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# The Essential Worker



Even as they devastate lives, crises can create opportunities—not certainties, but possibilities—for usually powerless people to exercise historical agency. The empowerment of working people relative to employers, in particular, can create durable changes in broader patterns of social inequality. The Great Depression and the end of World War II unleashed massive strike waves that undermined longstanding inequalities in American life. Pathogens, too, have the potential to help dismantle the durable norms and institutions that can seem impervious to social intervention. With aspects of our social order crumbling under the burden of COVID-19, the question becomes: what will people do? Will workers take the opportunity to change the balance of power? A labor history of healthcare provides some possible answers.

Take our last great pandemic: the human immunodeficiency virus. HIV moves slower than SARS-CoV-2, and its relatively low transmissibility and long incubation period make its infections socially clustered. In its early years, the pandemic devastated stigmatized subpopulations—gay men, intravenous drug users, Haitian-Americans—while mostly sparing others. Yet when the virus arrived on hospital wards in the 1980s, it dramatically destabilized work. Although we now know that it carried a comparatively low probability of infection for frontline care workers, a needlestick injury that led to infection meant certain death early on. The combination of perceived risk and patient stigma created a distinct dilemma for workers and patient advocates: those pursuing greater workplace precautions were sometimes at odds with advocates

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The following abbreviations are used: AIDS, acquired immune deficiency syndrome; CDC, Centers for Disease Control; PPE, personal protective equipment.

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seeking to lessen the stigma of infection. Advocates resolved this tension by identifying new antagonists—the state and employers—which helped patients make common cause with care workers.[1]

The pandemic was about homophobia, yes, but it was also a labor issue. This path was not inevitable: the pursuit of workers' safety through the mobilization of stigma was clearly an option. But activists navigated these tensions with a politics of solidarity that threaded the needle, rearticulating the pandemic as, in part, a matter of class oppression. Solidarity arose precisely where stigma seemed to cut against it, redefining essential workers not *against* their patients, but rather *in alliance* with them. The virus unleashed an unprecedented wave of disease-centered disruptive activism, in the wards and on the streets. Many of these activists would go on to play key roles in healthcare institutions, remaking the politics of their unions and professional associations. This was only one of the surprising effects of a pandemic with profound, acknowledged social dimensions.

Activists reshaped the healthcare industry in durable ways. Some of these changes were direct, and visible: safety needles, which retract or get automatically covered with small plastic barrels, are now ubiquitous. Other changes were indirect, but perhaps more significant. By the end of the 1990s, for example, healthcare was one of few industries in which unionization rates were increasing, a feat built upon unions' moral claims about the convergence of workers' and patients' interests.[2] Acquired immune deficiency syndrome, AIDS, was not alone in affecting the healthcare industry in these years, but its blend of personal and political conflicts over exposure and risk had come to be defined, in part, along class lines. Infectious disease had become political, and the virus profoundly reshaped the identity and experience of the healthcare workers it touched.

AIDS, transformative as it was, is estimated to have infected 57 American healthcare workers through documented occupational exposure between 1985 and 2010. According to the Centers for Disease Control (CDC), COVID-19 killed 1,138 healthcare workers in 2020. Though it is difficult to identify sites of

1. John Mehring, "Union AIDS Education Committee Helps Healthcare Workers, Patients," *Labor Notes* (Aug 1987). See also: "The AIDS Book," SEIU Health and Safety Department, 1988, SF State Labor Archives and Research Center, ms.0392, Box 3 Folder 1; "AIDS in the Workplace: Labor's Concern," Service Employees International Union, 1987, SF State Labor Archives and Research Center, ms.0392, Box 3 Folder 1.

2. Pablo Gastón, "A Caring Class: Labor Conflict and the Moral Economy of Care in California Hospitals" (PhD dissertation, University of California, Berkeley, 2017).

exposure, this figure is likely an undercount. National Nurses United (NNU) has counted 2,133 deaths among healthcare professionals by November 2020.[3]

COVID-19 risk has broken down along politically volatile lines of class and race. Beyond geography, exposure risk is based primarily on work status and access to protective wealth. The greatest risk of infection has fallen on workers deemed systemically "essential"—healthcare providers, grocery workers, logistics and transportation workers—yet individually disposable. Cell phone data has shown that lockdowns led people in wealthier areas to stop moving earlier and more consistently than those in poorer areas. Racial disparities in COVID-19 mortality are largely determined by these differences in the risk of infection. And of course, leading comorbidities for serious illness build on lifetimes of poverty and racial exclusion. Illness and death from COVID-19 are now textbook cases of what Celeste Watkins-Hayes has called "injuries of inequality": those injuries "that produce, and are produced by, a compromised ability to protect oneself from harm." The pathways of infection both reflect and illuminate the unique pathologies of American capitalism, our own system's preexisting conditions.[4]

If AIDS activists had to work hard to reframe the pandemic as a class issue, COVID-19 poses no such challenges. While people are harmed by exposure and interaction, capital is harmed when they fall idle, making debates about "opening up" debates about labor. Unequal risks faced by "essential" workers have exposed the glaring conflict between business interests and workers'

3. *CDC HIV deaths estimate*: CDC, 2011, "Surveillance of Occupationally Acquired HIV/AIDS in Healthcare Personnel, as of December 2010," https://www.cdc.gov/hai/organisms/hiv/surveillance-occupationally-acquired-hiv-aids.html (accessed 31 Dec 2020). *CDC COVID-19 deaths estimate*: CDC, 2020, "CDC COVID Data Tracker: United States COVID-19 Cases and Deaths by State," https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (accessed 6 Dec 2020). *NNU estimate*: NNU, 2020, "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity," https://www.nationalnursesunited.org/campaign/deadly-shame-report (accessed 31 Dec 2020).

4. *Wealth and location data*: Kentaro Iio, Xiaoyu Guo, Xiaoqiang "Jack" Kong, Kelly Rees, and Xiubin Bruce Wang, 2020, "COVID-19 and Social Distancing: Disparities in Mobility Adaptation by Income," *ArXiv:2011.12510*; Jennifer Valentino-DeVries, Denise Lu, and Gabriel J. X. Dance, "Location Data Says It All: Staying at Home During Coronavirus Is a Luxury," *The New York Times*, 3 Apr 2020. *Racial disparities*: Monica Webb Hooper, Anna María Nápoles, and Eliseo J. Pérez-Stable, "COVID-19 and Racial/Ethnic Disparities," *JAMA* 323, no. 24 (2020): 2466–67; Jon Zelner, Rob Trangucci, Ramya Naraharisetti, Alex Cao, Ryan Malosh, Kelly Broen, Nina Masters, and Paul Delamater, 2020, "Racial Disparities in Covid-19 Mortality Are Driven by Unequal Infection Risks," *Clinical Infectious Diseases* (ciaa1723), https://doi.org/10.1093/cid/ciaa1723 (accessed Jan 2021). *"Injuries of inequality"*: Celeste Watkins-Hayes, *Remaking a Life: How Women Living with HIV/AIDS Confront Inequality* (Berkeley: University of California Press, 2019), 13.

protections. This conflict is occasionally surreal—such as with unemployment and infection rates surging alongside stock prices. And the state has taken sides. Congressional leaders push for liability protection for employers while undermining workers. The Labor Department has curtailed jobless protections as a means of compelling work *despite* risks. The Occupational Safety and Health Administration declined to enforce aggressive safety in hospitals. The evident privileging of capital over labor has become, as Josh Seim put it, "social murder."[5]

What are workers to do? In the early days of the pandemic, personal protective equipment (PPE) shortages forced nurses to wear bandanas and trash bags as protection, while the CDC weakened existing protections, including guidance on PPE and patient isolation. Workers' responses have been varied, ranging from individual insubordination to collective disruptions. Actions demanding PPE and adequate staffing began in the early days of the pandemic. Nurses stood outside hospitals holding photos of colleagues who died in the first wave. Small groups of hospital workers organized coordinated refusals to treat COVID-19 patients without better protection. Larger groups held sit-down protests, calling attention to short-staffing. They mounted car caravans, pickets, and community protests. Credible threats of strikes in unionized facilities won wage increases. Small-scale strikes continued into July.[6]

Such actions reflect a proliferation of labor unrest throughout the economy. While official strike activity is down, journalists and advocates have documented a large number of small-scale, unauthorized wildcat strikes that elude statisticians. And new forms of protest will no doubt emerge, tailored to the unique, converging issues we face today.[7]

5. *Worker protection regulation*: Jeff Stein, Heather Long, and Josh Dawsey, "Labor Secretary Eugene Scalia Faces Blowback as He Curtails Scope of Worker Relief in Unemployment Crisis," *Washington Post*, 10 Apr 2020. "*Social Murder*": Josh Seim, "COVID-19 as Social Murder," *Spectre Journal*, 22 Apr 2020, https://spectrejournal.com/covid-19-as-social-murder/ (accessed 6 Dec 2020).

6. *PPE protests*: Marco McShane and Larry Poggio, "NYC Nurses, Clutching Photos of Dead Colleagues, Demand Better Protective Gear on Pandemic's Front Line," *nydailynews.com*, 3 Apr 2020; Kristen Jordan Shamus, Darcy Moran, and Robin Erb, "Nurses Protest Conditions at Detroit's Sinai-Grace, Said They Were Told to Leave," *Detroit Free Press*, 6 Apr 2020; Josh Eidelson, "When Working Means Deadly Risk, Backlash Brews," *Bloomberg Businessweek*, 7 Apr 2020. *Strikes and strike threats*: Bryce Covert, "Hit Hard by Covid, Nursing Home Workers Threatened to Strike—and Won," *The Nation*, 8 May 2020; Lisa Schencker, "Hundreds of Joliet Nurses Strike after Hospital, Union Fail to Reach Contract," *Chicago Tribune*, 4 July 2020.

7. Mike Elk, "COVID-19 Strike Wave Interactive Map," *Payday Report*, https://paydayreport.com/covid-19-strike-wave-interactive-map/ (accessed 6 Dec 2020).

If the AIDS crisis helped make the healthcare industry exceptional in terms of relative worker power in the 1990s, the COVID-19 pandemic has the potential to spread these bounds of solidarity much further afield. It is difficult to disentangle a pandemic's moral challenges from its economic and political outcomes. The workplace impact of AIDS suggests that how healthcare workers politicize risk, define its moral stakes, and define their antagonists will play a key role in shaping any coming conflicts. Although the acute phase of this pandemic will pass, the virus will continue to circulate and essential workers will continue to be put at risk. For the time being, there is tremendous solidarity between these "heroes" and the public. Healthcare unions were mostly still young when HIV hit; today, they are among the most powerful forces in the American labor movement. In the next few years, they will develop new procedures, bureaucratic structures, and standards of care. They will also continue to hone a moral critique that just might signal a resurgence of worker power coming out of this crisis.