Thank you for inviting me to speak at this hearing. Health care in our state is such a vital topic and I hope to clarify what the nurses of Pennsylvania have endured over the last year and a half. I also want to acknowledge that many physicians suffered during Covid, too, but my mandate today is to talk about nurses.

I am going to paint a mental picture of what nurses' work was like during the pandemic. We heard from two nurses today. Let me pull you in to their stories.

The first thing you need to know is why patients get sent to ICU. Patients go to intensive care because usually they would die if they didn't. As a bedside nurse, I sent one patient to the ICU because his oxygen saturation was 70% and he was turning blue—that is not a joke. Another patient's blood pressure was too low to pump blood to his whole body, putting his organs at risk of dying. Without the tools of the ICU—ventilators, and drugs to raise blood pressure and control heart rate—those patients would have died.

Now imagine yourself working in a Covid ICU. Covid patients' oxygen saturations can drop on a dime from low normal to not compatible with life. Their ventilators and IV drugs need careful adjustments and anywhere from 20-40% of the patients will need to be proned, a process that takes 6 people to carefully position patients face down in special beds. Simply entering patients' rooms requires an entire set of protective gear—which many hospitals either didn't have or rationed—because the patients are contagious and put nurses at risk. The patients aren't allowed visitors so the nurse has to be friend, sister, husband, chaplain. When patients are dying, nurses use ipads to allow families to say good-bye.

Clinical recommendations called for one ICU nurse for each Covid patient. However, the usual ICU standard is one nurse for every two patients, so imagine you show up at work and you have two Covid patients. Meanwhile, nurses are getting sick from Covid, others are simply

quitting, and the hospital is overwhelmed, so now you show up at work and have 3 patients, then 4 patients, then 5. I heard reports of nurses in Covid ICUs treating as many as 6 patients. They worked for twelve+ hours barely eating or drinking, terrified they would infect their families or friends with the coronavirus.

For over a decade we have known that the more patients a nurse has above a certain number, the more patients die who would not have otherwise. Nurses working in Covid ICUs knew that some of their patients would die because they could not care properly for them. Has anyone here ever had another person's life riding on their job performance? Patients dying because nurses were given impossible workloads is the definition of moral distress. It causes trauma, and calling someone a hero will not heal that wound.

The burdens placed on nurses during Covid reflect an existing problem in health care: the idea that nurses can infinitely stretch, like rubber bands. That idea may arise from sexist notions about a mostly female profession, or may result from health care profiteering coupled with an entrenched indifference to the well-being of nurses and patients. Nurses do not generate income for hospitals and as a result are viewed as an undesirable cost-center for hospitals. Patients come to hospitals for nursing care, but squeezing nurses, expecting them to do more with less, is a time-honored way for hospitals to improve their bottom line.

The problem is, a nursing shortage was predicted before the pandemic. The Bureau of Labor Statistics expects that almost 1.5 million registered nurse positions will need to be filled by 2029. After Covid, many nurses are burned out and asking themselves tough questions. I had been teaching nursing when the pandemic struck and wanted to return to the bedside. "Only if there's enough Personal Protective Equipment," my 21-year-old daughter told me, insisting that I not return to hospital nursing if it might kill me. And Covid did kill nurses. Health care systems

seem to want to return to business as usual: making money while papering over the wounds of their staff. I do not see that strategy working. Half of all working nurses say they are burned out, and female nurses are roughly twice as likely to die by suicide than women in general.

The recent collapse of the Surfside condominium in Miami showed that tragedy can result when "unseen" structural problems are ignored and allowed to worsen. But we don't have to let health care in Pennsylvania follow that same disastrous course. Here are some options to really support Pennsylvania's nurses, and keep them focused on saving lives and caring:

1. Legislate staffing ratios. Do not install so-called "staffing committees," and do not listen to arguments about how ratios are bad for patients. Those arguments depend on staffing models without slack and the lack of slack—flexibility—in health care is part of the problem.
2. Encourage unionization of health care workers and collective bargaining. Management appears unlikely to do the right thing on their own. Unions force administrators to bargain with nurses about safe staffing and improving their work environment.
3. Establish stronger whistle-blower protections. Health care workers highlighting safety issues need legal protection from on-the-job retaliation.
4. Mandate mental health coverage for nurses. Nurses are buckling under the strain caused by the pandemic, yet sometimes their insurance does not cover mental health care.

If we do not fix our health care problems, nurses will quit and patients will die. Truth. Some may say that I am exaggerating, being melodramatic, but I'm not. My heart breaks for my overburdened colleagues, and I fear for our patients. Surely we can do better for the nurses and patients of Pennsylvania.

Addendum to Spoken Remarks

I have submitted seven documents and one video to complement my spoken remarks. If you only have time to read one, I suggest my *New York Times* column from Feb. 25, 2021: "Covid-19 Is 'Probably Going to End My Career.'"

On the subject of staffing ratios, I have included two of my *New York Times* columns: "Is There a Nurse in the House?" (June 18, 2010), and "When No One Is on Call" (Aug. 17, 2013). See also two relevant peer-reviewed articles, one by Jack Needleman at UCLA "Nurse Staffing and Inpatient Hospital Mortality" and the other by Linda Aiken at U. Penn "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction." The articles are ten years old and though more recent articles are available, I included these to show that for a decade we have known that nurses' workloads track with patient mortality, and yet the issues with staffing have only worsened in that time.

On why nurses (and physicians) need whistle-blower protection, read my *New York Times* piece "The Reason Hospitals Won't Let Doctors and Nurses Speak Out" (April 21, 2020).

On the problem of female-nurse suicides, I have included a peer-reviewed article by Matthew A. Davis "Association of US Nurse and Physician Occupation With Risk of Suicide" (April 14, 2021).

The *New York Times* has a very moving 15-minute documentary called "Death, Through a Nurse's Eyes," that shows what working in a Covid ICU is really like.