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BY

A KITES READER

THE LIVING NIGHTMARE OF HEALTHCARE WORK DURING THE COVID-19 PANDEMIC

kites *received the following submission, which is based on interviews with healthcare workers in a hospital setting during the COVID-19 pandemic, from a reader in a major US city. While this piece is the result of an initial investigation, it gives more than a sense of the possibilities for communists to integrate with the massive concentrations of proletarians in the lower rung of the healthcare industry.*

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At the beginning of the COVID-19 pandemic, doctors, nurses, and other healthcare workers were treated as heroes, with restaurants donating coffee and food to local hospitals and people cheering nightly from their doors and windows across major US cities. Roughly one year later, an article from a larger report called *Lost on the Frontline*[1] published findings that more than 3,600 US healthcare workers had died during the first 12 months of the pandemic. Those deaths were disproportionately concentrated among nurses and support staff, and among those that died, half were Black or Asian, including migrant Filipinos who work in healthcare. National Nurses United reported that roughly one-third of registered nurses to have died of COVID were Filipino.[2]

A floor nurse in his late 30s spoke with me about his experience working in a non-ICU (intensive care unit) COVID unit at a "big hospital" in a major metropolitan area for most of 2020. He described the non-ICU COVID unit as a place for "people sick enough [with COVID] to be in the hospital, but not sick enough to need intensive care." Reflecting on the situation at his workplace in the early days of the pandemic, he said

1 Jane Spencer and Christina Jewett, "12 Months of Trauma: More Than 3,600 US Health Workers Died in Covid's First Year," *Kaiser Health News* and *The Guardian*, April 8, 2021, khn.org/news/article/us-health-workers-deaths-covid-lost-on-the-frontline/ (accessed August 1, 2021).
2 "Sins of Omission: How Government Failures to Track Covid-19 Data Have Led to More Than 1,700 Health Care Worker Deaths and Jeopardize Public Health," *National Nurses United*, September, 2020, nationalnursesunited.org/sites/default/files/nnu/documents/0920_Covid19_SinsOfOmission_Data_Report.pdf (accessed October 1, 2021).

> In the beginning, it felt very disorganized, and rules would change from day to day. We'd hear some things from one manager and other things from another manager. Talking to doctors and nurses who worked at other hospitals, [I came to the conclusion that] where I work ended up having a pretty good system and was relatively well-resourced compared to other places that sounded even worse, with even less PPE [personal protective equipment] and even more chaotic. But we didn't get a lot of training, and they weren't testing us for COVID, either, unless we were sick and symptomatic. The whole year that I was working there, I got tested one time for COVID [by my hospital, and that wasn't until] October or November, [at least seven or eight months after the pandemic had already begun really spreading in the US]. I would go to the free city testing sites every two or three weeks, but that's then putting the burden on the public of what should be something that the private hospitals are paying for.

I also talked to an Asian transplant nurse in her mid 30s who has worked in a large, nationally known hospital throughout the pandemic. She was assigned to the COVID ICU unit during her city's surge in cases over the winter months and spent considerable personal time and resources donating PPE to smaller community hospitals in the midst of nationwide shortages. Speaking to the chaos and confusion that set the tone during the initial months of the pandemic, she said,

> In the beginning, everything was so in flux; one day, the CDC was saying "Don't wear a mask," and the second day, the CDC was saying "Wear a mask in the hospital." So [there] was a lot of mistrust in what was going on with the hospitals and the way that they were responding, and we felt very exposed in the sense that we didn't know where [COVID] would come from, who it would come from, because testing was very limited at the time. Testing was difficult to find, and it was taking a long time to get results. We didn't know what types of isolations we were supposed to use. When the shortages started to happen with the protective equipment, it got really, really scary.

The floor nurse related how scary things got for both patients

and staff at his hospital due to shortages:

> They didn't even want to give us N95s, and then they wanted us to use the same [masks and] shoe covers all day long, so we were tracking COVID in and out of the unit. It did get a lot better in terms of PPE on the non-ICU COVID unit, and we were pretty well-staffed for most of the time, so we were still getting breaks and still only had two to four patients each. In the ICU, nurses weren't getting breaks at all—there were some days where they'd work the whole shift without a break—or they'd have to cover each other's patients when they went on breaks. And then, in the emergency department, at times, they wouldn't have enough oxygen for patients, they wouldn't have enough oxygen monitors for patients, there were electrical fires in the tents [that were set up in the parking lot to deal with overcapacity], the tents flooded during a big rain and people were soaked up to their knees, when it was hot outside, it was like 130 degrees inside the tents.... So the emergency department was like a battlefield medical tent.

The lack of PPE, including crucial N95 masks and other face coverings, that healthcare workers faced was blamed on supply chain breakdowns due to a system of "just in time" manufacturing. In reality, those supply chain breakdowns are an *expression* of the functioning of a highly financialized system of global capitalism-imperialism, driven by the anarchy of production. This phenomenon is spoken to in Kenny Lake's "Things Done Changed,"[3] in which he writes "Choices about where to invest capital are now often arrived at by advanced mathematical algorithms—worlds apart from the rational social planning needed for production to serve humanity's all-around development."

Is there a more damning indictment of the current ruling order than the inability to quickly manufacture masks and other PPE for frontline healthcare workers? During the pandemic, the bourgeoisie managed to continuously produce McDonald's cheeseburgers, weapons of war, and *Keeping Up with the Kardashians*, yet they could

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3 Available in *kites* #2.

Nurses proudly sporting their self-made PPE: Hefty garbage bags.

not re-purpose empty factories to manufacture life-saving equipment on a scale needed to meet basic human needs.

The transplant nurse went on to describe the desperation—even at the institutional level—that resulted from the bourgeoisie's mismanagement of the pandemic and the production and exchange of PPE:

> People were told to tape their protective masks back together, because there was nothing. I had small community hospitals asking me for isolation gowns because they were using trash bags. People were putting plastic bags over their mouths, on top of their masks, because they didn't think the mask they were wearing was protective enough. If you're thinking about how COVID is transmitted, the only protective equipment is an N95 mask, so [they were correct to assume that] a surgical mask is insufficient. The shortage of PPE didn't really lift until around the [2020 general] election, when they lifted trade [restrictions] from China. And then, we find out from the government that the ones we're importing from China are not the high-quality N95 masks, but that they're only 30–40% effective. So then, there's even more mistrust on top of that.

The failure of the government and hospital administrators to provide proper safety equipment, reliable testing, and scientifically accurate information about COVID meant that, in addition to

their own lives being at risk, frontline healthcare workers also risked bringing the virus home to their loved ones. One worker I spoke with told me that

> It was scary thinking that I could pick [COVID] up at work and then bring it home to my loved ones, so for most of the year, I was really distancing myself from close friends and family because of that fear. And I saw it happen at work, where patients would come in [who] had family members that were nurses or work in the medical field and brought home COVID, and then family members died from it. That was the really terrifying thing, and it also meant that I was much more physically isolated from people, which was one of the other hardest things about it.

In the midst of that genuine fear and precautionary isolation, the Asian transplant nurse related how she and her colleagues were targets of classic American racism and philistinism while going about their everyday lives:

> On top of that [fear and uncertainty], there was going out into the regular world and getting called a "germ," a "spreader of disease." I've had coworkers that have had bleach thrown at them. And this was all while everyone was talking about the hand-clapping that was going on, the cheering for healthcare workers; there was a lot of anger still towards the healthcare community. You go to the store in your scrubs before work, because you work 12 hours—you don't have time go [otherwise], and people would think you are a walking germ, because they would think you're coming *from* the hospital.

Many people go into the healthcare field because they want to care for others, to make the world a better place. Yet for hospitals and other healthcare facilities in the contemporary US, the pursuit of profit at all costs is placed over the humane care of patients and staff. Indeed, while healthcare workers were wearing trash bags for PPE and COVID was ravaging prisons and meat-packing facilities, the largest private insurers in the US doubled their profits in 2020.[4]

4 Reed Abelson, "Major U.S. Health Insurers Report Big Profits, Benefiting From

The floor nurse lamented this bourgeois subordination of people to profit, saying

> If our society prioritized *real health*, we could train tens of thousands of more nurses to be out in the community doing health promotion and making sure people have what they need to live healthy lives and not even need to go to the hospital. We could have more nurses at the hospital so that the quality of care would be a lot better.

Even as the worst of the pandemic surges seem to have subsided, healthcare workers are still dealing with the long-term consequences of having been ill-prepared and understaffed. The transplant nurse reflected that she was

> honestly surprised that not more suicides [among healthcare workers] were reported during the surges, because there was *so much death*. Death and dying is always something that needs to be processed; it stays with you. That's what people don't understand when they say "This is what you signed up for." I did not sign up to be Death's handmaid. I signed up to help people heal. I signed up to make sure that people felt cared for. It's just a [feeling of] powerlessness—that there's nothing else we could do. We were literally waiting for the next person to die so that we could clean the machine and put it on another person so they could [have] their chance at living. It was a lottery.

The US has the technology and material resources to murder people around the world with killer robots, and yet it could not meet people's basic healthcare needs during a global pandemic. That alone is reason to fight to overthrow the whole goddamn system and not rest content with merely struggling for reforms, including those that might be worth supporting. And these interviews make clear that the antagonism faced by healthcare workers is not simply with hospital administrators or bosses, but with the whole capitalist-imperialist system that prioritizes profit over basic human dignity.

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the Pandemic," *New York Times* nytimes.com/2020/08/05/health/covid-insurance-profits.html (accessed September, 11 2021).