms of how many people become sick from it is not a pandemic. 260 84 Global Challenges — Twelve risks that threaten human civilisation — The case for a new category of risks 3.1 Current risks 3.1.4.1 Expected impact disaggregation 3.1.4.2 Probability Influenza subtypes266 Infectious diseases have been one of the greatest causes of mortality in history. Unlike many other global challenges pandemics have happened recently, as we can see where reasonably good data exist. Plotting historic epidemic fatalities on a log scale reveals that these tend to follow a power law with a small exponent: many plagues have been found to follow a power law with exponent 0.26.261 These kinds of power laws are heavy-tailed262 to a significant degree.263 In consequence most of the fatalities are accounted for by the top few events.264 If this law holds for future pandemics as well,265 then the majority of people who will die from epidemics will likely die from the single largest pandemic. Most epidemic fatalities follow a power law, with some extreme events — such as the Black Death and Spanish Flu — being even more deadly.267 There are other grounds for suspecting that such a highimpact epidemic will have a greater probability than usually assumed. All the features of an extremely devastating disease already exist in nature: essentially incurable (Ebola268), nearly always fatal (rabies269), extremely infectious (common cold270), and long incubation periods (HIV271). If a pathogen were to emerge that somehow combined these features (and influenza has demonstrated antigenic shift, the ability to combine features from different viruses272), its death toll would be extreme. Many relevant features of the world have changed considerably, making past comparisons problematic. The modern world has better sanitation and medical research, as well as national and supra-national institutions dedicated to combating diseases. Private insurers are also interested in modelling pandemic risks.273 Set against this is the fact that modern transport and dense human population allow infections to spread much more rapidly274, and there is the potential for urban slums to serve as breeding grounds for disease.275 Unlike events such as nuclear wars, pandemics would not damage the world’s infrastructure, and initial survivors would likely be resistant to the infection. And there would probably be survivors, if only in isolated locations. Hence the risk of a civilisation collapse would come from the ripple effect of the fatalities and the policy responses. These would include political and agricultural disruption as well as economic dislocation and damage to the world’s trade network (including the food trade). Extinction risk is only possible if the aftermath of the epidemic fragments and diminishes human society to the extent that recovery becomes impossible277 before humanity succumbs to other risks (such as climate change or further pandemics). Five important factors in estimating the probabilities and impacts of the challenge: 1. What the true probability distribution for pandemics is, especially at the tail. 2. The capacity of modern international health systems to deal with an extreme pandemic. 3. How fast medical research can proceed in an emergency. 4. How mobility of goods and people, as well as population density, will affect pandemic transmission. 5. Whether humans can develop novel and effective anti-pandemic solutions.

## Framework

#### Extinction comes first under any framework—it’s the ultimate form of oppression and violence.

Pummer 15 [Theron, Junior Research Fellow in Philosophy at St. Anne's College, University of Oxford. “Moral Agreement on Saving the World” Practical Ethics, University of Oxford. May 18, 2015] AT

There appears to be lot of disagreement in moral philosophy. Whether these many apparent disagreements are deep and irresolvable, I believe there is at least one thing it is reasonable to agree on right now, whatever general moral view we adopt: that it is very important to reduce the risk that all intelligent beings on this planet are eliminated by an enormous catastrophe, such as a nuclear war. How we might in fact try to reduce such existential risks is discussed elsewhere. My claim here is only that we---whether we’re consequentialists, deontologists, or virtue ethicists---should all agree that we should try to save the world. According to consequentialism, we should maximize the good, where this is taken to be the goodness, from an impartial perspective, of outcomes. Clearly one thing that makes an outcome good is that the people in it are doing well. There is little disagreement here. If the happiness or well-being of possible future people is just as important as that of people who already exist, and if they would have good lives, it is not hard to see how reducing existential risk is easily the most important thing in the whole world. This is for the familiar reason that there are so many people who could exist in the future---there are trillions upon trillions… upon trillions. There are so many possible future people that reducing existential risk is arguably the most important thing in the world, even if the well-being of these possible people were given only 0.001% as much weight as that of existing people. Even on a wholly person-affecting view---according to which there’s nothing (apart from effects on existing people) to be said in favor of creating happy people---the case for reducing existential risk is very strong. As noted in this seminal paper, this case is strengthened by the fact that there’s a good chance that many existing people will, with the aid of life-extension technology, live very long and very high quality lives. You might think what I have just argued applies to consequentialists only. There is a tendency to assume that, if an argument appeals to consequentialist considerations (the goodness of outcomes), it is irrelevant to non-consequentialists. But that is a huge mistake. Non-consequentialism is the view that there’s more that determines rightness than the goodness of consequences or outcomes; it is not the view that the latter don’t matter. Even John Rawls wrote, “All ethical doctrines worth our attention take consequences into account in judging rightness. One which did not would simply be irrational, crazy.” Minimally plausible versions of deontology and virtue ethics must be concerned in part with promoting the good, from an impartial point of view. They’d thus imply very strong reasons to reduce existential risk, at least when this doesn’t significantly involve doing harm to others or damaging one’s character. What’s even more surprising, perhaps, is that even if our own good (or that of those near and dear to us) has much greater weight than goodness from the impartial “point of view of the universe,” indeed even if the latter is entirely morally irrelevant, we may nonetheless have very strong reasons to reduce existential risk. Even egoism, the view that each agent should maximize her own good, might imply strong reasons to reduce existential risk. It will depend, among other things, on what one’s own good consists in. If well-being consisted in pleasure only, it is somewhat harder to argue that egoism would imply strong reasons to reduce existential risk---perhaps we could argue that one would maximize her expected hedonic well-being by funding life extension technology or by having herself cryogenically frozen at the time of her bodily death as well as giving money to reduce existential risk (so that there is a world for her to live in!). I am not sure, however, how strong the reasons to do this would be. But views which imply that, if I don’t care about other people, I have no or very little reason to help them are not even minimally plausible views (in addition to hedonistic egoism, I here have in mind views that imply that one has no reason to perform an act unless one actually desires to do that act). To be minimally plausible, egoism will need to be paired with a more sophisticated account of well-being. To see this, it is enough to consider, as Plato did, the possibility of a ring of invisibility---suppose that, while wearing it, Ayn could derive some pleasure by helping the poor, but instead could derive just a bit more by severely harming them. Hedonistic egoism would absurdly imply she should do the latter. To avoid this implication, egoists would need to build something like the meaningfulness of a life into well-being, in some robust way, where this would to a significant extent be a function of other-regarding concerns (see chapter 12 of this classic intro to ethics). But once these elements are included, we can (roughly, as above) argue that this sort of egoism will imply strong reasons to reduce existential risk. Add to all of this Samuel Scheffler’s recent intriguing arguments (quick podcast version available here) that most of what makes our lives go well would be undermined if there were no future generations of intelligent persons. On his view, my life would contain vastly less well-being if (say) a year after my death the world came to an end. So obviously if Scheffler were right I’d have very strong reason to reduce existential risk. We should also take into account moral uncertainty. What is it reasonable for one to do, when one is uncertain not (only) about the empirical facts, but also about the moral facts? I’ve just argued that there’s agreement among minimally plausible ethical views that we have strong reason to reduce existential risk---not only consequentialists, but also deontologists, virtue ethicists, and sophisticated egoists should agree. But even those (hedonistic egoists) who disagree should have a significant level of confidence that they are mistaken, and that one of the above views is correct. Even if they were 90% sure that their view is the correct one (and 10% sure that one of these other ones is correct), they would have pretty strong reason, from the standpoint of moral uncertainty, to reduce existential risk. Perhaps most disturbingly still, even if we are only 1% sure that the well-being of possible future people matters, it is at least arguable that, from the standpoint of moral uncertainty, reducing existential risk is the most important thing in the world. Again, this is largely for the reason that there are so many people who could exist in the future---there are trillions upon trillions… upon trillions. (For more on this and other related issues, see this excellent dissertation). Of course, it is uncertain whether these untold trillions would, in general, have good lives. It’s possible they’ll be miserable. It is enough for my claim that there is moral agreement in the relevant sense if, at least given certain empirical claims about what future lives would most likely be like, all minimally plausible moral views would converge on the conclusion that we should try to save the world. While there are some non-crazy views that place significantly greater moral weight on avoiding suffering than on promoting happiness, for reasons others have offered (and for independent reasons I won’t get into here unless requested to), they nonetheless seem to be fairly implausible views. And even if things did not go well for our ancestors, I am optimistic that they will overall go fantastically well for our descendants, if we allow them to. I suspect that most of us alive today---at least those of us not suffering from extreme illness or poverty---have lives that are well worth living, and that things will continue to improve. Derek Parfit, whose work has emphasized future generations as well as agreement in ethics, described our situation clearly and accurately: “We live during the hinge of history. Given the scientific and technological discoveries of the last two centuries, the world has never changed as fast. We shall soon have even greater powers to transform, not only our surroundings, but ourselves and our successors. If we act wisely in the next few centuries, humanity will survive its most dangerous and decisive period. Our descendants could, if necessary, go elsewhere, spreading through this galaxy…. Our descendants might, I believe, make the further future very good. But that good future may also depend in part on us. If our selfish recklessness ends human history, we would be acting very wrongly.” (From chapter 36 of On What Matters)

#### All values terminally lead to pleasure or pain. Occam’s razor means err on the side of util.

Moen 16 [Ole Martin Moen, Research Fellow in Philosophy at University of Oslo “An Argument for Hedonism” Journal of Value Inquiry (Springer), 50 (2) 2016: 267–281] SJDI

I think several things should be said in response to Moore’s challenge to hedonists. First, **I do not think the burden of proof lies on hedonists to explain why the additional values are not intrinsic values. If someone claims that X is intrinsically valuable, this is a substantive, positive claim, and it lies on him or her to explain why we should believe that X is in fact intrinsically valuable.** Possibly, this could be done through thought experiments analogous to those employed in the previous section. Second, **there is something peculiar about the list of additional intrinsic values** that counts in hedonism’s favor**: the listed values have a strong tendency to be well explained as things that help promote pleasure and avert pain.** To go through Frankena’s list, life and consciousness are necessary presuppositions for pleasure; activity, health, and strength bring about pleasure; and happiness, beatitude, and contentment are regarded by Frankena himself as “pleasures and satisfactions.” The same is arguably true of beauty, harmony, and “proportion in objects contemplated,” and also of affection, friendship, harmony, and proportion in life, experiences of achievement, adventure and novelty, self-expression, good reputation, honor and esteem. Other things on Frankena’s list, such as understanding, **wisdom, freedom, peace, and security, although they are perhaps not themselves pleasurable, are important means to achieve a happy life, and as such, they are things that hedonists would value highly.** **Morally good dispositions and virtues, cooperation, and just distribution of goods and evils, moreover, are things that, on a collective level, contribute a happy society, and thus the traits that would be promoted and cultivated if this were something sought after.** To a very large extent, the intrinsic values suggested by pluralists tend to be hedonic instrumental values. Indeed, pluralists’ suggested intrinsic values all point toward pleasure, for while the other values are reasonably explainable as a means toward pleasure, pleasure itself is not reasonably explainable as a means toward the other values. Some have noticed this. Moore himself, for example, writes that though his pluralistic theory of intrinsic value is opposed to hedonism, its application would, in practice, look very much like hedonism’s: “Hedonists,” he writes “do, in general, recommend a course of conduct which is very similar to that which I should recommend.”24 Ross writes that “[i]t is quite certain that by promoting virtue and knowledge we shall inevitably produce much more pleasant consciousness. These are, by general agreement, among the surest sources of happiness for their possessors.”25 Roger Crisp observes that “those goods cited by non-hedonists are goods we often, indeed usually, enjoy.”26 What Moore and Ross do not seem to notice is that their observations give rise to two reasons to reject pluralism and endorse hedonism. The first reason is that if **the suggested non-hedonic intrinsic values are potentially explainable by appeal to just pleasure and pain** (which, following my argument in the previous chapter, we should accept as intrinsically valuable and disvaluable), **then—by appeal to Occam’s razor—we have at least a pro tanto reason to resist the introduction of any further intrinsic values and disvalues. It is ontologically more costly to posit a plurality of intrinsic values and disvalues, so in case all values admit of explanation by reference to a single intrinsic value and a single intrinsic disvalue, we have reason to reject more complicated accounts.** **The fact that suggested non-hedonic intrinsic values tend to be hedonistic instrumental values does not, however, count in favor of hedonism solely in virtue of being most elegantly explained by hedonism; it also does so in virtue of creating an explanatory challenge for pluralists.** The challenge can be phrased as the following question: **If the non-hedonic values suggested by pluralists are truly intrinsic values in their own right, then why do they tend to point toward pleasure and away from pain?**27

#### The standard is maximizing expected well-being

#### 1] No side constraints – they freeze action because government policies are always contextual and require trade-offs since they have finite resources

#### 2] Util is a lexical pre-requisite to their framework – existence and threats to it preclude the ability for moral theory. Value existential risks first

#### 3] Phenomenal introspection – it’s the most epistemically reliable, since we all value happiness because we determine that we value it the same way we can observe a lemon’s yellow-ness. We make those same judgements about happiness

#### Also, any uncertainty means preventing extinction is the highest priority – err aff.

Bostrom 12 [Nick Bostrom. Faculty of Philosophy & Oxford Martin School University of Oxford. “Existential Risk Prevention as Global Priority.” Global Policy (2012)]

These reflections on **moral uncertainty suggest** an alternative, complementary way of looking at existential risk; they also suggest a new way of thinking about the ideal of sustainability. Let me elaborate.¶ **Our present understanding of axiology might** well **be confused. We may not** nowknow — at least not in concrete detail — what outcomes would count as a big win for humanity; we might not even yet **be able to imagine the best ends** of our journey. **If we are** indeedprofoundly **uncertain** about our ultimate aims,then we should recognize that **there is a great** option **value in preserving** — and ideally improving — **our ability to recognize value and** to **steer the future accordingly. Ensuring** that **there will be a future** version of **humanity** with great powers and a propensity to use them wisely **is** plausibly **the best way** available to us **to increase the probability that the future will contain** a lot of **value.** To do this, we must prevent any existential catastrophe.