# AFF – Healthcare

## 1AC

### Adv

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

#### 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. Neg arguments concerning “patient abandonment” are rooted in hypocritical neoliberal ideologies. Mercy Hospital proves.

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 – Kabul 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 new HRH strategy reveals 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).

#### Denying the right to strike is morally indefensible in all instances.

Chima 13 [Chima, S.C. Program of Bio & Research Ethics and Medical Law, Nelson R Mandela School of Medicine & School of Nursing and Public Health, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa. “Global medicine: Is it ethical or morally justifiable for doctors and other healthcare workers to go on strike?” *BMC Med Ethics* **14,** S5 (2013). <https://doi.org/10.1186/1472-6939-14-S1-S5>. Accessed 10/28 //gord0]

It has been suggested that doctor and HCW strikes can create a tension between the obligation on doctors and other HCWs to provide adequate care to current patients versus the need to advocate for improved healthcare services for future patients and for society in general [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2), [31](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR31)]. There is also a potential conflict between doctors' role in advocating for improved healthcare service for others versus the need to advocate for justifiable wages for self and the fulfilment of basic biological needs like all humans [[4](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR4), [32](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR32)]. It has been suggested that since strikes are considered a fundamental right or entitlement during collective bargaining and labour negotiations [[33](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR33)]. Therefore to deny any employee the right to strike would be an argument for enslavement of such an employee, because this would simply mean that whatever the circumstances-such an individual must work! A situation deemed to be both ethically and morally indefensible [[4](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR4)]. It is pertinent to observe that there is an on-going paradigm shift in the organization of healthcare services and doctors' employment options with a change in the role of doctors from self-employment, and medical practice based on benevolent paternalism, to consumer rights and managed healthcare [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2)]. Historically, doctors had the sole responsibility within the doctor-patient relationship, to determine the costs of medical care to their patients, however, current trends show that doctors are increasingly becoming employees of managed healthcare organizations (HCOs) or employees of public health services [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2), [34](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR34)–[36](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR36)]. These changes in physicians' practices and methods of payment may impact on patient trust, physician behaviour and decision-making, thereby permanently altering the doctor-patient relationship [[3](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR3), [37](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR37)]. It has been observed, especially in advanced capitalist societies like the United States, that there is an on-going shift in doctors practice options from self-employment as owners of their own practices [[34](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR34)–[36](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR36)], to doctors becoming employees of HCOs in a managed healthcare environment [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2), [34](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR34), [35](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR35)]. The factors driving this sea change in physicians employment options have been ascribed to "the complex corporate environment coupled with the stress of high malpractice rates, the struggle for reimbursement, administrative duties and the general risks and burden of solo or small group practice" [[35](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR35), [38](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR38)]. One can therefore anticipate that in the near future there could be more wage negotiations and collective bargaining between doctors as employees and the employing HCOs [[35](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR35), [36](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR36)]. This will be similar to the practice in systems where medicine is centralized or socialized, and where doctors and HCWs are mostly public service employees [[7](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR7), [10](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR10), [11](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR11), [14](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR14), [16](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR16), [18](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR18), [20](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR20)]. These ongoing changes in the organization of healthcare services and modern medical practice may denote a change in the Hippocratic tenets of the medical profession, creating ethical and moral dilemmas [[2](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR2), [39](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR39)], which could permanently alter the nature of the relationship between doctors and patients [[3](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR3), [37](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR37)], and the putative 'contract' between medicine and society [[10](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR10), [40](https://bmcmedethics.biomedcentral.com/articles/10.1186/1472-6939-14-S1-S5#ref-CR40)].

#### 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.

### 1AC – Framing

***Only* pleasure and pain are intrinsically valuable.**

**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

Let us start by observing, empirically, that **a widely shared judgment about intrinsic value and disvalue is that pleasure is intrinsically valuable and pain is intrinsically disvaluable.** **On virtually any proposed list of intrinsic values and disvalues (we will look at some of them below), pleasure is included among the intrinsic values and pain among the intrinsic disvalues.** This inclusion makes intuitive sense, moreover, for **there is something undeniably good about the way pleasure feels and something undeniably bad about the way pain feels, and neither the goodness of pleasure nor the badness of pain seems to be exhausted by the further effects that these experiences might have.** “Pleasure” and “pain” are here understood inclusively, as encompassing anything hedonically positive and anything hedonically negative.2 **The special value statuses of pleasure and pain are manifested in how we treat these experiences in our everyday reasoning about values.** If you tell me that you are heading for the convenience store, **I might ask: “What for?” This is a reasonable question, for when you go to the convenience store you usually do so**, not merely for the sake of going to the convenience store, but **for the sake of achieving something further that you deem to be valuable.** You might answer, for example: “To buy soda.” This answer makes sense, for soda is a nice thing and you can get it at the convenience store. I might further inquire, however: “What is buying the soda good for?” This further question can also be a reasonable one, for it need not be obvious why you want the soda. You might answer: “Well, I want it for the pleasure of drinking it.” **If I then proceed by asking “But what is the pleasure of drinking the soda good for?” the discussion is likely to reach an awkward end. The reason is that the pleasure is not good for anything further; it is simply that for which going to the convenience store and buying the soda is good.**3 As Aristotle observes**: “We never ask [a man] what his end is in being pleased, because we assume that pleasure is choice worthy in itself.**”4 Presumably, a similar story can be told in the case of pains, for if someone says “This is painful!” we never respond by asking: “And why is that a problem?” We take for granted that if something is painful, we have a sufficient explanation of why it is bad. If we are onto something in our everyday reasoning about values, it seems that **pleasure and pain are both places where we reach the end of the line in matters of value.**

#### Thus, the standard is maximizing expected well-being – prefer:

#### 1] Actor specificity

#### 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.

#### 2] **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.**

#### 3] Only consequentialism explains degrees of wrongness—if I break a promise to meet up for lunch, that is not as bad as breaking a promise to take a dying person to the hospital via intuitions. Intuitions outweigh—they’re the foundational basis for any argument and theories that contradict our intuitions are most likely false even if we can’t deductively determine why.

#### 4] Prioritize probability.

Kessler 08 (Oliver; April 2008; PhD in IR, professor of sociology at the University of Bielefeld, and professor of history and theory of IR at the Faculty of Arts; Alternatives, Vol. 33, “From Insecurity to Uncertainty: Risk and the Paradox of Security Politics” p. 211-232)

The problem of the second method is that it is very difficult to "calculate" politically unacceptable losses. If the risk of terrorism is defined in traditional terms by probability and potential loss, then the focus on dramatic terror attacks leads to the marginalization of probabilities. The reason is that even the highest degree of improbability becomes irrelevant as the measure of loss goes to infinity.^o The mathematical calculation of the risk of terrorism thus tends to overestimate and to dramatize the danger. This has consequences beyond the actual risk assessment for the formulation and execution of "risk policies": If one factor of the risk calculation approaches infinity (e.g., if a case of nuclear terrorism is envisaged), then there is no balanced measure for antiterrorist efforts, and risk management as a rational endeavor breaks down. Under the historical condition of bipolarity, the "ultimate" threat with nuclear weapons could be balanced by a similar counterthreat, and new equilibria could be achieved, albeit on higher levels of nuclear overkill. Under the new condition of uncertainty, no such rational balancing is possible since knowledge about actors, their motives and capabilities, is largely absent. The second form of security policy that emerges when the deterrence model collapses mirrors the "social probability" approach. It represents a logic of catastrophe. In contrast to risk management framed in line with logical probability theory, the logic of catastrophe does not attempt to provide means of absorbing uncertainty. Rather, it takes uncertainty as constitutive for the logic itself; uncertainty is a crucial precondition for catastrophes. In particular, catastrophes happen at once, without a warning, but with major implications for the world polity. In this category, we find the impact of meteorites. Mars attacks, the tsunami in South East Asia, and 9/11. To conceive of terrorism as catastrophe has consequences for the formulation of an adequate security policy. Since catastrophes hap-pen irrespectively of human activity or inactivity, no political action could possibly prevent them. Of course, there are precautions that can be taken, but the framing of terrorist attack as a catastrophe points to spatial and temporal characteristics that are beyond "rationality." Thus, political decision makers are exempted from the responsibility to provide security—as long as they at least try to preempt an attack. Interestingly enough, 9/11 was framed as catastrophe in various commissions dealing with the question of who was responsible and whether it could have been prevented. This makes clear that under the condition of uncertainty, there are no objective criteria that could serve as an anchor for measuring dangers and assessing the quality of political responses. For ex- ample, as much as one might object to certain measures by the US administration, it is almost impossible to "measure" the success of countermeasures. Of course, there might be a subjective assessment of specific shortcomings or failures, but there is no "common" currency to evaluate them. As a consequence, the framework of the security dilemma fails to capture the basic uncertainties. Pushing the door open for the security paradox, the main problem of security analysis then becomes the question how to integrate dangers in risk assessments and security policies about which simply nothing is known. In the mid 1990s, a Rand study entitled "New Challenges for Defense Planning" addressed this issue arguing that "most striking is the fact that we do not even know who or what will constitute the most serious future threat, "^i In order to cope with this challenge it would be essential, another Rand researcher wrote, to break free from the "tyranny" of plausible scenario planning. The decisive step would be to create "discontinuous scenarios ... in which there is no plausible audit trail or storyline from current events"52 These nonstandard scenarios were later called "wild cards" and became important in the current US strategic discourse. They justified the transformation from a threat-based toward a capability- based defense planning strategy.53 The problem with this kind of risk assessment is, however, that even the most absurd scenarios can gain plausibility. By constructing a chain of potentialities, improbable events are linked and brought into the realm of the possible, if not even the probable. "Although the likelihood of the scenario dwindles with each step, the residual impression is one of plausibility. "54 This so-called Othello effect has been effective in the dawn of the recent war in Iraq. The connection between Saddam Hussein and Al Qaeda that the US government tried to prove was disputed from the very beginning. False evidence was again and again presented and refuted, but this did not prevent the administration from presenting as the main rationale for war the improbable yet possible connection between Iraq and the terrorist network and the improbable yet possible proliferation of an improbable yet possible nuclear weapon into the hands of Bin Laden. As Donald Rumsfeld famously said: "Absence of evidence is not evidence of absence." This sentence indicates that under the condition of genuine uncertainty, different evidence criteria prevail than in situations where security problems can be assessed with relative certainty.

#### 5] Structural violence is the most important impact – ignoring them actively exacerbates exclusion

Winter and Leighton 99 |Deborah DuNann Winter and Dana C. Leighton. Winter|Psychologist that specializes in Social Psych, Counseling Psych, Historical and Contemporary Issues, Peace Psychology. Leighton: PhD graduate student in the Psychology Department at the University of Arkansas. Knowledgable in the fields of social psychology, peace psychology, and justice and intergroup responses to transgressions of justice “Peace, conflict, and violence: Peace psychology in the 21st century.” Pg 4-5

Direct violence is horrific, but its brutality usually gets our attention: we notice it, and∂ often respond to it. Structural violence, however, is almost always invisible, embedded in∂ubiquitous social structures, normalized by stable institutions and regular experience.∂ Structural violence occurs whenever people are disadvantaged by political, legal,∂ economic, or cultural traditions. Because they are longstanding, structural inequities∂usually seem ordinary—the way things are and always have been. But structural violence∂ produces suffering and death as often as direct violence does, though the damage is∂ slower, more subtle, more common, and more difficult to repair. The chapters in this∂ section teach us about some important but invisible forms of structural violence, and alert∂ us to the powerful cultural mechanisms that create and maintain them over generations.∂ Johan Galtung originally framed the term “structural violence” to mean any constraint∂ on human potential caused by economic and political structures (1969). Unequal accessto resources, to political power, to education, to health care, or to legal standing, are forms of structural violence. When inner-city children have inadequate schools while∂ others do not, when gays and lesbians are fired for their sexual orientation, when laborers∂ toil in inhumane conditions, when people of color endure environmental toxins in their∂ neighborhoods, structural violence exists. Unfortunately, even those who are victims of∂ structural violence often do not see the systematic ways in which their plight is∂ choreographed by unequal and unfair distribution of society’s resources. Such is the∂ insidiousness of structural violence.∂ Structural violence is problematic in and of itself, but it is also dangerous because it∂frequently leads to direct violence. The chronically oppressed are often, for logical∂ reasons, those who resort to direct violence. Organized armed conflict in various parts of∂ the world is easily traced to structured inequalities. Northern Ireland, for example, has∂ been marked by economic disparities between Northern Irish Catholics—who have∂ higher unemployment rates and less formal education—and Protestants (Cairns & Darby,∂ 1998). In Sri Lanka, youth unemployment and underemployment exacerbates ethnic∂ conflict (Rogers, Spencer, & Uyangoda, 1998). In Rwanda, huge disparities in both∂ income and social status between the Hutu and Tutsis eventually led to ethnic massacres.∂ While structural violence often leads to direct violence, the reverse is also true, as∂ brutality terrorizes bystanders, who then become unwilling or unable to confront social∂ injustice. Increasingly, civilians pay enormous costs of war, not only through death, but∂ through devastation of neighborhoods and ecosystems. Ruling elites rarely suffer from∂ armed conflict as much as civilian populations do, who endure decades of poverty and∂ disease in war-torn societies.ecognizing the operation of structural violence forces us to ask questions about how∂ and why we tolerate it, questions that often have painful answers. The first chapter in this∂ section, “Social Injustice,” by Susan Opotow, argues that our normal perceptual/cognitive∂ processes lead us to care about people inside our scope of justice, but rarely care about∂ those people outside. Injustice that would be instantaneously confronted if it occurred to∂ someone we love or know is barely noticed if it occurs to strangers or those who are∂ invisible or irrelevant to us. We do not seem to be able to open our minds and our hearts∂ to everyone; moral exclusion is a product of our normal cognitive processes. But Opotow∂ argues convincingly that we can reduce its nefarious effects by becoming aware of our distorted perceptions. Inclusionary thinking can be fostered by relationships,∂ communication, and appreciation of diversity.∂ One outcome of exclusionary thinking is the belief that victims of violence must in∂ some way deserve their plight. But certainly it is easy to see that young children do not∂ deserve to be victims. The next two chapters in this section address the violence∂ experienced by children. In the first, “The War Close to Home: Children and Violence in∂ the United States,” Kathleen Kostelny and James Garbarino describe the direct and∂ structural violence which children in Chicago and other urban areas of the United States∂ endure, paralleling that experienced by children who live in countries at war. Children∂ who endure these environments often become battle weary, numb, hopeless, and/or∂ morally impaired. But children not only suffer directly from violence, they also suffer∂ from the impaired parenting and communities which poverty inflicts. The authors∂ describe how community and family support mechanisms can mitigate these effects. For xample, home visitation and early childhood education programs provide crucial family∂ and community support.∂ While Kostelny and Garbarino focus on community intervention techniques, Milton∂ Schwebel and Daniel Christie, in their article “Children and Structural Violence,” extend∂ the analysis of structural violence by examining how economic and psychological∂ deprivation impairs at-risk children. Children living in poverty experience diminished∂ intellectual development because parents are too overwhelmed to be able to provide∂ crucial linguistic experiences. Schwebel and Christie’s discussion concludes that∂ economic structures must provide parents with living-wage employment, good prenatal∂ medical care, and high-quality child-care if we are to see the next generation develop into∂ the intelligent and caring citizens needed to create a peaceful world.∂ If children are the invisible victims of society’s structural violence, so are their∂ mothers. In the chapter “Women, Girls, and Structural Violence: A Global Analysis,”∂ Diane Mazurana and Susan McKay articulate the many ways in which global sexism∂ systematically denies females access to resources. From health care and food to legal∂ standing and political power, women and girls get less than males in every country on the∂ planet. Mazurana and McKay argue that patriarchy-based structural violence will not be∂ redressed until women are able to play more active roles making decisions about how∂ resources are distributed.∂ Patriarchal values also drive excessive militarism, as Deborah Winter, Marc Pilisuk,∂ Sara Houck, and Matthew Lee argue in their chapter “Understanding Militarism: Money,∂ Masculinism, and the Search for the Mystical.” The authors illuminate three motives ueling excessive military expenditures: money, which, because of modern market forces,∂ leads half the world’s countries to spend more on arms than on health and education∂ combined; masculinism, which leads societies to make soldiering a male rite of passage∂ and proof of manhood; and the search for the mystical, as men attempt to experience∂ profound human processes of selfsacrifice, honor, and transcendence through war. Like∂ William James, these authors argue that we will need to find a moral equivalent to war, in∂ order to build lasting peace.