# Beyond the Picket Line: Impacts and Implications of Nursing Strikes

**by Diya Cherian**

On January 9, 2023, hundreds of nurses marched outside Mount Sinai Hospital in New York City after conveying to the hospital that their working conditions were no longer sustainable. They wore red hats and scarves and carried signs with messages like "More Nurses, Less Millionaire Exec$" (Kudacki). The picket line was a symptom of a much larger problem. After their contracts expired in December, nurses at hospitals across New York City had planned to strike to advocate for better working conditions. But while other hospitals reached contract agreements before the union's negotiating deadline, Mount Sinai Hospital in Manhattan and Montefiore Medical Center in the Bronx did not (Otterman and Piccoli). According to Lucia Lee, a spokesperson for Mount Sinai, union leadership "[refused] to accept the exact same 19.1% increased wage offer agreed to by eight other hospitals'" (qtd. in Isidore et al.). For their part, union officials pointed out that despite the consistent percentage wage increase, nurses at Mount Sinai's main campus faced differences in seniority payments and overall lower wages compared even with other Mount Sinai hospitals, which, compounded by concerns over long-term safety for patients, prompted nearly seven thousand nurses at these hospitals to strike (Otterman and Piccoli). Certainly, nurses deserve fair working conditions that are safe for both them as well as their patients, but in a profession dedicated to saving lives, was this strike an ethical negotiating tactic?

According to the New York State Nurses Association (NYSNA), the nurses "[went] on strike for fair contracts that improve patient care" (New York State Nurses Association). Their main concern was patient-to-staff ratios. While safe staffing advises one nurse per two intensive care unit (ICU) patients at most, Mount Sinai nurses were working with three or four ICU patients apiece; in the emergency room, they tended to eighteen patients at a time (Otterman and Piccoli). A 2021 law mandating safer staffing ratios has not been enforced due to the COVID-19 pandemic (Otterman and Piccoli). Judy Sheridan-Gonzalez, former president of NYSNA and an emergency room nurse of over thirty years, describes how nurses faced with these ratios "leave exhausted and unfulfilled, unable to deliver the kind of care we're trained for" (Sheridan-Gonzalez). A study published in the Journal of the American Medical Association (JAMA) found that "the odds of patient mortality increased by 7 percent for every additional patient in the

average nurse's workload in the hospital" (Aiken). This rate rises catastrophically for nurses juggling too many patients, resulting in poorer outcomes all around. Researchers have found that "The nurse-patient ratio is a direct determinant of the effects of psychological, mental, emotional health and nurse productivity in the workplace which also determines the patients' overall health" (Gutsan et al.).

From the NYSNA's perspective, the consequences of the strike are not more dangerous than continuing current working conditions in the absence of definitive action. As Sheridan-Gonzalez explains:

*nurses decide to strike when it becomes a matter of life and death for our patients. When months and years of meetings, documentation, evidence, petitions, letters, research, protests, speeches, essays, negotiations, pickets, rallies and media outreach fail to achieve these goals, our employers leave us with no other choice. (Sheridan-Gonzalez)*

Still, for nurses tasked with saving lives, the strike and its consequences raise troubling questions about how to ethically negotiate for better working conditions while holding to the principles of beneficence and non-maleficence, the basic tenets of healthcare professions. The strike, which only lasted three days, caused ripple effects across the city. Mount Sinai's CEO said that the hospital had "'no choice but to implement [their] strike plan,'" rerouting ambulances, delaying-emergent surgeries, discharging patients, and forcing labor and delivery patients to find other hospitals (Klein). One family lost their four-month-old son in the neonatal intensive care unit (NICU), a case now under investigation. The baby had a low blood count that went undetected for hours, which according to "sources who work in the NICU" would not have happened with "seasoned NICU nurses" (Ostadan). Negative repercussions from nurse impacts aren't unprecedented. Researchers from MIT and Cornell University have found that "strikes increase in-hospital mortality by 18.3 percent and 30-day readmission by 5.7 percent for patients admitted during a strike . . . . The results suggest that hospitals functioning during nurses' strikes do so at a lower quality of patient care " (Gruber and Kleiner 127). The study, which looked specifically at the impact of strikes in New York State, further suggested that for patients with nursing-intensive conditions, care from replacement employees was akin to not having hired replacements at all (128). Gruber and Kleiner argue that the conditions caused by nurses' strikes lead to dangerous patient care conditions and that the patients who need care the most end up faring the worst (152).

This argument, while important, must be seen in the larger context of poor health outcomes across the United States healthcare system. The United States outwardly invests heavily in the health and well-being of its citizens, spending the most money on healthcare of any country in the Organization for Economic Co-operation and Development (OECD) (Tikkanen and Abrams). Still, the United States struggles to provide top-quality medical care. The reason lies partly in the systems that sustain unfavorable working conditions for medical professionals. Dylan Scott, a healthcare policy senior correspondent at *Vox*, argues that while they exist to benefit patients, hospitals are set up financially to benefit wealthy executives, whose profits do not depend on patient outcomes shaped by adequate nursing staff ("NYC"). He writes, "Hospitals behaving on pure altruism would spend more on clinical staff without their nurses needing to go on strike to force their hand," yet we know that hospitals are far from altruistic entities ("NYC"). A profitable hospital isn't necessarily one that best serves its patients: Scott claims that "the way the US health system pays for medical services generally doesn't encourage hospitals to consider the link between nursing and care quality in their staffing decisions" ("United States"). Within hospitals, revenue is generated primarily by physicians. Because of the tests ordered, procedures performed, and medications prescribed, doctors rake in money for the hospital as an entity. But nursing work isn't billed the same way. Regardless of the fact that some patients are more medically complex than others, and that nurses are the healthcare personnel working around the clock to provide that care, they do not generate profit for the hospital in proportion to the services they perform. Consequently, hospitals lack the incentive to maintain well-staffed nursing workforces.

The nurses at Mount Sinai and across New York City were right to call for better conditions, but minimal wage increases and marginally reduced patient-to-staff ratios don't address the root of the problem. Presently, nurses have no choice but to continue operating within a system that undervalues patient outcomes and only applies the 'fee-for-service' model to doctors. Perhaps it is time for a drastic shift when it comes to the way we structure our approach to healthcare.

Modern debates around healthcare question whether healthcare access is a human right or a commodity, in which hospital personnel provide services and patients act as consumers. The old adage 'health is wealth' implies a subconscious belief that underpins these discussions: profits are useless without the health and well-being to make use of them. This truth was evident during the pandemic; the economic stability of our nation and world is contingent upon a healthy society, and whether we like it or not, our collective health has implications beyond the profits at one hospital. While at a local level, policymakers and hospital administrators believe that they can influence decisions regarding health by controlling staffing ratios and hired personnel, ultimately it is the health of society that restricts the bounds within which we operate and that has the power to radically shift the status quo. Continually emphasizing siloed economic

profitability causes us to lose sight of the global ramifications of the profits-over-patients model.

There are proposed practical solutions to the issues plaguing the healthcare system. As per a May 2021 report by the National Academy of Medicine, these solutions range from allowing telehealth billing for nurses to larger-scale reforms of value-based payment (Flaubert, et. al 365). Pilot programs like accountable care organizations (ACOs) are initiatives launched by the federal government that allow groups of diverse healthcare providers to push for higher quality care for Medicare patients and consequently share in the savings generated (Center for Medicare and Medicaid Services). ACOs represent one viable option to solving the value problem plaguing American healthcare, but they remain limited in their scope due to their reliance on rewards for hospitals that have better patient outcomes.

The real healthcare problem we face is not economic but ethical. In more sectors than health, we avoid long-term improvements in favor of generating revenue. So regardless of whether healthcare is considered a human right or a commodity, seeking better patient outcomes should lie at the center of the system. At the core, the way we think about health needs to change, for the sake of both healthcare workers and the populations they serve. If goodwill won't move the needle, it may be time to start reconsidering the way that the larger system financially rewards hospitals for the work of their healthcare professionals. Without drastic measures, our value problem may turn into a full-fledged value crisis for patients everywhere. Our healthcare system must act now—it really is a matter of life and death.

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