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What We Owe Workers in Health Care Earning Low Wages

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FROM THE EDITOR

What Do We Owe Health Care Workers Who Earn Low Wages?

Noelle Driver, MD, MS

The notion that one is too good to do what is necessary for somebody to do is always weakening. The unwillingness, or the inability, to dirty one's hands in one's own service is a serious flaw of character. . . [I]t can curtail or distort a society's sense of the means, and of the importance of the means, of getting work done; it prolongs and ramifies the life and effect of pernicious abstractions.
Wendell Berry[1]

The health care industry employs thousands of individuals at dismal wages. These workers are essential to health care and include patient care assistants, certified nursing assistants, home health aides, paramedics, custodial and security personnel, and environmental services workers, to name a few whose roles are often unrecognized in ethics and health policy investigations. Patient care assistants earn on average $17 000 to $27 000 per year,[2] while certified nursing assistants earn on average $22 000 to $31 000 per year, depending on the state in which they practice.[3] Nationwide, the median wage of all health care support, direct care, and service workers was $13.48 per hour in 2019, while home health and personal care workers earned a median hourly wage of only $11.57.[4] Despite working full-time or more, these workers rarely live on their wages alone. In 2019, nearly 20% of care workers lived in poverty, and more than 40% received public assistance.[4] Women made up 81% of these workers, and an inequitable number were women of color.[4] Their work is heavily relied upon by clinicians of status and by the systems in which they operate, but it is compensated meagerly, with unsustainably low pay and few benefits.

Moreover, demand for long-term care of elders and persons with disabilities is growing in the United States, as more people seek to age in place in their homes. The US Department of Labor predicts that demand for personal care aides will grow 33% between 2020 and 2030.[5] Turnover among workers in these roles, which influences quality and continuity of care, was more than 60% in 2014.[6]

Yet we must take care to avoid focusing too narrowly on the economics of employment and these roles' "essential" nature, which risks further commodifying the bodies and personhood of those performing this work. Many workers earning low wages, especially home health aides, patient care assistants, and certified nursing assistants, bring critical emotional knowledge to their jobs as caregivers. What's at stake is more than typically supposed by supply-demand models, since US health care relies on these workers for daily, or even hour-to-hour, care of so many of our most vulnerable patients.[7] Can clinicians of status care for patients in good faith without promoting good pay,

benefits, and organizational support for workers delivering care that is valued at a small fraction of their own?

This issue of the *AMA Journal of Ethics* considers clinical and ethical dimensions of this question and investigates what we—as citizens, clinicians of status, and organizations—owe to these vulnerable workers. How should we better advocate for and build authentic solidarity with our colleagues? How should we improve the systems in which they work? How should we illuminate, amplify, and lift up their—and their roles'—importance? Preparatory to answering these questions, this issue investigates vast differences in power, education, compensation, and job security among workers on health care teams, as well as historical perspectives on policy that led to the low compensation for and invisibility of the labor of those earning low wages. The issue specifically considers wage theft, exploitative labor expectations, exclusionary pathways to professionalization, and patterns of marginalization among health care workers who earn low wages, despite their significant responsibilities. Finally, this issue offers examples of partnerships and solidarity from which all health professionals and students can learn.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Do Organizations and Clinicians of Status Owe Their Patients' Home Health Aides?

Eileen Boris, PhD and Jennifer Klein, PhD

Abstract
This commentary on a case offers a historical perspective on how home health work became separate from other sites and means of professional caregiving, exacerbating poor continuity of care in the US health care system. Categorizing home health work as domestic work continues to racialize and marginalize workers. Poor public policy responding to market pressures to keep home health work cheap also perpetuates home health workers' classification as independent contractors, their lack of training, and low wages. This commentary suggests an alternative model for the future of home health work in the United States.

Case

Mr G, who is 77 years old and lives alone, has mild cognitive impairment, type 2 diabetes mellitus, and chronic kidney disease and currently has a suprapubic catheter due to urinary incontinence. His 2 adult children hire Ms S through a home care agency to help bathe Mr G, prepare his meals, clean as needed, organize (and often administer) his medications, and spend time with Mr G.

Ms S sought asylum in the United States 10 years ago and first began working for a cleaning service and then also for the home care agency as a home health aide. Ms S is 46 years old and most proud of her role in health care, which she considers her primary job and for which she received no formal training. The agency hires its employees as independent contractors and does not sponsor benefits (ie, health or dental insurance, paid leave, retirement contributions, or employee assistance counseling services). Ms S works full time at minimum wage, and, though she pays federal and state income taxes, her annual income falls below the federal poverty level and has been and remains insufficient for her to accrue savings. Ms S and her children currently qualify for Medicaid, are currently enrolled in their state's supplemental nutrition program, and visit a food pantry for groceries.

Mr G is currently Ms S's sole patient. Ms S is grieving the loss of a patient for whom she cared for 3 years until his transfer to home hospice and subsequent death. Ms S hopes her agency will assign another patient to her soon, as she needs the income, and is

considering taking on a third job. To make her typical morning arrival time of 6:30 am, Ms S makes 3 bus transfers from her apartment in the city to Mr G's suburban home. When Ms S arrives, Mr G is in his bathroom. She checks on him there, verifies that he is safe, and then returns to the kitchen to clean up milk on the floor that appears to have been spilled after she left yesterday. She then prepares Mr G's breakfast and medications. Mr G has spent more time with Ms S than any other person during the past 2 years and regularly calls her at home for companionship, comfort, and reassurance.

Ms S prepares a Center for Medicare and Medicaid Services Home Health Certification and Plan of Care (CMS-485) form online, which must be signed by Dr P, Mr G's physician. She was also asked to document prescription medication modifications ordered by Dr P, following Mr G's primary care appointment earlier this week. Ms S makes the changes but is unsure about how to implement a change to Mr G's insulin and is unsure whether one of Mr G's new prescriptions, just received by mail, contains the correct number and kind of pills, as the shapes and colors of and numbers on the capsules do not match those in a photograph she references online. Ms S calls Dr P's office to confirm; a member of Dr P's staff returns her call the next day but confirms only the name and dose of the medication. Ms S remains unsure what to do, so she also contacts Mr G's son. He is unfamiliar with the prescription changes and advises, "Just fill the boxes in the pill container for each day of the month as best you can. Dad will know which ones to take."

Still unsure what to do, Ms S leaves out the capsules that don't look right to her as she fills Mr G's pill box slots. She attaches an electronic sticky note in the online CMS-485 form, hoping Dr P will see it and clarify the prescription. Dr P does not see the electronic sticky note, signs the CMS-485 form, and moves to the next electronic health record document requiring review and sign off.

Commentary

How did we develop a system of home care that insufficiently sustains those who need assistance with the activities of daily life but also leaves personal attendants and aides in legal, economic, and social limbo, as neither nurses nor maids, within the labor market yet outside labor standards and regulations? We rely on the service ethos of female workers, predominantly immigrant and US-born women of color, when neither families nor professionals can care for frail elders and people with disabilities on a daily basis.[1] A historical perspective illuminates 3 conundrums highlighted by the case: (1) the separation of home aides and personal attendants from medical care, (2) their occupational categorization as domestic workers, and (3) the provision of home care on the cheap through racialized stigmatization of the work and workers' lack of training, low wages, and classification as independent contractors or "companions." In consequence of home aide standing outside of a medical team, continuity of care suffers. This situation was not inevitable but rather developed from historical choices and actions: public policies, responsibilities for services being divided between public and private agencies, and competing professionalization agendas of social work, nursing, public health, and medicine. In addition, the persistent association of hands-on care in domestic spaces with unpaid mother love and wifely duties continually lessened its value, regardless of the labor supply.

It is important to emphasize that we are talking about a job and not the uncompensated care that family members give to each other. The tasks might be similar, and the aide might be as attentive as—and even more experienced than—middle-class professionals

who, for example, leave their own jobs to tend to an incapacitated relative or friend. Aides may embrace caring as a calling and adhere to a service ethos but are not salaried employees. Thus, they can be economically exploited by working beyond assigned hours without proper payment and at the same time take pride in their labor.[2]

In what follows, we offer a historical perspective on how home health work became separate from other sites and means of professional caregiving, exacerbating poor continuity of care in the US health care system. We also suggest an alternative model for the future of home health work in the United States.

Home Care's New Deal Origins

The conflation of home care with domestic labor stems from more than alleged categorical equivalency. It's rooted in institutional arrangements, gender ideologies, occupational segregation by race (and gender), and deliberate labor policies. Home health care was defined as domestic service in part because home health care workers, hospital and nursing home workers, and household employees often have been the same people who have moved between work in low-wage labor markets and receipt of government assistance (commonly known as welfare).[3]

Home care developed as a distinct occupation during the Great Depression, when the New Deal was introduced to respond to the economic crisis. Under the Works Progress Administration (WPA), relief programs called homemaker or housekeeper services sent unemployed women into poor households where a mother was in the hospital, ill, or incapacitated; the WPA "homemaker" was assigned to perform labor such as cooking, cleaning, comforting, and caring for children.[4] These New Deal home care programs solved 2 problems: they provided African American women—who composed the majority of household workers in the Northeast, South, and Midwest—alternative income to day-labor street corner sites, in which would-be employers picked up women for a day's cleaning for pennies an hour.[4] WPA homemaker or housekeeper services additionally relieved strained public hospitals of the burden of maintaining patients with chronic illness by enabling such individuals to be tended to in their homes.[4]

At the same time, the new permanent social and economic security legislation under the New Deal excluded occupations in which African Americans predominated, in part to overcome Southern Dixiecrat opposition to expanding Black rights. Hence, the Social Security Act, the National Labor Relations Act, and the Fair Labor Standards Act (FLSA) drew poor Black women outside the boundaries of labor and social protection; the New Deal perpetuated a form of occupational Jim Crow.[5] It conflated paid labor in the home with family labor, which even New Dealers believed defied regulation. Occupations associated with women, and particularly with Black women, such as nurse companions, homemakers, and other in-home care workers, were thus excluded under old age insurance, unemployment benefits, and collective bargaining legislation, as well as from the national minimum wage, maximum hours, and right to overtime compensation provisions of the FLSA. Not until 3 decades later would employees of nonprofits come under the labor law, including most nurses and health aides.[4]

Public policy shaped the contours of home care, but New Dealers did not act alone. Nurses and physicians also left their mark on the shape of home care by limiting the housekeeper's repertoire of tasks. As *The Trained Nurse and Hospital Review* editorialized in 1939: "This care is not nursing, but the use of such workers, under the supervision of physicians and nurses, will free more technically prepared workers for the

medical care of such patients which is still in its infancy."[6] Seeking to carve out the professional competency of licensed nurses, leading voices, such as the New York State Nurses Association and the Board of Nurse Examiners, drew the line where "simple home care" ended and nursing care began. Home aides might make beds and help with daily personal care, including "giving bed pan and care of it, filling of hot water bottle … and helping patient to take simple medicine."[7] But they were not to give nasal or eye drops, apply bandages, or help "the patient apply a brace, hypodermic injection of insulin, and administration of enemata and douches"—procedures that registered nurses insisted were part of the repertoire of a practical nurse, not a housekeeper.[7] Thus 3 legacies emerged from the New Deal: filling home health care jobs with women on public assistance, excluding these jobs from labor standards, and separating them from the health care professions.[4]

Occupational Narrowing

After World War II, home care expanded, but attempts to make it a good job ran up against its low prestige and lack of professional standards. Some nonprofit family and child welfare agencies, many of them denominational, sought to improve conditions by targeting older women with career ladders, benefits, and decent wages. Along with public welfare departments, these agencies—led by women social workers and aided by the US Children's Bureau—established visiting homemaker programs to maintain the aged and people with disabilities in the community rather than in more expensive hospitals and nursing facilities. However, they managed to create only a few civil service positions before lack of funding stymied this effort.[4] At the same time, for-profit employment bureaus that provided domestic servants sent women into homes to assist the elderly.[4] Despite their different intentions, both for-profit and nonprofit private sector agencies joined government programs in funneling women into hands-on caring positions complementary to but distinct from hospital or clinic-based care, which required licensed professionals. For homemaker service, job training tended to consist of domestic tasks—laundry, making beds, cooking—the labor that poor women of color had so long been expected to do. Because these jobs went by the terms *homemaker*, *visiting housekeeper*, *home aide*, and *personal attendant*, the US Department of Labor soon classified them as domestic service in its *Dictionary of Occupational Titles*, further conflating the status and function of so-called housekeepers and domestic servants.[8]

Further separating medical professionals from home aides, hospitals began instituting their own home care programs in the 1950s. The home care unit run by Montefiore Hospital in New York City promised "continuity of care" for patients sent home by the hospital, touting the close attention of an integrated medical team. Yet because hospital officials treated home aides as casual workers whose presence didn't serve any medical need, they made little effort to consistently build this workforce.[4] The Hospital Council of Greater New York—an agency that bridged public and private institutions—more narrowly defined the home care team as "the physician, the nurse, and the social worker."[9] Hospitals offered a range of services but would contract out home nursing to independent visiting nurse agencies. When it came to home aides, a hospital social worker could hire "any individual she deemed suitable to perform housekeeping duties,"[9] including relatives and friends, thereby treating the labor as casual and marginal. State employment bureaus also kept lists of potential housekeepers.[9] Whereas welfare administrators repeatedly stressed the "professional" character and training of public homemakers,[4] the hospital programs operated under a different premise: "housekeeping service … did not involve professional personnel."[7] Indeed, a

survey of housekeeper duties found that cleaning consumed more hours than any other chore, with the bedridden requiring the most personal care.[9]

Although housekeepers' home visits were far more regular than those of nurses or physicians, their labor was mostly invisible—like other forms of domestic or care work—and precarious. The refusal to recognize the hands-on knowledge and emotional support of home aides deprived physicians of crucial information, impeding care. With hospitals viewing housekeeper services outside of their mission—indeed, beyond their understanding of care—nonprofit and later for-profit agencies supplied aides, especially once Medicaid funding became available, which has served as the de facto payment system for long-term care.[7]

Unionization?

By the 1970s, service sector unions were looking to organize household workers, but, unable to reach domestic workers hired by individuals, they found home care workers employed by agencies or directly paid by governments.[10] In 1974, private household workers gained protection under the FLSA; at the very same moment, however, the Department of Labor reclassified home aides as "elder companions," akin to casual babysitters, and excluded them from the FLSA's minimum wage and overtime provisions, even if they were employed by third-party agencies and hospitals.[4] Once again, home aides would be denied the legal status of "workers" and the rights that have accompanied that status. Treated as companions rather than breadwinners, thousands of New York home attendants experienced nonpayment of wages in the latter half the 1970s. They took to the streets to protest these conditions with signs reading, "Take Us Out of Slavery" and "I am Not A Slave."[10]

Law and public policy changes in the 1980s, combined with fiscal constraints and the emergence of a for-profit home care industry, facilitated the contracting out of home health care and the classification of home care workers as independent contractors.[10] By that time, recent immigrants had joined African Americans in the home care workforce.[4] Hence both public and private services could deny their responsibilities as employers, extending the disjunction between such jobs and professional health care by paying minimum wages without benefits or career ladders.[11]

Since the end of the 20th century, home care workers have fought to gain recognition as workers worthy of living wages. In urban areas such as Chicago and San Francisco, unions won inclusion in minimum wage protections.[4] They bargained for training programs that aides eagerly and often desperately sought, especially to protect themselves and their clients from injuries. Where they had sufficient leverage, as in New York, unions could incorporate training and safety programs into collective bargaining contracts.[12]

A surge in home care unionization in the late 1990s and early 2000s, however, faltered by the 2010s when some states negated prior agreements with care unions, governments restricted resources, and public sector workers suffered conservative backlash. Rulemaking put home care workers back in the FLSA in 2013, but the US Supreme Court ruled in *Harris v Quinn* (2014) that home care workers could not be considered public employees for collective bargaining purposes, which undermined home care unions' financial viability.[4] Since then, state governments and private agencies have sought to avoid paying overtime by cutting hours or rejecting pay for on-call sleep time during 24-hour shifts.[13]

Where unions were blocked, grassroots groups of workers began mobilizing outside of formal trade unions. In New York, for example, the Ain't I A Woman?! Campaign challenged the wage and time theft of 24-hour shifts, even as local unions accepted the state's rationale for underpaying workers for lack of funds and failed to demand full compensation.[14] Immigrant worker centers and ethnic associations under the National Domestic Workers Alliance pushed for inclusion of home care in state-level bills of rights as a mechanism to extend labor standards; since 2010, activists have won legislative passage of a domestic workers bill of rights in 10 states and 2 cities.[15] In the early 2020s, a feminist care network, including unions and domestic worker organizations, lobbied government to include home care as crucial human infrastructure.[16,17]

Conclusion

A recent finding that nursing associations and councils have "been a major impediment to the expansion of the aide role and inclusion of these aides in team-based care"[18] reminds us that the struggle of nurses to elevate their profession involved nurses moving out of the home and into the hospital and differentiating their tasks from those of workers with less training and authority. We recognize that it is difficult to think of those without professional certification as valuable members of the care team, and some readers of this commentary will bristle at the thought. And yet the order of things is not natural; it is made by public policy and all-too-human institutions. Providing "competency-based" training and living wages to the hands-on home attendant could improve client outcomes—but only if we truly value the observational knowledge of home aides. As the case shows, it was the aide—not the physician or family member—who was on the scene and noted changes and patient difficulties. While electronic monitoring and forms may be efficient, they rarely substitute for communication and coordination.

We are not talking about diversity, equity, and inclusion when we suggest taking seriously the knowledge of workers who happen to be predominantly women of color. We believe that the most ethical response is to acknowledge the value of this labor force. Is it ethical to generate jobs that fail to generate living wages? Will not our neglect produce worn-out and sicker future patients who have spent their lives tending to others but cannot afford the care they now require themselves? We ask readers to consider fixing a system that public policies have wrought by providing the infrastructure and funding for good jobs that allow workers a voice in the work they perform. We concur with the conclusion of a February 2022 Paraprofessional Health Institute study: leaders in the field of long-term care should address "discrimination based on race, gender, and immigration status … as well as their manifestations in … low wages due to the systemic undervaluing of care work."[1] Both clients and home care workers then could obtain the dignity and security they deserve.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Do We Owe Health Workers Earning Low Wages Who Are at Risk of Harm?

Constance E. George, MD, MA

Abstract
Psychiatric aides and psychiatric technicians are part of direct care workforces in psychiatric inpatient units. They experience high rates of violence, but, compared to other members of treatment teams—including physicians, nurses, and social workers—they receive low wages. This commentary on a case considers the nature and scope of the ethical obligations of clinicians of higher social status (eg, physicians and nurses) and organizations to workers whose safety is at risk for little compensation.

Case

After high school graduation, HH hopes someday to go to college and become a health professional. For now, HH takes care of their mother, as they have for the last 3 years, and takes a 40-hour course to become a psychiatric aide. HH now works full time in an inpatient psychiatry unit, earning just above minimum wage during an overnight 8-hour shift in which they monitor a patient, who is involuntarily committed.

HH's patient is ZZ, who is 58 years old and has a history of bipolar I disorder. ZZ's symptoms were well controlled with risperidone and lamotrigine until a right rotator cuff repair surgery 5 days ago. Since then, ZZ has been demonstrating acute psychosis and hyperverbalism (inability to stop talking). Dr P's and nurses' efforts to redirect, interrupt, or calm ZZ have not succeeded, and ZZ's agitation has now increased to aggression toward anyone who tries to administer medication.

None of the psychiatric aides wants to monitor ZZ, whose hyperverbalism is exhausting and whose aggression, when not well controlled, is unpredictable and generally feared. HH is assigned to monitor ZZ for the third night in a row. Last night was particularly stressful, as ZZ asked HH to help her use the bathroom and then pressed HH to a wall before others intervened.

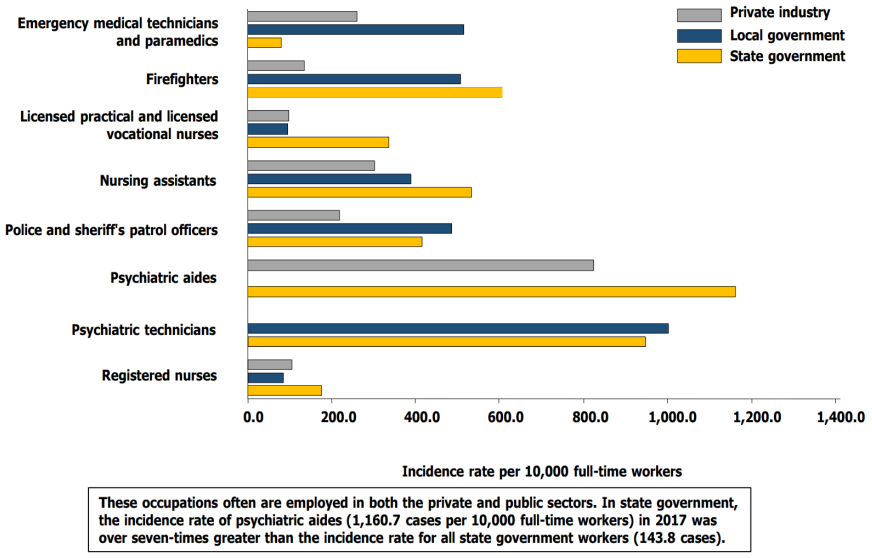
In the morning, during rounds, ZZ points to a bruise on her right shoulder and shouts, "That dyke man-handled me!" Dr P, the lead psychiatrist, asks HH about the incident. Dr P looks to HH and says, "Don't worry, we know nothing happened."

"Nothing happened to ZZ," HH thought, recalling yesterday when a fellow overnight psychiatric aide stated to Dr P during morning rounds that a patient had threatened her overnight. HH observed that Dr P ignored her, so HH decided not to say anything this morning about being pressed to a wall.

Commentary

Psychiatric aides and psychiatric technicians experience workplace violence at rates significantly higher than members of the general work force.[1] Moreover, these workers experience violent injuries at higher rates than workers in like positions, such as nursing assistants (see Figure 1).[2] A survey published by Kelly et al in 2016 examined the perceptions of well-being and safety of inpatient staff at a large public mental health hospital in California. Roughly 45% of respondents reported feeling unsafe at work, and, notably, psychiatric technicians composed 41% of the inpatient staff sampled.[3]

Figure 1. Nonfatal Occupational Injury and Illness Incidence Rates for Cases Involving Days Away From Work for Selective Healthcare and Protective Service Occupations by Ownership, 2017[a]



[a] Reproduced from US Bureau of Labor Statistics.[2]

In 2018, Payscale (as reported in *CNN Money*) listed mental health technician as one of the 15 most stressful and underpaid professions.[4] The duties required of psychiatric aides and technicians are extensive, physically demanding, and hazardous. A sample description of psychiatric aides' and technicians' duties is presented in Figure 2.

Figure 2. Duties of Psychiatric Aides and Technicians[a]

Psychiatric Aide Duties

- "Monitor patients' behavior and location in a mental health care facility"
- "Help patients with their daily living activities, such as bathing and dressing"
- "Serve meals and help patients eat"
- "Keep facilities clean by doing tasks such as changing bed linens"
- "Participate in group activities, such as playing sports and going on field trips"
- "Help transport patients within a hospital or residential care facility"
- "Restrain patients who may become physically violent"

Psychiatric Technician Duties

- "Observe patients' behavior, listen to their concerns, and record their condition"
- "Lead patients in therapeutic and recreational activities"
- "Give medications and other treatments to patients, following instructions from doctors and other medical professionals"
- "Help with admitting and discharging patients"
- "Monitor patients' vital signs, such as their blood pressure"
- "Help patients with activities of daily living, including eating and bathing"
- "Restrain patients who may become physically violent"

[a] US Bureau of Labor Statistics.[5]

Despite the demanding and hazardous nature of their work, psychiatric aides and technicians are poorly compensated and disproportionately female. In 2021, the median salary for psychiatric aides and technicians combined was $36 230 per year, or $17.42 per hour[6]; 73.5% of psychiatric technicians were women and 26.0% were African American.[7] Educational requirements vary, but both jobs typically require a high school education, and, for technicians, a postsecondary school certificate is generally required.[6] Psychiatric aides' and technicians' high rates of workplace violence and low pay and education levels are consistent with the finding that staff victims of psychiatric assaults tend to be younger, less formally educated, and less trained mental health workers.[8]

This case commentary considers barriers to employees speaking up about safety concerns and the nature and scope of the ethical obligations of higher-status clinicians (eg, physicians and nurses) and organizations to workers whose safety is at risk for little compensation.

Barriers to Communication

In this case, the psychiatrist tells HH not to worry about ZZ's allegations, as the psychiatrist knows nothing has happened to the patient at the hands of ZZ. This interaction suggests that the problem in this patient-staff conflict is ZZ's accusation of being "man-handled" by HH. HH's account and experience is not solicited by Dr P, the verbal epithet cast at HH is not addressed, and the reason the psychiatrist gives no weight to ZZ's allegations is not communicated. Given the statistics regarding the high rates of workplace violence experienced by psychiatric aides,[1,2] this stance is reflective of a culture that does not protect or support them. The physical and verbal assaults experienced by direct care health care workers affect them not only physically but also psychologically by arousing feelings of helplessness, shock, anger, anxiety, frustration, and humiliation.[9,10] Psychiatric unit staff who have been assaulted by patients also have

an elevated risk of experiencing posttraumatic stress disorder and other mental illnesses.[11]

So why doesn't HH speak up? One reason is made explicit in the case: resignation. HH's observation that a coworker who communicated a similar experience a day earlier and was subsequently ignored left HH feeling that their voice had no ear and, therefore, there was no point in speaking up. Assessments of futility are a known reason why direct health care staff remain silent.[12,13] Other reasons that staff do not speak up to team leaders such as Dr P are deeply rooted in the presence and manifestation of a long-entrenched medical hierarchy. In one survey, health care workers at lower levels of the hierarchy, such as psychiatric aides and technicians, reported speaking up about concerns less frequently than staff at higher levels of the hierarchy.[13] Those of lesser prestige and power may be complying with a perceived social norm that they should stay silent.[14] In addition, this norm is reinforced by those who hold authority and power.[15]

Thus, psychiatric aides and technicians might be afraid to speak up. This fear is linked to the concept of psychological safety. Do direct care workers feel psychologically safe to communicate concerns, ask questions, and receive and give feedback in a high-risk setting?[16,17] The ability and freedom to speak up without fear of denigration or indifference helps workers at lower levels of the hierarchy navigate difficult workplace environments and thereby promotes a reduction in workplace violence and an environment of safety.[18]

Health Care Organizational Obligations

What are the ethical obligations of the health care organization with respect to the safety of direct care health aides and technicians? The psychiatric hospital is by nature a high-risk place. A highly reliable organization is defined as an organization with an inherent probability of hazard, such as an inpatient psychiatric unit, where the consequences of error are high but the occurrence of errors and adverse events is low.[19] How is this reliability achieved?

First, the organization must have a stated commitment to the physical and psychological safety of employees.[20] It must provide appropriate training to address safety and provide adequate staffing to implement a safe environment. Appropriate training, staffing, and implementation of safety procedures regarding workplace hazards does result in a reduction in the occurrence of workplace violence.[21]

Second, there must be an appropriate response to violent incidents, including appropriate methods for reporting and addressing violent incidents. Addressing the incident could include measures such as critical incident stress debriefing, a structured small group storytelling process combined with psychoeducation that is intended to normalize group members' reactions to a critical incident and facilitate their recovery.[22] This debriefing could be followed by counseling for individuals and reassessment of safety procedures for the organization.[20] These are essential processes and have proven effective in helping employees cope with workplace violence and in reducing the consequences of violence to employees.[23]

Third, organizations owe workers who earn low wages inclusion in decision making. Direct care workers are the front line of observation and the front line of patient encounters. According to the Occupational Safety and Health Administration (OSHA), "A basic prerequisite for preventing injuries and illnesses is knowledge of the types,

location, and underlying reasons for their occurrence in the workplace."[18] For this reason, OSHA recommends involving frontline workers in the design and implementation of policies and procedures that affect them as well as their patients.[18] This type of inclusiveness minimizes the risk of harm to staff and patients alike.[21,24] Conversely, direct care workers may point out that their experience of poor team communication, combined with dismissal of their experience by health care organizations, places patients and staff in danger.

Fourth, the organization owes all staff just treatment. Is there a commitment on the part of the organization to equal process—that is, are the responses of the organization to violent and adverse events suffered by doctors, nurses, social workers, therapists, aides, and technicians addressed in a like manner?[25] Is there an organizational commitment to a living wage, health care, education, and promotion for all employees? Inadequate compensation is a disincentive to investment in the treatment team and can result in employees' feelings of resignation,[26,27] such as displayed by HH in the described case. Joan Acker, a well-known American sociologist, researcher, writer, and educator described inequality in organizations as follows:

> I define inequality in organizations as systematic disparities between participants in power and control over goals, resources, and outcomes; workplace decisions such as how to organize work; opportunities for promotion and interesting work; security in employment and benefits; pay and other monetary rewards; respect; and pleasures in work and work relations.[28]

In terms of compensation, physicians and organization administrators earn salaries 4 to 7 times higher than psychiatric aides and technicians,[29] who are undercompensated for the work they perform. In Texas, for example, it requires $21.98 an hour to afford a 2-bedroom rental,[30] yet the average hourly wage of a psychiatric aide in Texas is $22.00 and of a technician is $27.19.[31,32] In a 2019 study, Budig et al found that childcare workers, nursing aides, and health aides suffered a steep pay penalty (15% among women and 6% among men) compared to other workers of similar education, licensing, and skill.[33] These disparities reflect a long history in the United States dating all the way back to slavery, a history denigrating direct care health workers based on the race and gender of these workers. The current compensation paradigm in the health care industry is the manifestation of systemic racism and misogyny within the health care industry.[34]

Finally, is the work culture just? A just work culture supports a psychiatric aide or technician who reports an unsafe situation or an adverse event without making that person fear reprisals from the organization.[25] Such reprisals can have significant economic impact if an aide loses their employment as a result of making a report. As are psychologically safe cultures, just cultures are associated with reductions in adverse events.[16,25]

Psychiatrists' Obligations as Team Leader

Olivia Ray Friedman explored interdisciplinary team functioning, coherence, and unit effectiveness in a long-term adolescent inpatient psychiatric unit in her doctoral thesis, *Exploring Communication Between Staff and Clinicians on an Inpatient Adolescent Psychiatric Unit*.[35] Her survey study was particularly focused on capturing the perceptions of mental health counselors (eg, psychiatric aides and technicians) on team functioning and how satisfied these team members were with their level of input and involvement in team decision making. The results of her survey of 84 team members, including mental health counselors, physicians, psychologists, nurses, and social workers, indicated that one of the biggest barriers to effective function was that clinician

leaders didn't invite input from mental health counselors,[35] much like Dr P did not solicit input from HH. How can clinician leaders be more inclusive?

First, Dr P, presumably as the team leader, owes all members of the direct care staff strong leadership. Strong leadership cultivates a culture of cohesiveness and effective communication; it is a characteristic of success in highly reliable organizations.[36] Psychiatrists are, by education and practice, particularly skilled in building rapport, negotiating, understanding group dynamics, managing conflict, and prioritizing relationships.[21] Given these skills, they can be motivational and help guide the team toward mutually recognized objectives.[36] To do so, the leader must utilize the knowledge and skills of all those on rounds who are involved in patient care, including psychiatric aides and technicians, by soliciting their input, giving them voice, and supporting their position. It is notable that direct care staff appreciate the presence of psychiatrists on the floor with them in providing guidance, reassurance, and support.[37]

Second, psychiatrists as team leaders owe the psychiatric aides and technicians a strong response to violent incidents. Violent events decrease staff morale, increase staff turnover, and harm individuals.[21,37] Team leaders owe them, just as organizations do, an acknowledgment of experienced events and a consistent method for addressing these events with the provision of assessment, comfort, and support.

Third, physicians and team leaders owe their staff justice, just as organizations do. Physicians benefit greatly within health care organizations as employees, contractors, or administrators. In not hearing HH, Dr P makes the psychiatric unit a more dangerous place and agrees, if tacitly, with a system of inequality that puts workers earning low wages at risk by taking advantage of the fact that it would be difficult for HH to walk away, given the limited economic power held by such workers.[26]

It is within the ethical purview of physicians to advocate for essential, direct care employees to receive dignified salaries and other benefits that cover the necessities of life and good health: safe workplaces, stable housing, transportation, food, comprehensive health insurance, paid sick leave, and prospects for career advancement.

Justice as a Conclusion

Psychiatric aides and technicians have voiced their desire for safe environments, better working conditions, better compensation, higher regard, and being part of the team.[37] Organizations are ethically obligated to remove barriers to these voiced concerns by providing training and opportunities for education and tuition assistance that pave the way for career advancement.[38] These interventions increase productivity, improve morale, and offer direct care workers opportunities for a better life—that is, they open up possibilities of home ownership, appropriate health care for the workers and their families, and advancement opportunities.[26]

Organizations and team leaders are ethically obligated to make a commitment to strong leadership and to creating and maintaining a physically and psychologically safe workspace for patients and team members. They must address the inequalities that exist within the organization between those with high prestige and those with less, and, by doing so, they will confer their regard and respect for those on the front lines of psychiatric care and make the psychiatric unit a safer place.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians of Status Express Solidarity With Workers Earning Low Wages in Health Care?

Richard Parker, DPhil

Abstract
What clinicians of status owe health workers earning low wages has been changed by the events of the past 2 years of the COVID-19 pandemic, national racial reckoning, and increasing national income and wealth inequality. Reasons why clinicians of status should actively promote the interests of health workers earning low wages are numerous and urgent.

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Of all the forms of inequality, injustice in health is the most shocking and the most inhuman.
Martin Luther King, Jr[1]

A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
AMA Code of Medical Ethics[2]

Case

Several health systems' house staff members have unionized in recent years to address working conditions during residency program and fellowship training. Dr T, a third-year resident physician, has suggested that they have obligations to help other workers in the organization to unionize, too. Dr T convinced several other resident physicians, nurses, and other clinicians of status in the organization to join a rally outside a hospital entrance to draw attention to environmental services workers having not been paid overtime or hazard pay during the worst of the 2020-2021 COVID-19 pandemic. In response, some clinicians and organizational senior managers have suggested that rallies are not helpful to employees with lower incomes, that bad press is costly overall to the organization and community, and that those attending the rally should gather somewhere other than the hospital entrance.

Dr T and others respond by inviting them, other organizational senior managers, attending physicians, and members of the organization's Office of General Counsel to join the rallies scheduled at the hospital entrance during times when they're off duty. Rally speakers remind those listening about high-exposure risks of infection and injuries

that environmental services employees endured and suffered during the pandemic. Those within earshot of Dr T's and other rally speakers' calls consider whether to join the rally.

Commentary

The title question—how should clinicians of status express solidarity with low-wage workers in health care settings?—raises, in philosopher Bernard Williams' terms,[3] additional "thick" questions. Daily practices of customary roles in the health professions are deeply embedded with ethics, identity, politics, power, and economics in ways that demand consideration beyond whether one's actions or attitudes are "good" or "bad" in a local, specific context. As a recent scholarly summary of thick and thin ethical concepts explains:

> We don't evaluate actions and persons merely as good or bad, or right or wrong, but also as kind, courageous, tactful, selfish, boorish, and cruel. The latter are examples of thick concepts, the general class of which includes virtue and vice concepts such as generous and selfish, practical concepts such as shrewd and imprudent, epistemic concepts such as open-minded and gullible, and aesthetic concepts such as banal and gracious. These concepts stand in an intuitive contrast to those we typically express when we use thin terms such as *right*, *bad*, *permissible*, and *ought*.[4]

A challenge for clinicians and administrators in the case is to incorporate, diagnostically and prescriptively, the multiple thick-concept frames and claims at play in the case that go beyond the invitation to join a demonstration in solidarity with workers who earn low wages. In 2022, amid what a colleague has grimly begun calling "the COVID decade," the concept of solidarity among health workers has, in Williams' thick-thin distinction, both fresh complexities and pressing importance for situations beyond the one described in the case—a specific rally at a specific hospital over the wages and working conditions of specific employee groups.

Context

The first thick-concept layer is the larger yet powerfully immediate context presented by the COVID experiences we've lived through so far. We all can hope the pandemic will soon be over and, with it, daily additions to the more than 5 000 000 deaths worldwide as of October 2021,[5] as well as the continuance of our collective exhaustion, profound economic dislocations, vitriol and recriminations bred from misinformation and prejudice, and threats and divisions we can't seem to resolve, escape, or silence. Some have "weaponized" medicine and public health to fundamentally delegitimize science and facts. To the list of COVID ills just named, we must add a second thick context layer: America's explosive, still-unfolding racial reckoning maelstrom (eg, George Floyd protests, the Black Lives Matter and defund the police movements, and critical race theory). At its heart, this reckoning is a demand for racial justice that requires solidarity with a laser focus on what many Americans count as the nation's "original sin" of slavery. Perhaps we can emerge from these experiences a better, wiser people and a better, more generous nation.

To America's racial reckoning we must then graft the thick context of America's other too-commonplace prejudices about gender, age, ability, and sexual identity, all capped by surging inequalities of income, wealth, mobility, and opportunity—gaps that have steadily grown larger over the past 50 years and were worsened dramatically by the Great Recession.[6] Our COVID pandemic has suddenly cast all those prejudices and inequalities in flashing-neon relief—in terms of who has been struck, who has lost jobs, who has lacked the basic material resources to survive not just the virus but the

massive economic harm it has caused. Now consider the thick context of our collective responses so far to these challenges—some of which seem powerfully affirmative. For one, our government—under both parties—has responded in ways and at a scale unimaginable even during the Great Recession. The pandemic prompted 2 US presidents, Congress, and the Federal Reserve to provide gargantuan sums—almost $14 trillion as of May 2022[7]—to millions of individuals, families, communities, businesses, state and local governments, financial markets, schools, churches, and nonprofits.

Nevertheless, this pandemic has increased those underlying fundamental inequalities asymptotically. That's partly because much of what government has done so far is temporary—and was designed to be. Right now, Washington is locked in a bitter partisan struggle over longer lasting solutions, their nature (public or private) and scale, spending and taxation, who will benefit, and who will pay. In truth, what those solutions will be and how effective they will be is in part unknown. What we do know is that before COVID, the 400 richest Americans—the *Forbes* 400—were wealthier than 64% of US households.[8] Our COVID economy then caused the 400's wealth to soar a further 40% to $4.5 trillion in less than 18 months.[9] Meanwhile, nearly half of American families have told researchers that they lack even a modest $400 in ready savings in case of financial emergency.[10]

Some of what's been done so far nonetheless can be characterized as dramatic, breakthrough measures of social solidarity that will leave enduring marks: 2 rounds of government checks sent to almost all Americans, additional aid sent to families with children, and hundreds of billions of dollars in forgivable loans to small businesses and local governments meant to keep them open and their workers paid. Add to these actions by government remarkable private-sector decisions taken by scores of the nation's largest companies to raise wages—including Amazon, Walmart, and Bank of America, which in 2021 raised their starting hourly wages to $18, $16.40, and $21, respectively[11]—decisions that are capable of reducing poverty among the working poor. Moreover, from individuals and nonprofits simultaneously have come dogged and granularly focused aid of all sorts, from food banks to free clinics to supplemental tutoring and childcare, much of it seeming to arise almost spontaneously, and all of it all meant to ease the pain so many are feeling.

Yet, in the midst of all this, there is the overarching thick context of our poisonous national politics—and our apparent collective inability even simply to talk with one another. I've no wish to sound Pollyanna-ish here: American politics has never been a Norman Rockwell painting or a kumbaya affair. But January 6th in Washington should have made clear to us all that we've entered a time that's unusually dangerous—dangerous not just for a candidate or party or an election but for the health and even the survival of democracy itself.

Health Care and Thicker Challenges

How, given all that's just been outlined, should clinicians or managers think about, and engage with peers about, the matter of solidarity with health care workers earning low wages when so many issues are enmeshed in each of these thick contexts I've named? I quite understand concerns of some that demonstrating isn't professional or that demonstrating at a hospital entrance is inappropriate or that bad press potentially poses greater risks than benefits. Indeed, I once might have urged clinicians and managers to initiate more conversations, polite and rather low-key but earnest, with a procedural focus on fairness and rebalancing competing local claims (common to all large

institutions) between wages, revenues, and overall costs. Workers, after all, have a right to organize—and we all have a legally protected right to our opinion (even if that right is far more constrained in private institutions than public ones).

But encouraging such conversations risked not looking beyond immediate local circumstances and institutions: Is the workplace treating all employees with a fairness we can agree on? What's needed that would make it "fairer"? Those conversations would not have particularly challenged the basic hierarchy in the institution or managerial privilege or the relative isolation of the institution from the world around it. In other words, I'd have given my colleagues cautious but determined encouragement in voicing their concern about their colleagues' low wages and unionization as one partial solution.

Now, however, I think the contexts and scale of what we face—and what's called for—are quite different. We are at a major, multifaceted societal turning point whose scale far exceeds simple pay-and-benefit issues at specific institutions. Let me be clear: answering the question of how clinicians or managers should think about or promote solidarity with health care workers who earn low wages is of profound importance—not just for clinicians and their coworkers who earn low wages, but for the nation and its future. The concerns, so expectable in "normal" times, that "rallies are not helpful," that bad press is "costly overall to the organization and community," and that those attending the rally "should gather somewhere other than the hospital entrance" seem almost naive in terms of understanding the current moment.

Thanks to massive news coverage of frontline medical workers, the public is acutely aware of the care crisis that COVID created—and the unfair ways in which medical personnel at all levels have paid for it. No week in the past 18 months has gone by without front-page newspaper and magazine stories or lead TV news reports about it. And with that intensive reporting of personal heroism as well as the suffering of medical personnel has come stories about low wages and unsafe working conditions. Those stories have also, because of the moment we're in, tied those challenges for frontline medical workers to race, gender, and occupational status in ways that amplify calls for racial justice and solidarity. In a 2021 poll, over 70% of Americans—irrespective of gender, race, or political party—expressed trust in doctors and nurses, but only 25% said the same of hospital executives.[12] At the same time, a majority of Americans polled considered nurses (and implicitly caregivers earning lower wages) underpaid.[12]

Outbreaks of labor unrest at hospitals and health care systems over wages, benefits, and working conditions are growing around the country: nearly half the strikers in America in 2021 were health care workers,[13] with Kaiser's walkout of thousands of workers being the most visible so far of such actions across the country.[13] The ongoing effects of these actions are potentially enormous: the health sector will experience continued growth, adding some 3.3 million new jobs between 2020 and 2030, according to the US Bureau of Labor Statistics.[14] The executive branch has moved swiftly to make leadership at the National Labor Relations Board more union friendly, and a Senate Committee has before it the PRO Act, which would significantly increase unions' ability to organize.[15] Management and its labor lawyers and consultants take this all quite seriously. A recent private advisory memo for health care executives led off its 8-point "action agenda" with warning #1: "Get your union avoidance plan in place."[16] The low wages of some health care workers that give rise to their demands—including for higher wages and unionization—are documented in a recent Brookings study. It found

that the median wage in 2019 of the 7 million workers in health care support, service, and direct care was $13.48 per hour, with home care workers being paid nearly $2 per hour less—neither a living wage.[17] More than 80% of these workers were women, 46% were Black or Latino, a fifth lived in poverty, and more than 40% relied on some form of public assistance.[17] Clinicians' solidarity with coworkers earning low wages today is thus far more urgent than it was before COVID. It calls for much closer examination and weighing of the problems America's largest industry[18] is facing. Although solidarity entails concrete near-term actions to address wages and working conditions, beyond that, how to promote solidarity is a conversation the profession desperately needs even if there is no immediate end to problems that have no simple solutions.

Good clinicians don't shy away from challenges of complexity when treating patients. They shouldn't then shy away from the same in addressing the ways coworkers are treated in their profession. There are the obvious existing guidelines: the Hippocratic Oath's "first, do no harm" principle and the American Medical Association's injunction that physicians "participate in activities contributing to the improvement of the community and the betterment of public health."[2] To actualize those injunctions, however, entails recognizing what Williams calls thick contexts that situate decisions—and what might seem straightforward calls of right and wrong for professionals—in larger contexts. Recognizing how to navigate larger ethical frames, each one with its own often strongly emotive terms and arguments, is essential for arriving at an ethical (rather than a correct) conclusion. Such recognition does not provide a conclusion; what it can do is create the ground for a conclusion seen as ethical by those who must live with its consequences.[19]

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Health Care Organizations Protect Personnel in Environmental Services and Related Fields?

Abigail E. Lowe, MA and Shawn G. Gibbs, PhD, MBA, CIH

Abstract
This commentary on a case discusses oft-overlooked roles of health care organizations' personnel in environmental services and related fields, such as waste management. Such personnel are not protected in the same ways frontline clinicians are, although their risk of exposure to pathogens in the course of their work can be high. This article describes why such personnel should be included in planning personal protective equipment access and in administrative and engineering operations concerning infectious disease emergence, containment, and management.

Case

Ms A is a hospital administrator at RR Hospital in the United States. RR Hospital is a 150-bed community hospital in an urban environment. Dr V, an infectious disease physician, oversees RR's Department of Hospital Epidemiology and Infection Control, which includes developing infection prevention and control (IPC) protocols and planning for pandemics. A novel strain of influenza that is airborne transmissible has emerged and is beginning to impact the entire United States and RR Hospital.

Effective IPC plans must include hospital personnel in environmental services and related fields ESRF)—who enter, maintain, repair, and clean all areas of the hospital, including patient's rooms—and waste management staff in protocol development, but Dr V realizes the IPC plans were not created in consultation with the waste management firm with which RR Hospital contracts. The contract stipulates that waste management workers will enter hospital rooms and empty biohazardous containers and that RR Hospital must provide gloves. For an airborne transmissible pathogen, however, gloves are insufficient personal protective equipment (PPE); N95 respirators are also needed.

RR Hospital does not have enough N95 respirators for the waste management firm's workers, however, due to national shortages. The waste management firm does not have an N95 supplier, as respirators were previously not needed, and they cannot secure one. Ms A and Dr V are concerned about the safety of waste management workers, who, in addition to not having N95s, have little training in IPC. Ms A has neither extra staff nor available supplies but recognizes the importance of protecting all

workers, especially RR's lowest paid workers from historically marginalized communities. Ms A and Dr V wonder what to do.

Commentary

Health care workers (HCW) are typically familiar with risks of caring for patients with infectious diseases. They also typically benefit from training on how to properly implement evidence-based IPC protocols—especially for emerging infectious diseases—that bolster the safety of HCWs, patients, and communities. Those working to safeguard health have social and institutional obligations to ensure the safety of not just HCWs but of everyone integral to IPC and containment.[1] During the COVID-19 pandemic, IPC guidance tended to emphasize the importance of adequate protections for some frontline workers but often neglected personnel in other key roles.[2,3] Workers in ESRF within hospitals are sometimes relegated to contractor status, which prohibits them from participating fully in an organization's employment benefits (eg, training, insurance, paid time off) and can entail receiving lower pay and not having their health and safety needs prioritized, despite their risk of COVID-19 infection being higher than that of frontline clinicians.[4] In addition to inequitable protection, many of these workers belong to historically disenfranchised groups, whose minoritized status can be compounded by lack of or inadequate insurance, limited paid time off, food insecurity, and housing instability.[5]

The literature addressing protections for workers in ESRF in hospital settings during emerging infectious disease outbreaks is underdeveloped.[6,7] Current scholarship provides a strong rationale for prioritizing HCWs in emerging infectious disease preparedness,[8] but in order for workers in ESRF to be fully protected, the following requirements must be met:

1. Health care organizations must be proactive about emerging infectious disease threats and inclusive about response planning.
2. Health care organizations must treat workers' risk equitably, regardless of their status as frontline clinicians or contractors, even when contractual documents do not consider the changing environmental conditions of infectious disease transmission risk.
3. Infectious disease experts must recognize that workers in ESRF are key stakeholders in planning because they have essential roles in organizational functioning and IPC execution prior to and during infectious disease outbreaks.

This commentary discusses the oft-overlooked role that health facility workers in ESRF can play in IPC planning for an emerging infectious disease and its implications for health justice.

Safety Culture

The US Occupational Safety and Health Administration (OSHA) identifies hospitals as one of the most hazardous places to work,[9] with health care support workers suffering an increasing number of fatal occupational injuries between 2017 and 2020 and nursing aides and workers in ESRF within hospitals suffering a substantial proportion of injuries and illnesses resulting from health care employment.[10,11] Inequity in death and illness among workers is due to interrelated factors (eg, the nature and hazards of jobs performed, baseline health conditions, socioeconomic determinants).[7] The COVID-19 pandemic illuminated these workers' exacerbated vulnerability.[12] For example, frontline workers likely have the highest risk of exposure to SARS-CoV-2, and older workers with

comorbidities and co-exposures are at higher risk of adverse clinical consequences of COVID-19 infection.[7] HCWs knowingly bear increased risk of infection, but, generally, workers in ESRF in hospitals do not explicitly agree to, are not compensated for, and are not trained to protect themselves from increased risk.[13] In the case, Dr V realizes that, in the current IPC protocols, cleaning and waste removal fall to hospital environmental services and waste management staff, although such workers were not invited to participate in planning and were not offered training to ensure their readiness to respond to an emerging infectious disease threat or increased risk of harm.

For a safer environment to be established and maintained, planning must include workers in ESRF within hospitals,[14] especially planning for hospital preparedness, which is central to responding effectively. Despite their key role in ensuring containment, workers in ESRF, such as cleaning staff, are seldom mentioned in the literature on IPC and industrial hygiene guidelines.[15] This neglect and lack of inclusion of ESRF workers in the guidelines results in less effective IPC practices.[15]

As the novel disease is understood to be an airborne threat, Dr V receives notice that the waste management firm employees need PPE and training. Both Dr V and Ms A realize that their policies and protocols did not account for PPE shortages and the uncertainty that accompanies an emergent, highly infectious disease. Dr V must know that, for this specific disease, the waste generated from patients with the novel influenza strain has been categorized by OSHA and RR Hospital's home state as a regulated medical waste, which requires handling according to the OSHA Bloodborne Pathogens Standard[16] but does not require the use of a respirator for the tasks of cleaning or emptying the sharps disposal containers. However, the patient care room environments in which waste is generated are no longer standard, as they now contain an airborne virus that requires the use of a respirator. And as the contract never intended these workers to enter rooms where patients were under airborne isolation protocols, RR Hospital's contract waste management workers did not undergo fit testing for respirators. More generally, such workers are not required to be consulted in the development of an exposure control program.[16] Had workers in ESRF been considered in the development and execution of the IPC protocol, the lack of PPE and fit testing might have been identified earlier—prior to the protocol's implementation when these deficiencies endanger workers and the community.

Ethics, Equity, and Safety

Workers who earn low wages have suffered disproportionately high morbidity and mortality rates during every US influenza pandemic.[4,17,18,19,20] In the first year of the COVID-19 pandemic, structural discrimination created inequities in risk of exposure and health outcomes of workers who earn low wages, such as home health aides.[21] These frontline workers were harmed by the lack of adequate worker protection policies, health care access, and preparedness efforts centered on their roles.[2,10,22,23] As a result, concerns about the health and safety of workers in ESRF were reactive, which had the effect of compounding existing health inequities and leaving many workers without essential protections that all workers who risk their health to do their job deserve. Despite a history of health injustice in previous pandemics and public health emergencies and calls from scholars to attend to health equity in pandemic planning,[18,24] the COVID-19 pandemic mirrored results from previous epidemics and pandemics, as workers in low-wage, frontline occupations suffered disproportionate risk of exposure and poor health outcomes.[21,22]

Health justice has both procedural and distributive implications. Procedural health justice requires transparency and accountability to promote the trust of those burdened with additional risk of exposure during an emerging infectious disease outbreak.[25,26] Distributive health justice necessitates the equitable distribution of resources and burdens informed by the consideration that an emerging infectious disease can disproportionately burden some groups, including workers in ESRF who earn low wages and often belong to historically disenfranchised groups.[5]

Finally, solidarity acknowledges the interdependence of community members in an infectious disease outbreak—a shared vulnerability that should incite a shared commitment to one another.[27] Solidarity also honors the dignity of and respect for community members, regardless of their individual productivity, abilities, or social standing.[28]

In the case of RR Hospital, procedural and distributive health justice would require the institution to ensure equity in the development of IPC policies and in protections for workers' health and would acknowledge that these workers becoming sick might have severe economic consequences for themselves and for the health of communities in which they reside, as these individuals might have fewer resources (eg, paid time off, health care, financial reserves) to address such an illness. The hospital should anticipate risks to the safety of workers in ESRF within hospitals, including contractors, as these risks can be controlled if given sufficient priority.

Organizational Commitment to Safety

Appropriate planning for the hospital should include engaging ESRF stakeholders within the hospital concerning PPE and administrative and engineering controls before an emerging infectious disease threat. Failure to include these workers in IPC planning is indicative of barriers within an institution to safeguarding their health.[15] Health care administrators like Ms A must consider all workers, including contract workers, in their IPC plans for responding to known or suspected highly infectious diseases. Established contracts and protocols often don't consider changing environments and increased risks associated with highly infectious diseases, so it is imperative that, in the face of these new environments, health care administrators reevaluate contracts and protocols that serve to protect both individuals and public health. Protections for these workers are foundational to the health ecosystem—they safeguard the health of patients, health care workers, and communities.

Straightforward, thoughtful solutions do exist. The hospital could both conserve N95s and better safeguard waste management workers' health simply by asking HCWs to pass the waste containers to the waste management workers who are outside the room. However, lack of contractual protections requires institutions to negotiate the structural barriers that impact worker health prior to an infectious disease outbreak.

Conclusion

In the face of an emerging infectious disease threat, IPC planning and response must be anchored in the public health values of health and safety, justice and equity, and interdependence and solidarity. Had workers in ESRF been included in RR hospital's preparedness efforts, the hospital might have had a chance to plan for the challenges of worker protections in advance instead of facing these issues for the first time in the middle of an emergency. Going forward, emergency and pandemic preparedness

planning should consistently integrate HCW and workers in ESRF alike out of an obligation to safeguard the health of all workers and the community.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Physician Leadership and Advocacy for Team-Based Care

Swapna Reddy, JD, DrPH, MPH, Jessica Todsen, MD, and Yeonsoo Sara Lee

Abstract
Team-based care is a strong focus and narrative in medical and health education and within health care systems. Yet it is essential to consider that there are vast differences in power, education, compensation, and job security among team members in most health professional teams. How should clinicians of status play a role in advocating for lower status members of their health care teams, and why is that role important in improving equity within clinic walls and equity and better patient care for the communities they serve?

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Roles of Physician Leaders

At its core, team-based care is providing health services to "individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers … to accomplish shared goals within and across settings to achieve coordinated, high-quality care."[1] This approach is an attribute of patient-centered care.[2] Team-based care, which can follow different paradigms and involve different stakeholders, has been shown to improve clinician workflow and the quality (via patient safety and satisfaction), effectiveness, and value of patient-centered care when integrated intentionally.[3]

Teams require leaders, but what exactly does the term *physician leader* entail? The American Medical Association (AMA) defines physician leadership as "the consistent use of a physician's leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of contributions needed to help patients achieve their care goals."[4] In this context, the term *team members* applies to those with high levels of direct clinical care such as "physicians, nurses, physician assistants, pharmacists, social workers, case managers and other health care professionals."[4]

Per AMA guidelines, the physician's role is to understand and utilize the strengths of each team member to create a high-functioning team. But is that enough? While health care team members may work in close physical proximity, they often—even when

working in the same team and caring for the same patients—inhabit starkly prescribed places in the traditional health care hierarchy, which, historically, has been systemically racialized and gendered. Within this system, physicians tend to maintain the highest status and position of power.

How can physician leaders support colleagues who are not accorded the same level of institutional power and status? We argue that physician leaders of the future should utilize their status to advocate on behalf of their health care team members—especially those who occupy lower positions of power and status—in the interests of justice and for the benefit of clinical practice, patient care, and medical education.

Who Makes a Health Care Workforce?

Within the larger health care "team" there are many smaller workforces. For example, core teams include nurses, dentists, pharmacists, doctors, assistants, and case managers; ancillary teams include cleaners and domestic staff; and support services include secretaries and executive management.[5] As such, a variety of specialties, educational backgrounds, compensation levels, and job security levels are represented in the health care team.

Racial and ethnic differences also starkly divide members of health care teams. While health professions are less racially and ethnically diverse than the general US population,[6] they are becoming increasingly racially and ethnically diverse, although the majority of that diversity has occurred within occupations that require less education and training—such as aides, assistants, and technicians—and, as a result, offer lower wages, job security, status, and power.[7] Workers vital to the effective functioning of a health care organization (eg, nursing assistants, phlebotomists, medical assistants, housekeeping and environmental services workers, and cooks), who are often women and disproportionately people of color, have a median pay of $13.48 an hour[7]—short of a living wage. According to the US Bureau of Labor Statistics, home health aides had a median annual wage of $29 430 in 2021, which was lower than the median annual wage for all occupations ($45 760).[8] More generally, workers in home health and personal care, among the fastest-growing occupations, earn a median hourly wage of $11.57; 20% of these workers live in poverty, with over 40% relying on some form of public assistance or safety net program.[7] While the lower pay of health support workers coincides with their lower level of education and training—and inequitable access to said education and training—this pay differential has real implications individually, in the workplace, and within teams that affects personal finances and family security, job stability, communication, trust, respect, teamwork skills, and a positive team attitude.[9]

Physicians as Advocates

Given the importance of team-based care and the existence of disparities within the health care team, we argue that physicians have a duty not only to coordinate among team members but also to advocate for them as part of helping patients meet their care goals. Advocating for improvements in working conditions and benefits and including the voice of health care workers with lower wages and less power will not only benefit those workers directly but also benefit patients and communities as a whole. Although workers with low incomes and little power have not been included in many studies of health care safety,[10] studies of high-reliability organizations in other fields show that buy-in is required from the vast majority of workers to create a culture of safety.[11] A true team-based care model allows everyone on the team to reach their full potential, with the result that patients experience excellence in all their interactions with the health care

system. Expanding this approach to consistently include more team members—such as transport staff, medical assistants, and home health aides—is necessary. Modern health care is enormously complex, and if any part of the system is disturbed—be it the lack of paper in an emergency department or no one to transport patients to a procedure—patient care suffers.

Luckily, physicians already have many tools that can be used in these efforts, as existing advocacy strategies can inform physician support for health care workers with low wages and little power. On a legislative level, physicians have experience advocating for fair wages for themselves and other direct-care team members. The AMA has multiple efforts targeted toward higher physician payment rates,[12] and physicians have also voiced opposition to proposed legislation to limit nurse wages.[13] Physicians could take these initiatives one step further and advocate for better wages and working conditions for health care workers with low wages and little power, especially given that many of these workers live in poverty.[7] For instance, while supporting their case for hazard pay, one group of residents and fellows also argued in favor of hazard pay for all frontline health care workers.[14] While advocating for proper personal protective equipment (PPE), physician groups have not limited their efforts to physicians but instead extended them to all health care workers.[15]

Advocating for workers with low wages and little power could have benefits in addition to improving working conditions of those employees. One physician research group evaluated its organization's *Clostridium difficile* infection prevention strategy through the lens of environmental services workers' experiences, which allowed it to identify additional strengths and weaknesses of the program.[16] Quality improvement projects require interdisciplinary teams, and "the people who do the work need to be the ones to change the work."[17] Environmental services workers are directly involved in implementing *Clostridium difficile* prevention protocols,[18] so formally including these workers in interdisciplinary teams responsible for quality improvement projects could facilitate discovery of new solutions to a problem that not only endangers patient safety but also unnecessarily increases health care costs.[19]

Equity for health care workers with low wages and little power will also result in increased equity for the groups and communities to which they belong. As racial and ethnic minorities tend to have higher representation in low-wage and low-power fields, advocating for these workers also entails advocating for the historically disadvantaged communities to which they belong. Further incorporating these workers' voices and perspectives in advocacy efforts to improve their professional and financial security could facilitate these workers' efforts to better connect health care systems to hard-to-reach communities since they would perceive themselves to be valued and vital employees of their organizations.

Medical School Leadership Training

Improving and changing our health care system involves educating and training physician leaders of the future to view their responsibilities more holistically.[20] Education,[21] training, and exposure to the expanded role of physician leadership can be highly instrumental in developing future physicians' understanding and appreciation of health care teams and acceptance of their role as an advocate for that team and the larger community served.

Some medical schools already have formalized coursework in equity, advocacy, and team-based care, along with interdisciplinary sessions involving students and practitioners across the health professions. Examples include the Certificate in the Science of Health Care Delivery required of all medical students at the Mayo Clinic Alix School of Medicine, which includes in its curriculum physician leadership, team-based care, health care disparities, and policy advocacy, and the University of Texas at Austin Dell Medical School's incorporating interprofessionalism, leadership, and social determinants of health concepts in medical education.[22,23,24] These programs are innovative and necessary. As they grow and mature, these programs could include the importance of physician leadership and advocacy for various members of the health care team so that students enter the workforce ready to do this essential work.

COVID-19

The COVID-19 pandemic has highlighted the demands placed on frontline health care workers as well as the disparities in outcomes experienced by communities of color in the larger society. The pandemic has demanded an "all hands-on deck" approach and unremitting commitment to patient care from health care teams and workers across the nation for over 2 years. The need for a high-functioning and coordinated health care system is apparent like never before. Yet for health care team members with low wages and little power, the strain of the pandemic, inadequate safety measures, and burdensome caregiving responsibilities, together with their desire for career growth and better compensation and benefits, has led to high rates of burnout.[25] Home health care workers, who were vital during the pandemic in providing care outside the hospital setting to patients who were elderly or disabled, not only continued to experience lower wages but also reported delays in receiving PPE.[26] Environmental services workers, who are directly responsible for sanitizing hospitals during a pandemic, have described not receiving hazard pay[14] and feeling "overlooked and deprioritized, even expendable."[7] Advocating for workers with low wages and little power, especially people of color and populations hit hardest by COVID-19, offers an important opportunity to increase these workers' trust and to educate and assist members of their communities in navigating health care during the pandemic.

Conclusion

As we consider how to move toward the health care system we need, it is critical to consider the realities, needs, and power dynamics of those who make up that system. As professionals of high status, physicians must utilize their status and voice to improve the conditions and status of colleagues who compose larger health care teams. For this to happen, we must expand the concept of physician leadership to include advocacy for not only the communities served—especially those that are lower income—but also other health care professionals—specifically, those who earn lower wages and occupy a lower place in the hierarchy of the health care system. Such advocacy requires innovative, bold, and brave steps forward in education, workplace norms, and culture—and physicians are up to the challenge.

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HEALTH LAW: PEER-REVIEWED ARTICLE

A Case for Federal Labor Legislation to Protect Underpaid Home Care Workers

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Abstract
The National Domestic Worker's Bill of Rights Act aimed to remedy nearly a century of labor and health inequities facing a majority of the home health workforce—including home health workers, personal care aides, and professional caregivers—who are women of color and immigrants. Although the bill did not pass, the National Domestic Workers Alliance and its affiliates continue to organize a new labor movement inclusive of home care workers that supports federal legislation and adequate labor protections for their members, particularly in right-to-work states like Texas and in municipalities where hazardous working conditions and low wages contribute to the perceived disposability and devaluation of care labor. Home care workers require federal labor protections that will hold states accountable for the health and well-being of this essential workforce.

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Workers Who "Make All Other Work Possible"

On July 15, 2019, Vice President Kamala Harris, then senator of California, introduced the Domestic Workers Bill of Rights Act (DWBRA). Although the bill did not pass into law, it highlighted that domestic workers are essential to the functioning of existing US economic structures, stating: "Domestic work makes all other work possible.... Without the millions of domestic workers caring for children, seniors, and individuals with disabilities, and cleaning homes, much of the economy would come to a standstill."[1] This quotation underscores the centrality of domestic work to the US economy. Simultaneously, it conflates domestic work and care work. Labor advocacy organizations, such as the National Domestic Workers Alliance (NDWA), use the term *domestic worker* to refer to any individual who provides care labor in the home, such as nannies, housecleaners, or home care workers.[2] Labor historians Eileen Boris and Jennifer Klein explain that this conflation historically led to the exclusion of women and racialized care laborers from protections provided to skilled workers outside the home.[3] The history of labor organizing suggests the need to acknowledge home care workers as a skilled labor force distinct from domestic workers who were left out of New Deal labor

protections, such as "old age insurance, unemployment benefits, collective bargaining, minimum wages, maximum hours, and other labor laws."[4] For the purposes of this article, I consider domestic workers to be care laborers—all of whom should benefit from federal labor protections—and I will refer to home care workers broadly when discussing home health workers, personal care aides, and professional caregivers.

Texas serves as an example of a state with a critical need for home care workers that fails to provide adequate labor protections and living wages to this vulnerable class of workers. With a focus on Texas, I argue that Congress' failure to pass the DWBRA reinforces our nation's and individual states' devaluation of home care, along with the women who provide their labor to care for others. As a nation fully dependent upon various forms of domestic care labor, we owe the millions of home care workers federal legislation that provides adequate labor protections and a living wage for urgently needed care labor and services in right-to-work states like Texas that undervalue this essential workforce.

Texas

Without home care laborers, many US workers could not meaningfully participate in the capitalist economy. In recognition of the value that in-home care labor offers, the DWBRA stipulated a temporary increase in federal medical assistance for Medicaid-funded services that home care workers provide.[5] The bill defined medical assistance as home or community-based services through federal or state programs, self-directed personal assistance, home health care, rehabilitative services, personal care services, and care services for functionally disabled elderly individuals.[6]

In states like Texas that rejected federal funds to expand Medicaid through the Patient Protection and Affordable Care Act of 2010,[7] the passage of the DWBRA would have expanded access to quality home and community-based services (HCS) for individuals currently on years-long waitlists. To put the magnitude of waitlists in perspective, the Texas legislature added 542 new HCS enrollment slots in the 2022-2023 legislative biennium for 108 838 waitlisted residents as of March 2022, with nearly 1 in 3 people waiting 10 or more years for services.[8] Many families who need HCS cannot afford to pay the cost out of pocket and resort to hiring home care from a "shadow economy" of mostly women of color and immigrants who may be undocumented.[4]

In states such as Texas, where right-to-work laws undermine labor unionizing and fair wages and where home care labor is significantly undervalued, a state-by-state approach to care labor protections can lead to lower wages and fewer protections for an already vulnerable class of workers. An investment in HCS for low-income and working poor families who need quality care in the home would also be an investment in the workforce of professional caregivers and home care aides historically excluded from labor protections that other US workers receive.

Protections of a New Labor Movement

Wage protections. Labor activists and lawmakers intended for the DWBRA to bridge the gender and racial equity gaps for domestic workers that the Fair Labor Standards Act (FLSA) of 1938 and its amendments created. The FLSA as originally passed excluded domestic workers from federal labor protections, such as a minimum wage and overtime pay afforded other US workers.[9] New Deal Era legislation thus denied home care workers protections when lawmakers identified them as domestic workers, citing the intimate nature of work carried out within the home that could not easily be regulated.[3]

A significant number of domestic workers in the South were Black women, adding a gendered and racial component to the exclusion of this group of workers.[3] A later amendment (1974) provided coverage for "domestic service" while still explicitly excluding some home health aides and professional caregivers deemed companionship service providers.[9,10] Thus federal legislation, such as the DWBRA, is needed to address historical exclusions that continue to affect mostly women of color and immigrant workers today.

Worker safety. The DWBRA also specifically addressed the health and safety of domestic and home care workers. The bill would have mandated that employers make educational materials on safety requirements available to individuals using toxic cleaning products.[11] The safety measures recommended the use of nontoxic cleaning products for daily use in order to avoid adverse health effects.[11] Long-term health consequences and injury on the job are major concerns for the NDWA, the leading labor advocacy organization for home health workers and professional caregivers in the United States, including the right-to-work state of Texas.

Collective bargaining. Care labor organizers continue to face barriers when advocating for home care workers on a state-by-state basis. Right-to-work laws limit workers' potential collective bargaining with the state that could lead to greater labor protections and safety regulations for home care workers hired through Medicare- and Medicaid-funded home care agencies. Moreover, the US Supreme Court decision in *Harris v Quinn* (2014) diminished the power of collective bargaining for state-funded workers—defined as "quasi-public employees"—who provide home care services by effectively rendering all states a right-to-work state for the home care workforce.[12] Due to government pay structures that fund home care services, home care workers' ability to collectively bargain directly with state governments remains critical to their labor organizing success.[4]

Political motivation could be one reason the NDWA and other labor advocacy organizations employ the umbrella term *domestic worker* in their literature to avoid the federal limitations of union organizing placed on home care workers at the state level. Domésticas Unidas (DU), a San Antonio-based NDWA affiliate, translates its name in English as "Domestic Workers United."[13] The organization offers trainings for home care workers who provide eldercare, child care, and home cleaning services. DU's labor organizers teach proper techniques for avoiding workplace injury, cleaning with nontoxic chemicals, and employing overall workplace safety.[13] DU also provides workshops that teach labor rights and how to negotiate contracts with employers to include a living wage,[13] a crucial skill for vulnerable home care workers in need of federal labor protections.

Why Home Care Workers Need Federal Labor Protections

The NDWA contributed many of the protections included in the DWBRA meant to end the devaluation and perceived disposability of its members who provide in-home care labor. For nearly 2.5 million domestic workers in the United States,[14] 90% of whom are women,[15] the DWBRA aimed to rectify unevenly applied labor laws by state for the country's fastest growing workforce.[15] Estimates projected that nearly 1.2 million home health aide and personal care aide jobs would be added between 2016 and 2026,[15] leading to growth rates of 47.3% and 38.6%, respectively.[16] The bill emphasized the disproportionate number of women of color and immigrants in these positions who faced added barriers,[17] making them a particularly vulnerable class of workers. The

NDWA and its affiliates serve as champions for our nation's essential home care workforce, highlighting the need for federal labor protections that prioritize the health of workers, safety regulations, and living wages.

In 2012, the NDWA published the report of a survey, "Home Economics: The Invisible and Unregulated World of Domestic Work," which examined poor working conditions and health hazards that domestic workers, including home care workers, experience on the job.[18] The respondents consisted of 2086 domestic workers surveyed in 14 metropolitan areas, including Houston and San Antonio, Texas. Analysts found that 50% of domestic workers surveyed reported the use of toxic cleaning supplies as a requirement of their position. Few employers provided protective gear, with respondents indicating that employers viewed such requests as "unreasonable" or "silly." Yet nearly one-third of workers who used toxic cleaners regularly reported skin irritation, and 1 in 5 indicated difficulty breathing. Additionally, 29% of caregivers reported work-related back injuries, and 38% of all domestic workers surveyed reported suffering from job-related wrist, shoulder, elbow, or hip pain within the previous 12 months. These staggering figures provide a glimpse into the rates of exposure to hazardous working conditions and injuries that result from a lack of protections for devalued domestic and home care workers viewed as part of a disposable workforce.

A state-by-state comparison of hourly wages for professional caregivers reveals that some states fail to financially invest in their home care workforces, with Texas being one of the worst offenders. Nationwide, the average wage of home health and personal care workers was $13.49 per hour, with an average annual income of $28 060 as of May 2020.[19] The average hourly wage increased 78 cents from the previous year's average of $12.71.[20] The 3 largest employers of home health and personal care aides in the country include California, New York, and Texas, respectively.[19] These 3 states are also the wealthiest according to state gross domestic product (GDP), with Texas having the second-highest GDP behind California, the most populous state in the nation.[21] Of the top 5 employers of home health and personal care aides, which also include Pennsylvania and Massachusetts, Texas has the lowest average hourly wage.[19] As the country's average home health and personal care aide wage rose in 2020, Texas's hourly wage decreased to $10.45 per hour from just $10.53 per hour in 2018, although it was up from $10.07 in 2019.[19,20,22] The state's 2020 average annual income for home health and personal care aides—$21 750—was also the lowest of the top 5 employers.[19] The next lowest average—$26 510—was Pennsylvania, which on average paid $1550 less than the national mean.[19] Of the top 10 metropolitan areas with the highest employment levels of home health and personal care aides in the country, the Houston-The Woodlands-Sugar Land area of Texas ranked eighth but had the lowest average wage of $10.15, down from $11 in 2018, although it was up from $9.81 in 2019.[19,20,22] This metropolitan area's average hourly wage was 30 cents lower than the state's already low average hourly wage in 2020 and $2.81 lower than Philadelphia-Camden-Wilmington, PA-NJ-DE-MD, the next lowest paying metropolitan area in the top 10.[19]

In sum, Texas, the second-wealthiest state in the country, greatly undervalues home care workers compared to peer states that employ similar numbers of workers. A comparative analysis of hourly wage trends from 2018 to 2020 shows a divestment in Texas home care workers rather than an increased valuation of their essential services, as over 100 000 eligible Texans wait for HCS.[8] Additional research is necessary to identify what factors may be driving down wages in the state, particularly in the Houston

metropolitan area. Regardless, the evidence clearly points to a devaluation of the home care workforce in Texas prior to the COVID-19 global pandemic. Additional research will also be necessary to understand how the pandemic affected home care worker and professional caregiver wages by state and nationally in order to bolster the case for federal legislation. We owe domestic and home care workers sweeping federal labor protections that hold states like Texas accountable for the safety of and living wages for its essential home care workforce.

Conclusion

I have argued in favor of federal labor protections for our nation's essential, yet underpaid, home care workforce. The DWBRA aimed to fill the historical gaps of the FLSA, but Congress' refusal to pass the crucial labor legislation has meant a lack of accountability in some states. Federal protections are paramount to ensuring home care workers' health, safety, and living wages in contrast to the devaluation and perceived disposability of their labor in a state like Texas, which pays some of the worst wages in the country compared to peer states. The NDWA and its affiliates, such as DU, work to fill the gaps in state-allocated labor protections as part of a new labor movement comprising domestic and home care workers across the country. The correlation between low-wage work and workplace injury[23] suggests that increased valuation of home care labor with adequate regulation and labor protections could lead to a reduction in home care work-related injuries. Future federal legislation must address the health, safety, and wage inequities facing home care workers nationally in order to hold states like Texas accountable for the protection of this essential workforce.

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AMA CODE SAYS

AMA *Code of Medical Ethics*' Opinions Related to What We Owe Health Care Workers Earning Low Wages

Danielle Hahn Chaet, MSB

Abstract
This article applies opinions in the AMA *Code of Medical Ethics* to organizational obligations and interprofessional collaboration in health care, especially concerning workers earning low wages. In particular, it examines what the AMA *Code* says regarding advocacy, discrimination, and collaborative care, as well as the ethical practice environment.

Introduction

The American Medical Association (AMA) *Code of Medical Ethics* offers guidance on topics that can inform physician team and organizational leaders' considerations of what is owed to health workers earning low wages. These topics include recognizing inequity among patient groups and physicians' responsibilities to marginalized patients and physician colleagues. The following examines what the AMA *Code* says about advocacy, discrimination, collaborative care, and the ethical practice environment.

Advocacy

When the AMA *Code* addresses physicians engaging in advocacy efforts, it focuses on the interests of individual patients and physicians' obligation to provide optimal care. (See opinions 11.1.2, "Physician Stewardship of Health Care Resources,"[1] and 11.1.4, "Financial Barriers to Health Care Access,"[2] for example.) When the *Code* speaks to political advocacy to promote systemic change, it merely states:

Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
(b) Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.[3]

This guidance highlights a physician's primary obligation to individual patients, even at the cost of benefiting patient populations or the health care system in the future. In other words, strikes or other large-scale bargaining tactics, which could be used to advocate for higher pay for workers earning low wages but could limit patient access to needed care, are prohibited by the AMA *Code*. However, it's reasonable to interpret this opinion as allowing bargaining tactics that are not expected to interfere with patient care. As we'll see below, other areas of the AMA *Code* encourage physician leaders of health care organizations to implement policies that support the workforce for which they are responsible.

Discrimination

In Opinion 1.1.2, "Prospective Patients," the AMA *Code* makes a fundamental statement that physicians must not discriminate against prospective patients based on protected class.[4] But in Opinion 9.5.4, "Civil Rights and Medical Professionals," the AMA *Code* also addresses not discriminating against individuals entering and moving through the medical profession.

> Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.[5]

Along the same lines, the AMA *Code* recognizes the effects of gender discrimination within the physician workforce in Opinion 9.5.5, "Gender Discrimination in Medicine."

> Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians.[6]

This opinion also outlines specific guidance for physicians to address gender discrimination.

> Collectively, physicians should actively advocate for and develop family-friendly policies that:
> (a) Promote fairness in the workplace, including providing for:
> (i) Retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family
> (ii) On-site child care services for dependent children
> (iii) Job security for physicians who are temporarily not in practice due to pregnancy or family obligations[6]

This guidance should be an essential part of any argument to protect all health worker colleagues, especially those of lower status earning low wages.

Collaborative Care and an Ethical Practice Environment

The AMA *Code* offers guidance on collaborative care for physicians working in health care teams that include health care workers who are not necessarily physicians, or even clinicians. In Opinion 10.8, "Collaborative Care," the AMA *Code* recognizes that "teams that collaborate effectively can enhance the quality of care for individual patients."[7] An effective multidisciplinary health care team, the opinion explains, requires an effective physician leader who facilitates decision making aimed at the end goal of efficiency within the group. The main responsibilities of this leader—such as understanding the other team members' skills and expertise; promoting core team values of honesty,

discipline, and commitment to continuous improvement; and generally fostering a team culture in which each member's opinion is heard and considered—are framed within the context of the team's effect on patient care and outcomes, again highlighting a physician's charge to prioritize patient interests.[7]

One can argue, however, that a team culture that upholds the core values of honesty and commitment to continuous improvement can only truly exist if those values are fully realized with respect to each individual team member. In practical terms, upholding these core values means that team leaders must respect and validate some team members' frustration with low wages and with working conditions that might differ from physicians'. To build trust within the team—and certainly to build commitment to continuous improvement—the most powerful team member—in this case, the physician team leader—must advocate on behalf of those colleagues who have legitimate concerns but no way of effecting meaningful change within the institution.

It's not just team leaders who have a responsibility to create better conditions of practice. Opinion 10.8 outlines guidance for physicians who hold leadership roles in the institution itself. These physicians have a responsibility to "advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills" and to "encourage their institutions to identify and constructively address barriers to effective collaboration."[7] Addressing legitimate concerns about less powerful colleagues' working conditions and motivating appropriate change certainly falls within this role.

Physicians in leadership positions can use the guidance in Opinion 8.5, "Disparities in Health Care," as a starting point. The opinion states that "stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways" and that one way physicians can fulfill their professional obligation to address inequity is to "examine their own practices to ensure that inappropriate considerations … do not affect clinical judgment."[8]

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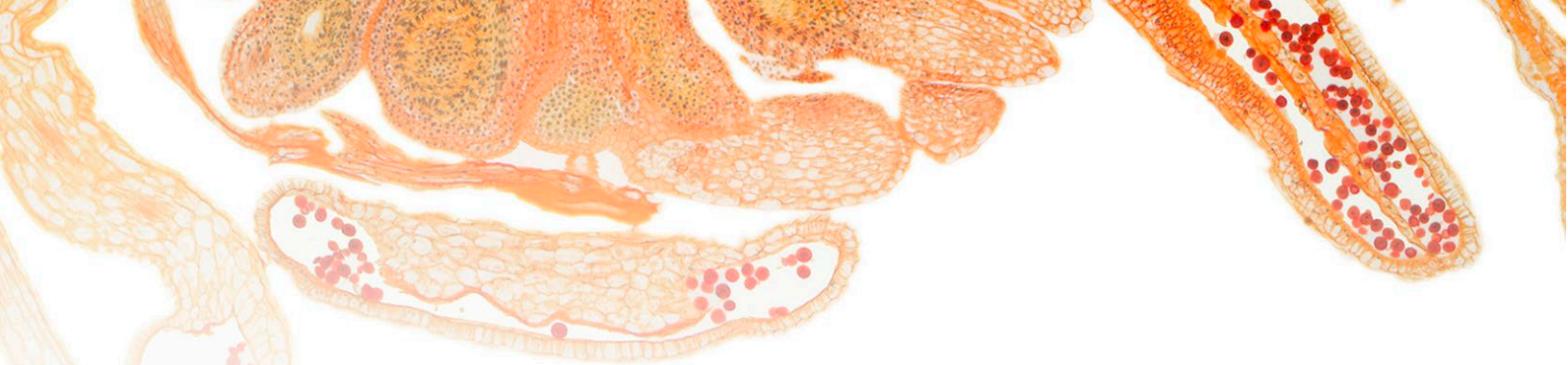

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POLICY FORUM: PEER-REVIEWED ARTICLE

Why Improving Low-Wage Health Care Jobs Is Critical for Health Equity

Mignon Duffy, PhD

Abstract
Health care workers earning low wages in the United States are positioned squarely at the intersection of class, race, gender, and migration fault lines. Commitment to health equity demands higher pay, improved benefits, and more workplace protections for these workers. Clinicians with higher status jobs must help dismantle stratifications created by racist, sexist, and classist histories of exclusion. Health equity is impossible without systemic and organizational responses to the needs of members of the health care workforce with low wages.

Intersecting Inequities in Low-Wage Health Care Work

The largest segment of health care—and the one that will add the most jobs—is long-term care for elderly adults with disabilities who live in private homes, assisted living communities, and institutions.[1] Direct care occupations—home health aides, residential care aides, and nursing assistants in nursing homes—make up the bulk of this workforce. Between 2010 and 2020, nearly 1.5 million jobs were added to direct care, and this growth is expected to continue into the future.[1]

This low-wage health care workforce in the United States sits squarely at the intersection of the fault lines of gender, race, and immigration, as well as class. These jobs are overwhelmingly held by women, who, in 2019, made up 91% of nursing assistants, 86% of home health aides, and 81% of residential care aides.[1] People of color, who make up 39% of the labor force in the United States, are heavily concentrated in direct care occupations: in 2019, 58% of nursing assistants, 63% of home health aides, and 52% of residential care aides were identified in US Census Bureau data as Black/African American, Hispanic/Latino, Asian/Pacific Islander, or other.[1] Immigrant workers are also overrepresented, constituting 31% of home health aides and 21% of nursing assistants and residential care aides but only 17% of the total labor force in 2019.[1] Within hospitals, low-wage direct care jobs are similarly dominated by women and people of color. In 2019, nursing assistants in hospitals were 86% women, 55% people of color, and 23% immigrant workers.[2]

There are also large groups of cleaning and food preparation workers earning low wages who are often not considered health care workers but who are vital to the work of hospitals and long-term care institutions. These health care support occupations are not as heavily feminized as direct care work: for example, women make up 59% of cleaning

workers in hospitals.[2] However, these jobs are among the most racialized in the sector, as 76% of cleaning workers in hospitals are people of color and 30% are immigrant workers.[2] We must take these support workers into account when thinking about how to promote racial equity in the health care sector.[3,4]

A commitment to health equity demands attention to these groups of workers, both as patients and as integral to the stratified modern medical enterprise, by dismantling stratifications created by racist, sexist, and classist histories of exclusion.

Health Workers Are Patients

In May 2021, the American Medical Association (AMA) released a strategic plan to dismantle structural racism and eliminate inequities in the health of patients.[5] At the risk of stating the obvious, the heavily racialized low-wage workforce within health care organizations are patients, too. Inadequate wages and unsafe working conditions in low-wage health care therefore create and reproduce health inequities by gender, race, and class, and addressing those injustices will require improving these jobs.

Wages in these segments of health care leave many workers living in poverty or in near-poverty conditions. The median hourly wage for direct care workers in 2020 was $13.56, and their median annual earnings were just $20 200.[1] In fact, 45% of direct care workers rely on some form of public assistance, including Medicaid for health insurance.[1] Among Black and Latina female direct care workers specifically, about 50% earned less than $15 per hour.[6] Maids and housekeeping cleaners in health care settings similarly earn low wages, averaging $32 000 a year in hospitals and $26 310 in nursing homes in 2020.[7] Socioeconomic status is a powerful predictor of disease and mortality, and living in poverty puts individuals at substantially higher risk for chronic disease, injury, and early death.[8]

In addition to experiencing poverty, low-wage health care workers are exposed to a range of other risks: biological agents such as viruses, toxic chemicals used in cleaning and sanitizing, heavy lifting of equipment and patients, physical and verbal assault, and high-stress conditions, including long hours and night-shift work.[9] Nursing assistants are more than 3 times as likely to experience workplace injuries than the typical US worker.[1] Attaining health equity requires mitigating the health risks of poverty and hazardous working conditions for this highly feminized and racialized group of workers within the health care sector.

"This Bridge Called My Back"[10]

From an ethical perspective, there is a related and perhaps even more compelling reason why medical professionals and health care organizations must confront stratification in the health care workforce as an equity issue. The economic status and social power of doctors and other medical professionals was built on exclusionary practices and racist and sexist cultural narratives. To borrow a phrase from the pathbreaking feminist anthology by Cherríe Moraga and Gloria Anzaldúa, women of color have long been forced to be the bridge to power and resources for other groups.[10] Health care workers earning low wages have been that bridge for medical professionals. Thus, a commitment to health equity requires examination of occupational stratifications created by histories of exclusion, reenvisioning the interrelationship of jobs within the health care sector, and addressing the cultural biases and structural inequities that persist.

While women were the primary caregivers for the ill in preindustrial times, the professionalization of medicine in the United States that began in the late 19th century systematically excluded women as physician jobs grew in number and prestige.[11] African Americans were also effectively barred from medical schools, residency programs, hospital staffs, and professional organizations (including the AMA).[12] The process of professionalization has been described as one of social closure, whereby members of an occupation erect barriers to entry in the form of education, credentialing, licensing, or membership requirements.[13] This process raises the social and economic rewards of the job in 2 related ways. First, there is a structural impact by restricting labor supply and enhancing demand. Second, there are "signaling" consequences, as professionals carve out a singular claim to expertise and quality service delivery.[13]

Physicians are widely considered the archetype of successful professionalization, a process led in large part by the AMA. Early physician advocates effectively erected barriers to entry through the development of extensive licensing requirements and moving medical education from an apprenticeship model to one embedded in formal educational structures. Through this process, medicine became highly credentialed, culturally associated with technical skills and scientific knowledge, and dominated by White men.[14]

White women activists, looking for opportunities for employment for daughters of middle-class families, carved out the niche of trained nursing as a "feminine" domain by focusing rhetorically on the moral and spiritual caring aspects of the job (despite the reality of hard physical labor for many nurses at that time).[15] Although Amitai Etzioni argued in the 1969 that nursing had not fully achieved professional status (he called a semi-profession),[16] trained nursing did establish some level of social closure through credentialing and education requirements. However, Black women (and other women of color) were essentially excluded from professional nursing well into the 1960s.[17] In the professionalization of both medicine and nursing, structural exclusion was complemented by cultural constructions of the nature of the job that emphasized certain characteristics, signaled expertise, and relegated other work to jobs identified as lower status.

The health care workers earning low wages whose numbers have expanded dramatically throughout the course of the 20th century and into the 21st century perform the labor excluded by the construction of doctors' and nurses' professional expertise: direct care for older, disabled, and ill bodies, as well as cleaning and food preparation and serving in hospitals and long-term care institutions. Scholars note that, throughout US history, a racialized division of labor channeled White women to become masters of the emotional, more performative aspects of care work, whereas women of color and immigrant women were forced to engage in more invisible "backroom" and physically intensive tasks.[18,19,20] The association of the "dirty work" of care with women of color has its roots as far back as slavery. In the context of slavery, White women of means were the hostesses and mistresses of the home, while Black enslaved women often did the backbreaking and never-ending work of cleaning houses and outhouses, laundering and maintaining clothing, and procuring, preparing, and serving food. Domestic servitude in the North in the pre-Civil War era mirrored this gendered and racialized division of care labor, despite the different economic structure, and women of color and immigrant women were heavily overrepresented in the expanding ranks of domestic servants across the nation in the second half of the 19th century.[18,19,20]

The structure of modern medicine was built on the backs of women of color performing the dirty work of health care for poverty-level wages. It is important to note that this stratification in health care has benefited not only higher status workers but also the health care organizations that drove this stratification. As Susan Reverby has noted in her history of nursing, it was in hospitals' economic interests to maintain a "divided and cheap" workforce.[15] Higher status health care workers, health care organizations, and professional associations have created and benefited from racialized stratification. If equity is the goal, this history creates an ethical imperative for the medical establishment to dismantle a system that places women of color in unsustainable jobs.

Building Better Health Care for All

The goal of health equity therefore requires us to address the poverty-level wages and high-risk working conditions faced by the women of color who perform the lowest wage jobs in the health care sector. In the short term, all workers must be offered living wages and basic benefits, including health insurance and access to paid leave. In the long term, the restructuring of health care will require a transformation of health care financing and insurance provision to emphasize adequately funded public investment. And, ultimately, attaining health equity will require revaluing all health care work and dismantling racist and sexist divisions of labor.

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POLICY FORUM: PEER-REVIEWED ARTICLE

Roles of Environmental Services Workers' Wages and Status in Patient Safety

David Sine, DBioethics and Lloyd Duplechan

Abstract
Environmental services is a mission-critical function of any health care organization, contributing in key ways to patients' health, well-being, and overall care experiences. This article offers context from a risk management standpoint on the importance of recognizing, valuing, and protecting environmental services professionals' contributions to health care organizations' capacity to be fulfilling, safe places to be a patient and to care for patients.

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Undervaluation of Environmental Services

Environmental Services (EVS) is a mission-critical function of any health care organization, contributing in great measure to patients' health, well-being, and overall care experiences. Without EVS, there is no waste management, and proper and safe management of the various regulated waste streams far transcends simply casting overfilled plastic bags through a chute down to the chthonic nether regions of the facility's basement. As others have noted, EVS workers should be appreciated and embraced as an integral part of the care management team. Patti Costello, executive director of the Association for the Health Care Environment, recently stated in her article, "We ARE Environmental Services," that the health care environmental services vocation should be recognized as a true profession and not just a calling to serve.[1]

It is unjust that environmental services in the modern-day health care industry does not appear to have been given recognition commensurate with its incontrovertible contribution to the health and welfare of patients. Often, a lack of recognition, spotty and disingenuous gestures of appreciation, safety issues, exclusion (eg, from discharge huddles, throughput planning meetings, decision making), and what appears to be a virtual revolving door of exiting coworkers can contribute to EVS workers' feelings of discontent and disenfranchisement and foment a divisive, tiered "class" structure (real or perceived) that widens the chasm between siloed health care workers within an organization.

In what follows, we discuss the challenges and contributions of EVS to assist health care workers and organizations in recognizing, supporting, protecting, embracing, and elevating the all-too-often taciturn and undervalued EVS workers and to foster EVS workers' sense of fulfillment and pride in their work.

Regulatory Challenges

It is important to recognize the fact that, as the unsung heroes of health care, EVS workers certainly play a critical role in addressing the myriad of regulatory compliance challenges and in helping health care organizations avoid running afoul of regulatory agencies. The health care industry is fastidiously regulated and scrutinized by a number of enforcement agencies and accrediting organizations—the Joint Commission, the Centers for Medicare and Medicaid Services (CMS), the Environmental Protection Agency, and even the Nuclear Regulatory Commission. In fact, as Robert I. Field notes: "Almost every aspect of the field is overseen by one regulatory body or another, and sometimes by several."[2] The importance of the contributions of EVS workers and managers to the ongoing process of regulatory compliance cannot be overstated.

One set of regulations that particularly affects hospitals and requires the engagement of EVS pertains to solid wastes. Regarding the basic management of solid waste, for example, both CMS regulations and the Joint Commission's hazardous materials standard (EC.02.02.01 EP19) stipulate that hospitals must have procedures for the proper routine storage and prompt disposal of trash.[3,4] The management of regulated waste, however, is anything but basic. Waste streams generated by health care facilities encompass a diverse range of materials and process by-products, such as infectious and biohazardous waste; waste chemical products and solvents; expired, unused, and contaminated pharmaceuticals; cytotoxic drugs used in cancer treatment; waste products contaminated by radioactive diagnostic or radiotherapeutic materials; and, of course, solid municipal wastes.

As an amendment to the Solid Waste Disposal Act (SWDA) of 1965,[5] Congress enacted the Resource Conservation and Recovery Act (RCRA) of 1976 to provide a framework for all federal solid waste regulations.[6] The RCRA's original objectives were actually to conserve energy and natural resources as well as to reduce the amount of waste generated. Congressional findings supporting the RCRA state: "The Congress finds with respect to materials, that … the recovery and conservation of such materials can reduce the dependence of the United States on foreign resources and reduce the deficit in its balance of payments."[7] The ensuing mishmash of legal mandates, however, includes the identification and classification of wastes and their management, collection, containment, and disposal in accordance with provisions essentially borrowed from regulations written for waste treatment storage and disposal facilities and the US Department of Transportation. For example, federal hazardous waste generator requirements include labeling and marking of containers "consistent with the Department of Transportation requirements at 49 CFR part 172 subpart E (labeling) or subpart F (placarding)."[8] The sheer breadth, depth, and complexity of something that prima facie might appear as simple as taking out the trash can be absolutely mind-boggling.

Another amendment to the SWDA, the Medical Waste Tracking Act of 1988,[9] was the antecedent for state-level biohazardous waste management laws, compelling leadership to ensure that EVS workers are trained and competent to safely and efficiently manage wastes contaminated with blood and other bodily fluids, human tissues and body parts,

contaminated sharps waste, and so on. Yet frontline EVS workers, who operate within a dynamic and often demanding work environment for low wages, often bear the brunt of compliance failures. Based on our experience in hospital administration, hospitals tend to reactively address such failures in an effort to protect themselves from consequences of enforcement without acknowledging the complexity of EVS and, all too often, by assigning blame to EVS workers in the spirit of accountability.

Understanding Attrition

Based on our experience and observations working in hospital administration, individuals working in EVS are often treated as a dispensable resource. The EVS department is too often viewed as a revolving door of unskilled labor, and, should EVS employees underperform, they are quickly and easily replaced. The US Bureau of Labor Statistics projects that there will be 314 900 openings for janitors and building cleaners each year, on average, between 2020 and 2030, but many of these job openings "are expected to result from the need to replace workers who transfer to different occupations or exit the labor force."[10] The negative attitude toward and ephemeral tenure of EVS workers can contribute to their not being accorded due respect and appreciation. Yet, if an EVS employee's short-term intent, commitment, and professional aspirations are anticipated and managed correctly, an EVS position can be an inroad to opportunity within an organization. Embodied within the language of the EVS job description is an implicit but important covenant between the employer and the employee, as individual professional development plans can pave the way for entry into other vocations or assuming roles of increasing responsibility.

Raising wages to retain frontline workers, however, can have negative consequences for the organization. Administrators might compensate for increased wages by reducing investments in training, job safety, working conditions, and fringe benefits, which in turn could lead to an increase in occupational injuries,[11,12] workers' compensation costs, and a need for replacement workers that incurs further training and orientation costs in a never-ending spiral of injury and costs to the organization.[13,14] Moreover, organizational leaders might respond by reducing hours of more highly paid workers or taking action to increase worker productivity.[14]

EVS' Critical Roles

If the hospital's infection control practitioner is analogous to the architect of infection prevention policy, EVS workers interpret the blueprint and carry out the general procedures for buttressing the all-important barriers between the patients and disease. The integral role of EVS in infection prevention and control and in safety in the patient care environment is described in the Centers for Disease Control and Prevention's *Best Practices for Environmental Cleaning in Healthcare Facilities in Resource-Limited Settings*:

> It is well documented that environmental contamination in healthcare settings plays a role in the transmission of HAIs [hospital acquired infections]. Therefore, environmental cleaning is a fundamental intervention for infection prevention and control (IPC). It is a multifaceted intervention that involves cleaning and disinfection (when indicated) of the environment alongside other key program elements.[15]

Accordingly, health care facilities should integrate EVS into their infection prevention programs as well as their foundational culture of safety. With this in mind, infection prevention policies and procedures should form the basis of strong, sustainable processes and systems that are connected through cross-functional, cantilever

scaffolding. Infection prevention professionals thus should develop strong bonds and partner with EVS workers, inasmuch as EVS is the tactical arm of infection control.

Protecting EVS Workers

In 2020, the incidence rate of nonfatal injuries and illnesses in the health care and social assistance industry was over 75% higher than that of the manufacturing industry and more than double that of the construction industry.[16] EVS workers are routinely exposed to just about everything that can cause harm—from lifting and repetitive motion to hazardous chemical products, blood and body fluids, and contaminated sharp implements.

Health care leaders must develop and implement programs designed to address the unique portfolio of risks and hazardous or deleterious conditions associated with EVS operations and tasks. According to Occupational Safety and Health Administration (OSHA) regulations and applicable accreditation standards, occupational safety programs should incorporate, at the very least, the following standards:

- Bloodborne pathogens safety and regulated waste handing[17]
- Personal protective equipment (PPE) regulations[18]
- Respiratory protection (especially poignant in light of the pandemic)[19]
- The provision of information and employee training to help safeguard against harmful exposures.[20]

The Joint Commission standard EC.02.02.01 EP4 compels hospitals to manage risks related to hazardous materials and waste and to implement procedures to address hazardous materials spills or exposures.[4] This standard includes providing unobstructed access to compliant emergency eyewash facilities where, during routine operations, the eyes of an employee may come into contact with a substance that can cause corrosion, severe irritation, or permanent tissue damage.[21]

Routinely, EVS workers may be exposed to risks related to ergonomics and body mechanics that can cause or exacerbate musculoskeletal disorders (MSD). These activities include lifting heavy items, bending, reaching overhead, pushing and pulling carts and trash bins, and performing repetitive tasks. To address these risks, leaders should incorporate ergonomic safety processes. According to OSHA guidelines: "An ergonomic process uses the principles of a safety and health program to address MSD hazards. Such a process should be viewed as an ongoing function that is incorporated into the daily operations, rather than as an individual project."[22]

Programs designed to comply with the various OSHA and other occupational safety regulatory requirements are merely the beginning. Statutes and regulations codify only the minimum basic requirements. They are the foundation upon which injury prevention programs are built—and the floor under which they must never sink. Effective worker protection includes preventive measures; risk assessments; proactive hazard mitigation and controls (engineering, administrative, and PPE); postinjury intake and follow up; and effective return-to-work programs.

Embracing EVS Workers

It is imperative that health care leaders anticipate, recognize, and address intimidating, disruptive, or demeaning behavior—whether overt or subtle—that could contribute to EVS workers feeling unimportant, ostracized, and sometimes frightened. It has been strongly

suggested that insouciance can be more damaging than rudeness. In "The Perils of Indifference," Elie Wiesel states: "Indifference elicits no response.... Indifference is not a beginning; it is an end. And ... it benefits the aggressor—never his victim, whose pain is magnified when he or she feels forgotten."[23] Indifference can make it difficult for an EVS worker to feel comfortable with and place trust in an organization's "just culture."

To underpin a functional, transparent culture of safety, it is important not only to reinforce basic principles of responsibility as they pertain to the treatment of others, but also to develop and implement zero tolerance policies that set forth a strict prohibition on intimidating, disrespectful, or otherwise inappropriate behaviors, irrespective of the role or level within the organization of the person who exhibits those behaviors. According to The Joint Commission's Sentinel Event Alert 40 ("Behaviors That Undermine a Culture of Safety"), leadership should "Provide skills-based training and coaching for all leaders and managers ... on appropriate professional behavior defined by the organization's code of conduct."[24] This code of conduct (or principles of responsibility) should place a particular emphasis on mutual respect and be enforced "consistently and equitably among all staff regardless of seniority or clinical discipline."[24]

All levels of the organization should consistently show deference to the unique expertise of the EVS professional. Showing respect underscores the importance of engendering a culture of inclusiveness, collaboration, and appreciation, wherein EVS staff is consistently considered and made to feel part of the team of caregivers. Health care professionals, including EVS, must work cross-functionally and seamlessly, demonstrating the leadership principle of interdependence, or being mutually reliant on one other. Additionally, health care facilities should recognize Environmental Services Week and celebrate incremental reductions in employee injury rates to show respect for EVS workers.

Elevating EVS

If a particular subject matter assists in making EVS managers or attendants better health care professionals, broadens their portfolio of skills, or improves quality of services, they should be supported and encouraged to really drill down—in other words, they should be encouraged to avail themselves of programs to explore, research, and study that subject matter and to eventually become resident subject matter experts. Relevant courses include infection prevention, biology, and courses of study offered through organizations such as the Association for the Health Care Environment of the American Hospital Association or the Indoor Environmental Healthcare and Hospitality Association.

In sum, the importance of placing particular emphasis and priority on the recognition and managing of some of the more intangible aspects of EVS cannot be overstated. These considerations include attrition, understanding the plethora of applicable regulatory demands, consistently providing for a safe workplace, and embracing and elevating EVS.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Tacit Knowledge in Low-Status Eldercare Work

Heidi Gottfried, PhD

Abstract
Cultural failure to recognize tacit knowledge that informs eldercare is key to understanding how and why the labor of workers in this area of professional caregiving, especially those earning low wages, is dramatically undervalued in the US health sector. This essay first explains key differences in credential-based knowledge and tacit forms of health knowledge and then considers how status differentiation privileges credential-based knowledge of clinicians of higher status, such as physicians and nurses, who do not perform the hour-to-hour care for most of our country's elders. Finally, this article suggests the ethical and clinical importance of health care organizations' sources of knowledge and roles in equitably valuing labor to promote quality service delivery, better working conditions, and better pay for workers earning low wages.

Tacit Knowledge in Health Professions

Rapidly aging societies like the United States face a looming labor shortage of care workers.[1] One-fifth of America's population has already reached retirement age.[2] Adding to demand, high turnover rates among poorly paid home care workers will create millions of job openings over the coming decades.[1] This exodus is driven by society's failure to recognize the value of tacit knowledge that underpins all types of care work—childcare, eldercare, and hospice care. In the case of geriatric care (the focus of this essay), long-serving eldercare workers confront an underestimation of the skills and knowledge required to successfully care for the frail elderly and particularly for those with dementia. Yet, intuitively, when a family member or medical staff member informally interviews eldercare workers about a client's well-being, the communicative act implicitly recognizes the importance of such workers' "tacit" knowledge.

In interactive service work, embodied capacities—such as gestures, facial expressions, ways of approaching, and touch—are consequential for delivering quality care. Sensory dimensions of care work require intuitive knowledge of both psychology and physiology learned on the job. Care workers administer care in tune with a patient's temperament while handling the patient's frail body. They tailor care to respond to their patient's moods, not merely to medically diagnosed health conditions.

As an anxious daughter caring for my elderly mother, who is lost in the depths of dementia, I relied on her care workers' firsthand narratives for understanding the

vagaries of her condition. Valuing care workers' tacit knowledge can enhance the quality of formal medical care and aid in the evaluation of best practices for treating seniors with a range of conditions.

Society's failure to recognize the tacit knowledge that informs eldercare is key to understanding how and why the labor of workers in this area of professional caregiving, especially the labor of those earning low wages, is undervalued in the US health care sector. To address this social deficit, I first explore how the tacit knowledge of low- and high-status health professions is valued and constructed differently. I then offer a menu of methods for acknowledging and encoding tacit knowledge that can be mobilized to improve the delivery of quality care and provide fair compensation to care workers. By failing to socially recognize and foster the development of eldercare workers' important contributions, the current health care system risks losing valuable and unappreciated sources of knowledge. An ethical point of view demands respect for the full range of competencies that eldercare workers utilize in taking care of the sick and vulnerable in our society.

Building and Valuing Tacit Knowledge

Tacit knowledge refers to knowledge gained by accumulating personal experience on the job that can be difficult to transfer to others via written or oral communication.[3] Physicians enjoy the benefits of years of accumulating tacit knowledge that is structured by career pathways. "Tricks of the trade" captures the notion of expertise honed on the job; these include the adjustments necessary to perform a job well and improvisational techniques of addressing problems in situ, all of which become part of physicians' tool kit applied in future cases. Professionals often communicate their tool kits through training protocols. Medical school students shadow doctors on their rounds, observing good practices that enable them to gain tacit knowledge, while they glean formal knowledge from coursework. Such a training structure, however, reflects the ability of physicians to monopolize knowledge certification. Even trainees in male-typed skilled trades must complete an approved apprenticeship to practice as an electrician, plumber, or mechanic.[4] By contrast, in low-status feminized health care work, the lack of a formalized training structure impedes the transfer of tacit knowledge as a valuable resource for enhancing care competencies. Health aides on the lowest rung of the job ladder tend to work in isolation from others, further depriving them of opportunities for communicating their tacit knowledge gained on the job.

How to value care work presents a conundrum. Is care work valued less because of its low educational requirements or because women perform this work? According to England et al, low relative wages "cannot be explained [fully] by low unmeasured human capital or a disinclination to bargain for high pay among care workers, because these individual characteristics would presumably affect their pay in all jobs."[5] Instead, gender bias associated with care work helps to account for unexplained differences. Despite having jobs with no formal educational requirements, cleaners and orderlies in 2021 earned a median hourly wage of $14.31 and $14.56 respectively,[6,7] whereas home health and personal care aides, who must meet some educational or training requirements, earned a median hourly wage of $14.15.[8] Home health and personal care aides typically need a high school diploma or equivalent, although some positions do not require it, and workers in certified home health or hospice agencies may need to complete formal training or pass a standardized test.[8] The definition of care work as unskilled labor reproduces a gendered hierarchy within low-wage jobs.

Care as Undervalued

The low social and monetary value accorded to care work has been attributed to its close association with devalued racialized, female-typed work[9] and to the unacknowledged and thus unremunerated tacit knowledge on which the emotional and affective labor involved in personal interactive services relies. Although such labor is undeniably important to the health and well-being of individuals, neoclassical and traditional political economic theories underestimate care work by reducing what counts as labor to easily quantifiable activities, such as the physical labor of bathing, feeding, and dressing an elder.[10] This human capital perspective is thus blind to distinctive, intangible aspects of the care encounter by excluding a range of labor activities and competencies vital to the performance of good care.

Health care systems structure occupations in finely graded hierarchies based on the value of assumed competencies.[11] In geriatric care, nursing staff with formal training and objectified qualifications (symbolized by credentials and licensing) in addition to knowledge gained on the job are higher in the hierarchy than health aides with little or no training or formally recognized expertise in health care. Moreover, socioeconomic status distinctions correspond to educational credentials and other forms of transferrable and explicit knowledge. Lacking credentials and status, eldercare workers are treated as unskilled irrespective of their actual educational attainment, years of job experience, or possession of tacit knowledge. For these reasons, tacit knowledge is lost to the health care system.

Revaluing Tacit Knowledge

Feminist scholars call for redefining care as relational—as enhancing the capabilities of others and deploying skills of emotional competence and bodily capacities.[12,13] More than other types of service work, care work produces something novel, as it generates affective relations and well-being.[14] Care work is performed through intimate, face-to-face interaction, during which the care worker enhances the recipient's human capabilities, including "physical and mental health, physical skills, cognitive skills, and emotional skills, such as self-discipline, empathy, and care."[5] The quality of care depends on the quality of relationships built up over time.[15]

In addition to redefining care work, some feminist scholars emphasize the entanglement of normative, economic, and social frameworks of care.[16] In a novel twist, Joan Tronto expands the notion of ethics to encompass many everyday judgments involving attentiveness, competence, responsibility, and responsiveness in caring for others.[17] Yet, as a social activity, care work tends to go unnoticed and become naturalized and "inseparable from the person producing it."[18] In general, tacit knowledge in care work, including emotional and affective competencies, remains invisible, unacknowledged, and devalued though critical to the care encounter, especially to establishing rapport with and soothing the patient. The art of good care involves enhancing a patient's moods and addressing a patient's physical and emotional well-being through talking and listening.

Other aspects of tacit knowledge enhance the care encounter, such as trust and rapport. Trust is considered essential to fostering relationships through mastery of 4 main elements: (1) consistency, (2) compassion, (3) communication, and (4) competency.[19] Because the quality of care depends on the quality of relationships, the care worker must establish rapport and trust cultivated through attentiveness to the patient's changing emotional and physical needs. Nevertheless, the work of building

trust tends to be overlooked in the care encounter even though its absence can have catastrophic effects if patients refuse to accept the course of treatment because they lack trust in the caregiver.

Overall, through their proximity and intimate contact with patients, eldercare workers calibrate care in real time in response to their patient's emotional states and changing needs. Like an ethnographer, eldercare workers' accumulated knowledge from their "field" experience enables them to form a holistic portrait of the patient's physical, emotional, and cognitive well-being constructed from their intimate and frequent contact with the patient. Sustained observations and extended contact are particularly relevant for patients with dementia, who cannot easily articulate their feelings and health conditions. All eldercare workers, especially live-in workers, command a wealth of largely unmined lodes of data on patients. The COVID-19 pandemic began to magnify this rich loam of hidden labor, as it increased the demand for tasks like cleaning and hygiene routines, emotional labor, and food preparation in private homes and senior facilities, all situations in which safety precautions devolved to the care worker. Restrictions on mobility and intermingling of households left many eldercare workers as the primary point of emotional and physical contact for clients.

Acknowledging Tacit Knowledge

By what methods can tacit knowledge be acknowledged and thus transferred in the training of care workers and in communicative action regarding a patient's health profile? New technologies can create opportunities to develop and transfer tacit knowledge, and such changes in practice can support the effort to revalue care work and eldercare workers.

First, new modalities of communication technology can transform care workers' smart phones into digital journals for recording patients' conditions on a routine basis. Used by other medical professionals, digital templates can provide checklists to input standardized data and designate a space for narrative accounts that can later be uploaded to the patient's web portal for use by the medical team to address the patient's condition.[20] From this vital source of data, medical staff can assess the efficacy of and patients' responsiveness to treatment plans, allowing for adjustments in real time to increase the effectiveness of health care. Digital journals, encrypted to ensure confidentiality, if required by the medical profession, would incentivize employers to allocate time to and compensate workers for performing this vital task.

Second, an innovative methodology for video hermeneutics can take into account the content and context of nonexplicit forms of knowledge in interaction. Visualization of sensory and bodily expressions through videography makes available objects and interactions for interpretation by preserving a record of the field in addition to the usual ethnographic notetaking.[21] Medical schools could add video hermeneutics to their curriculum, dispersing students to observe and interpret data collected through this field experience. Such data would not only deepen the medical community's understanding of best practices for eldercare, but also contribute evidence of the knowledge and skills utilized in the care encounter.

Third, instituting peer-to-peer ongoing education could formalize the transmission of tacit forms of knowledge among eldercare workers. The American Medical Association could partner with unions representing eldercare workers to establish channels for ongoing education and for certification of workers' experience, competencies, and skills.

Certification would have salutary effects for families tasked with navigating a confusingly opaque and often impenetrable cacophony of care options rooted in the fragmented and labyrinthine patchwork US health care system by giving them a yardstick for assessing care workers' skill sets that are necessary for addressing evolving eldercare needs.

Fourth, and finally, elevating health aides to members of medical teams would enhance the status of eldercare workers,[1] as well as enable the collection of vital data about patients' health conditions (affective, physical, and mental health) since care workers possess the most intimate knowledge of how patients react to and recover from health conditions—knowledge which would otherwise be lost to the care team.

In sum, acknowledging tacit skills would foster revaluation of care work and thus serve to rectify inequitable compensation and to recognize and upgrade the status of this essential workforce, thereby encouraging workers to enter and remain in the field while also improving the delivery of quality care. Treating care workers as vital members of the medical team will dignify both the work and the workers.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Wage Theft and Worker Exploitation in Health Care

Nicole Hallett, JD

Abstract
The COVID-19 pandemic has revealed a great irony in the labor market: workers essential to social functioning and safety are among the least valued by pay. Support workers (eg, medical assistants), direct care workers (eg, nursing assistants and personal care aides), and service workers (eg, janitors and food preparers) have long experienced wage theft and exploitation, although health care organizations would cease functioning without them. The health sector has opportunities to revisit wage hierarchies and to ensure living wages for these workers.

Individuality and Meritocracy

In his book, *What We Owe to Each Other*, the philosopher T.M. Scanlon tries to answer the question of when we can expect people living in a society to be duty bound to each other. His answer is that we must justify our duties to others based on principles that we cannot reasonably reject.[1] In other words, we must have reasons for our moral decisions, and those reasons must withstand collective scrutiny. His theory presupposes that we owe each other something—or at least recognizes that society would hardly function if we did not act like we did. While this reasoning might seem self-evident to some, our public discourse often assumes the exact opposite. Americans' devotion to rugged individualism often leads to the conclusion that we are responsible only for ourselves. Our faith in meritocracy leads us to believe that individuals' success or failure belongs to them and them alone. But the COVID-19 pandemic has forced a reckoning with these quintessentially American ideas, presented us with problems that cannot be solved by individuals, and revealed a great irony about social hierarchies created by meritocratic ideals: workers essential to social functioning and safety are among the least respected and lowest paid.

In the health sector, all workers are essential, but not all workers are treated—or paid—equally. Support workers (eg, medical assistants), direct care workers (eg, nursing assistants and personal care aides), and service workers (eg, janitors and food preparation staff) have long suffered from low wages, high rates of wage theft, and labor exploitation. Yet health care organizations would cease to function without them, a fact that became abundantly clear during the COVID-19 pandemic. Health care workers earning low wages saved countless lives during the pandemic at the risk of their own health, well-being, and sometimes their lives. What do we—health care employers, patients, and society at large—owe them now?

Wage Theft in Health Care

Based on how much some health care workers are paid, it appears that we believe we do not owe them very much. One study found that the median wage in 2019 for home health aides, for example, was $11.57 per hour.[2] The median hourly wage in 2019 of all health care support, service, and direct care workers was $13.48 per hour,[2] less than the $15 an hour demanded by living wage campaigns,[3] and well below the median wages in 2019 of nurses ($35.17 per hour) and doctors (more than $100 per hour).[2] These wages are only slightly higher than the minimum wage that employers must pay in most states, which ranges from $7.25 per hour in 21 states to $15.20 per hour in the District of Columbia.[4] In 2017, 15% of direct care workers lived below 100% of the federal poverty level, and 42% relied on public assistance to make ends meet.[5] These data suggest that the value of many health care workers' compensation is incommensurate with the value of their contributions.

Wage theft is rampant in many industries, including in health care.[6] A 2009 study found that 12% of home health aides make less than the minimum wage.[7] Many others are paid a fixed sum for a variable number of hours, which leads to frequent minimum wage and overtime violations. Despite several recent lawsuits against hospital systems,[8,9,10] lawsuits to recover wages are the exception, not the rule. Most workers never recover wages stolen from them by employers because those workers do not have access to legal representation, are worried about retaliation, or don't know their employers are stealing from them.[6,11] Wage theft costs health care workers millions of dollars per year in lost income.[12]

Burnout

Pay is not the only problem for these workers. They also struggle with unsanitary or unsafe working conditions and a lack of respect from their employers and supervisors. In 2018 and 2019, I led a team that interviewed home health aides in Buffalo, New York, and surrounding areas about their pay and working conditions.[13] The workers recounted verbal abuse, sexual harassment, bug and rodent infestations, and lack of personal protective equipment, such as gloves and masks. They were often required to provide care that they were not trained to provide or expected to do tasks that were not in their job description, such as cleaning and running errands. The workers complained of irregular schedules, not being paid overtime, having no paid leave, and job insecurity.

Many aides felt pride in the care they were able to provide, but fewer than half saw themselves staying in the job for more than 5 years.[13] The work was too hard, their employers too disrespectful, and the pay too low for them to consider their work as a long-term career. This lack of respect affects many health care workers at the bottom of the income scale. According to one survey, doctors and nurses enjoy among the highest levels of occupational prestige, while health care support, service, and direct care workers suffer from the lowest levels.[14] When workers do not feel respected, they are more likely to experience burnout and leave their jobs.

All of these issues have been exacerbated by the pandemic. Essential workers in all fields have reported higher rates of stress and burnout, and the pandemic has hit health care workers earning low wages particularly hard.[15] More than half a million health care workers quit in August 2021, a 20-year high.[16] Labor strikes are on the rise, as health care workers have become fed up with their pay and working conditions.[17] Hospitals cannot find enough workers to fill positions in an industry that is only expected to grow over the next 20 years.[18] A rising need for workers at the same time that many workers

have opted out is a recipe for disaster. As baby boomers continue to age, who will care for them when the pandemic is over?

Rendering What We Owe

The health care sector may be reaching a point at which it can no longer ignore how workers are treated. Employers have justified low wages and poor working conditions because these positions require less formal education. But it is not reasonable to deny someone a living wage or a safe workplace solely because the training they need for the job does not come with a fancy degree. That mindset has created the situation we are now in. It is not sustainable or defensible.

An obvious solution to this problem is to pay workers more and ensure that they have access to safe and sanitary workplaces, humane schedules, and adequate benefits, which would incentivize many to stay in their jobs. Employers might be forced to make some of these changes themselves, given worker shortages. Policymakers should also step in with policy interventions, such as raising the minimum wage and mandating certain working conditions and benefits. Such changes will require wages and benefits reallocation up and down the wage hierarchy, as well as an infusion of public funds. Government can also fund programs to ensure that enough workers are well trained to provide high-quality care to everyone and can authorize more employment-based visas for international health care workers. In order to make these important investments, all of us—regardless of whether we work in the health sector—must prioritize health care workers.

Health care workers have also begun demanding more. The pandemic has sparked a wave of unionization across the health care sector,[19] and community organizations, such as the National Domestic Workers Alliance, have used the pandemic to draw attention to the plight of some of the most vulnerable health care workers—people who work in private homes.[20] The pandemic provides the health care sector with opportunities to revisit wage hierarchies and ensure living wages for the lowest-paid workers. It allows us to do more than applaud the sacrifices these workers made during the pandemic by treating even the lowest paid workers with respect. The pandemic has been a reminder that we are all connected. Rejecting our obligations to others not only is morally bankrupt but also negatively affects the quality of care we will all need at some point in our lives. We owe each other more, and the time has come for change.

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ART OF MEDICINE

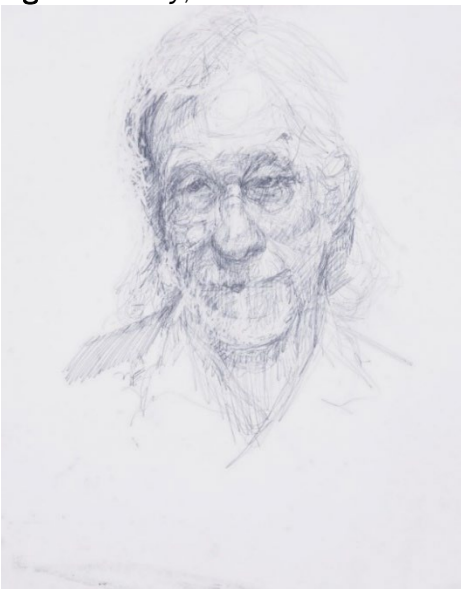
Witnessing Care and Cleaning Health Care Spaces

Mark Gilbert, PhD

Abstract
Two portraits of Barry, a housekeeping utility worker at the Veterans Memorial Hospital Memory Clinic in Halifax, Nova Scotia, are part of 80-piece arts-based research collection, led by this article's author, portrait artist Mark Gilbert. The 2-year study, Giving, Receiving, Observing & Witnessing Care (GROWing Care), explored experiences of patients living with dementia and their caregivers.

In collaboration with geriatrician Kenneth Rockwood, I co-designed the 2-year study, Giving, Receiving, Observing & Witnessing Care (GROWing Care) to explore experiences and to observe, in drawn and painted portraits, a range of interactions among older adults and their partners in care.[1,2] In time, we broadened the study's scope to include consideration of and regard for clinically and ethically relevant roles played by professional health care environmental services workers, including Barry.

Figure 1. *Barry*, 2018

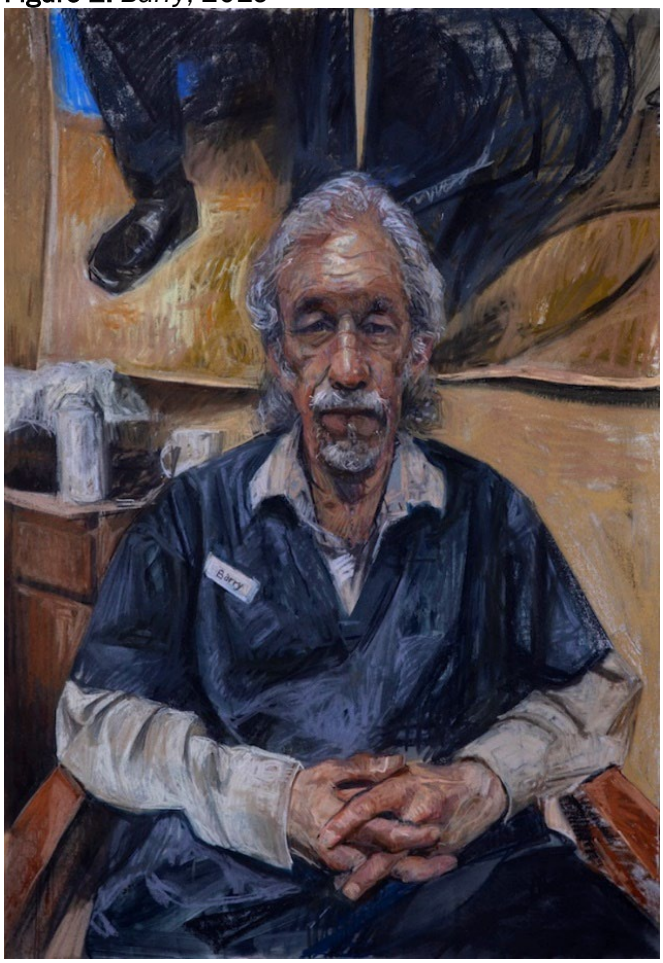


Courtesy of Mark Gilbert.

Media
Pencil on paper, 18" x 22".

I would see Barry at the end of each day just as he was beginning his 3:30 to 11:30 pm shift, and I was leaving. After Barry agreed to participate in the study and sit for his portrait, he visited me in my studio in the memory clinic. He sat with me there for an hour or so at a time while I drew him. During sittings, Barry described the daily responsibilities included in his "full service" maintenance of memory clinic offices (eg, of chaplains and pharmacists) and care spaces: emptying garbage, dusting vents, mopping and vacuuming floors, and sanitizing furniture equipment, such as pressure cuffs in 7 examination rooms. One of Barry's major responsibility sets included "ward checks," which required detailed cleaning of 4 floors of patients' rooms and common areas, emptying garbage, and removing soiled materials. Barry carried a pager, responding to calls to clean up "spills" in patients' rooms.

Figure 2. *Barry*, 2019



Courtesy of Mark Gilbert.

Media
Pastel on paper, 30" x 43".

At the end of the study, I interviewed Barry in the presence of his portraits. Reflecting on the process, Barry stated, "It's [been] a good experience.... I found it very enjoyable, actually." Considering the final pastel portrait, in particular, he said, "I was so surprised [when] I saw it and I said, oh my God, you got my little Barry nametag, you've even got the scars on my nose." Barry recognized how his portrait honors and presents his own experience and status as a health care professional and also testifies to his experience of being portrayed. The portrait transforms these aspects of Barry experience into a permanent aesthetic form. Upon learning of his and others' portraits' inclusion in an exhibition, he was comfortable with and eager to learn how viewers might engage with the portraits in different ways. "I think it's great. I think ... people have to make their own interpretation. I would love to be a 'fly on the wall.'"

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VIEWPOINT: PEER-REVIEWED ARTICLE

How to Better Value EMS Clinicians as Key Care Team Members

Andrew J. Torres, NRP and Rozalina G. McCoy, MD, MS

Abstract
Emergency medical services (EMS) clinicians, including emergency medical technicians and paramedics, are skilled professionals whose expertise is leveraged routinely to meet a wide range of patient needs. Collaborative interdisciplinary care requires mutual understanding, trust, and respect. Yet, among EMS clinicians and in- and out-of-hospital clinicians, these values are too often not expressed in working relationships. This article offers guidance on how to nourish successful partnerships with EMS clinicians and motivate good care.

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Undervaluing EMS Clinicians

Prehospital professionals—specifically, emergency medical responders (EMR), emergency medical technicians (EMT), and paramedics, presented here in an ascending order of training, experience, and scope of practice—make up the core of emergency medical services (EMS) in the United States. Despite the wide range of vital and highly skilled services that EMS clinicians provide, their contributions are often unknown to, or misunderstood and not acknowledged by, other health care professionals. Even patients often do not understand EMS and its full range of capabilities. This lack of appreciation and awareness adversely affects EMS clinicians, the patients they care for, and the health care system more broadly in terms of missed opportunities to fully leverage EMS clinicians' expertise and increasing rates of burnout within EMS.[1] The resulting departure of EMS clinicians from the workforce and pervasive shortages within EMS can negatively affect community safety and health.[2,3] We argue that there are 3 primary drivers of EMS underappreciation and its negative consequences: inadequate understanding of, trust in, and respect for EMS clinicians by other health care professionals and the community at large. Inadequate understanding of and appreciation for the vital role that EMS clinicians play within society is both manifest in, and worsened by, the reliance on volunteer EMS services in many areas of the United States,[4] which suggests that emergency medical care is not a profession but a volunteer activity—and which seems to justify the low wages that professional EMS clinicians are paid.[5] These barriers need to be recognized, called out, and addressed if we are to strive for higher quality, more efficient, and more accessible patient-centered care.

Burnout, Divorce, Suicide

Multiple factors contribute to EMS clinicians leaving the field for other—safer, easier, more valued, and higher paid—professions. Burnout rates in EMS exceed 60%.[1] Divorce and suicide rates among EMS clinicians are significantly higher than in the general population.[6,7] The average career span of EMS clinicians is just 5 years.[8] The high rates of stress and burnout among EMS clinicians are in turn due to a number of factors, including (1) low wages, often resulting in the need to hold multiple jobs; (2) heavy workloads and physical demands of the job; (3) the stress of responding to a wide range of emergencies in unknown, uncontrolled, and potentially unsafe environments; (4) exposure to potentially emotionally traumatic events; (5) lack of rest and chronic fatigue, likely the result of the first 4 factors; (6) documentation burden; (7) aggressive or violent patients; (8) poor career recognition, in part because of low wages and in part because of inadequate understanding of the full scope of EMS practice and expertise; and (9) emotional burden, likely a summation of all the above factors.[1,9,10,11,12,13] Moreover, these factors are all interrelated and stem from the societal and individual devaluation of and disregard for the vital role that EMS professionals play in the care of individual patients, the health care system, and society. Importantly, they are all amenable to change.

There are multiple manifestations of society's failure to acknowledge, appreciate, and value the contributions that EMS clinicians make to patient care. The "you call, we haul" attitude within EMS is emblematic of the erroneous perception that EMS clinicians lack clinical acumen, agency, and decision-making capacity.[14] Low wages in EMS are both a manifestation of the devaluation of their skills and contributions to society and a driver of burnout and departure from the profession. The median annual pay for EMTs and paramedics in 2021 was $36 930 compared to $48 070 for licensed practical nurses (who have, in many respects, comparable educational backgrounds to paramedics) and $77 600 for registered nurses.[15] Fellow health care professionals' ignorance of EMS clinicians' knowledge and expertise, coupled with the clear pay differential, conveys to EMS clinicians their designation as a "lower status" professional. This designation, and the accompanying negative attitudes and disregard of fellow health care workers, can stall forward momentum of EMS advocacy to improve EMS wages and working conditions and contributes to other health care professionals' role-based microaggressions that ultimately lead to EMS burnout and distress.

Dysfunction

Microaggression is defined as "commonplace daily verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership."[16] While seemingly harmless and often delivered by well-intentioned individuals, the consequence of microaggressions is to "invalidate the group identity or experiential reality of target persons, demean them on a personal or group level, communicate they are lesser human beings, suggest they do not belong with the majority group, threaten and intimidate, or relegate them to inferior status and treatment."[17] While the vast majority of microaggression research is focused on race, ethnicity, gender, sexual orientation, or disability stereotyping, microaggressions exist within any social hierarchy and are thus apparent within the health care workplace as well. In health care, these class-based microaggressions focus on individuals' occupational identity, education, language, prestige, and social location.[18]

Microaggression toward EMS clinicians can be overt or subtle. As a community paramedic, the first author (A.J.T.) has frequently encountered dismissive attitudes from physicians, nurses, and other health care professionals when caring for patients in the home or transporting them from sending facilities, such as nursing homes or hospitals. For example, a common task EMS accommodates is routine transport of patients between health care facilities, referred to as interfacility transports. Patient acuity and risk for acute deterioration vary widely, yet discharging physicians and nurses rarely perform a warm handoff to EMS clinicians caring for the patient en route to the next facility, while a warm handoff to physician and nursing peers is both expected and the norm. This lack of communication creates potential safety concerns for the patient, as EMS clinicians might not have sufficient information about the patient to inform the management of acute clinical deterioration. Ultimately, being left out of the care process signals to EMS clinicians that they are not important contributors to the patient's care.

Other clinicians also routinely make assumptions about EMS clinicians' presumed lack of knowledge, training, and experience, which occasionally manifest in offhand and dismissive comments regarding their care. One microinsult that reinforces these misconceptions is the use of the term *ambulance drivers* to refer to EMS clinicians. This microinsult suggests that EMS clinicians do little else but chauffer the patient from one location to the next.[19,20] There are also fewer depictions of EMS clinicians as story protagonists in the media and public culture in contrast to physicians, nurses, firefighters, and law enforcement, who feature in multiple shows. In the media, EMS clinicians are too often simply the backdrop, stretcher jockeys, or a mechanism to carry the patient away. This stereotype, too, reinforces the perception that EMS clinicians' most—and perhaps only—valuable trait is their ability to transport. And while being "drivers" and having ambulances with stretchers is an important aspect of EMS, the true value of EMS clinicians is their ability to treat critically or acutely ill patients at the site of injury, which is only possible because of their rigorous medical training and practical experience, and to ensure that these patients make it to their destination alive.

While microaggressions, such as using the term *ambulance driver*, might be unintentional or subconscious, all health care professionals can help stop microaggressions by purposefully changing how they act and how their behaviors and attitudes are perceived. These changes include (1) learning about and understanding EMS clinicians' roles and scope of practice, (2) trusting EMS clinicians to perform their duties competently and professionally, and (3) recognizing the contributions of EMS clinicians to the health care system and to patient health. Below, we offer our suggestions for implementing these changes.

Improving Working Relationships

Understanding. The first step in countering EMS underappreciation and reducing burnout is fostering a better understanding of EMS clinicians' training, expertise, scope of practice, and roles within the health care system. Indeed, while low wages[21,22] and difficult working conditions[23] are important drivers of burnout in EMS, the failure to recognize EMS' contributions to patient health and care delivery is at the core of both low wages and challenging working conditions and is an independent driver of burnout and distress. Although the name *emergency medical services* suggests that EMRs, EMTs, and paramedics are called upon only at the time of emergency to transport patients to the emergency department where they will receive definitive care, EMTs and (to a much greater extent) paramedics also evaluate and treat a wide range of health conditions across a variety of settings. The training for paramedics is extensive, with

some programs taking upwards of 2 years to complete to ensure competency across multiple domains.[24] Patient complaints vary widely, ranging from the highly acute (eg, chest pain, respiratory failure, stroke, multisystem trauma, childbirth) to the chronic (eg, pain, malaise, weakness, fatigue), and include behavioral, mental health, and substance-use related concerns. For each condition, EMS clinicians evaluate patients, stabilize them on site, and initiate treatment at the scene and en route to a higher level of care.[25] The breadth of patient populations and clinical scenarios that EMS clinicians encounter requires familiarity with all medical specialties, along with more focused education in critical interventions within certain specialties, such as cardiology, pulmonology, and trauma. EMS clinicians make decisions about patient care and perform interventions with limited information and often without the need for—and potentially without access to—real-time consultation with a physician.

Leveraging the profession's unique training and skills, the relatively new role of community paramedic has further expanded the reach of EMS to encompass the evaluation and management of lower acuity health conditions, chronic illness, and social determinants of health.[26] Community paramedics care for patients in a home environment—whether a private home, a long-term care facility, a shelter, or the street—with the explicit goal of providing definitive care and preventing emergency department or hospital use. As a result, community paramedics have the potential to narrow the gaps in access to medical care for underserved rural and urban communities, improve chronic disease outcomes and self-management skills, help address social determinants of health, and reduce health care utilization. The expanded scope of practice of community paramedics is a testament to the level of training EMS clinicians receive during their education, yet their attainments can be met with skepticism and disbelief, ultimately precluding the growth and expansion of community paramedic programs and the overall advancement of the EMS profession.

Trust. The second step is ensuring that we trust EMS clinicians to do their jobs competently and effectively. EMS is vital to reducing mortality and injury[27,28] and is often the initial entry point into the health care system, particularly for patients who struggle with physical, financial, or psychological barriers to care. Microaggressions that call into question or second-guess EMS clinicians' knowledge, competency, and ability to perform services that they are trained, certified, licensed, and credentialled in[25] reflect a lack of trust in EMS clinicians and negatively impact both their professional well-being and their ability to fully care for their patients. Moreover, once a patient arrives at their destination, the EMS handoff, both oral and written, can provide valuable information to the receiving clinicians, yet such information often is not sought or accepted by the destination physicians and nurses. This information might include trained observations of the scene, such as the conditions surrounding a motor vehicle collision or the patient's home environment, which can affect clinical decisions made by hospital staff.[29] EMS is a vital link in the patient's chain of survival and has the incredible responsibility of stabilizing a patient in the field with limited resources. Trust is an essential aspect of mutual respect, and we urge our colleagues across the health care profession to learn more about core EMS skill sets and responsibilities, trust them to do their jobs, and seek their insight and expertise as appropriate. Such professional collaboration is vital to maximizing the value of EMS to the health care system and to patient health.

Acknowledgement. Finally, EMS clinicians are core members of the health care team, yet most physicians and other health care clinicians have few interactions with them. We therefore urge our colleagues to learn more about EMS, take time to meet the

responders who work in their area and care for their patients, and engage them as partners in the journey to patient health. Taking these steps includes interacting with EMS in a clinical capacity whenever possible, engaging EMS clinicians in discussions and decision making related to patient care, being present for EMS handoffs, and reciprocating a warm handoff when releasing a patient for transport or accepting a patient in the emergency department. At the leadership level, we urge individuals to consider other engagement opportunities to recognize and elevate EMS' scope of practice, including supporting community paramedicine services and EMS staff utilization in emergency departments and urgent care settings. A wide range of care delivery models can benefit from engagement of EMS clinicians; leveraging their unique skill sets and clinical expertise in out-of-hospital care would benefit patients, support physicians and other health care staff, and reduce the operational costs of the health care system—all while increasing the visibility and value of EMS clinicians to other health care clinicians and society at large. Ultimately, confronting and disarming class-based microaggressions against EMS clinicians will require efforts similar to those used in addressing microaggressions against any other marginalized population.

Integral Team Membership

As the population ages and patients become increasingly complex, and as health care resources are stretched thin, interdisciplinary team care has become essential for safe, effective, and efficient patient care. Our collective experiences—as a community paramedic and as a primary care physician—underscore the incredible value that a partnership between EMS clinicians and other health care clinicians can bring. EMS clinicians can be physicians' eyes and ears in a patient's home and a patient's voice in clinics or hospitals. Whether treating patients in acute care settings (EMRs, EMTs, paramedics) or chronic care settings (community paramedics), EMS clinicians have unique insights into their patients' health and psychosocial experience that can inform and enrich physicians' decision making. Most of all, while the roles EMS clinicians play in health care differ from other clinicians', health care is—by necessity and value—a team endeavor. Each member of this team has a unique and important function that contributes to the overall health and well-being of the patients served.

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VIEWPOINT: PEER-REVIEWED ARTICLE

Why the Post-*Roe* Era Requires Protecting Conscientious Provision as We Protect Conscientious Refusal in Health Care

Isa Ryan, MD, MSc, Ashish Premkumar, MD, and Katie Watson, JD

Abstract
The US Supreme Court overturned *Roe v Wade* in June 2022, and now each state's legislature will decide if and when its citizens will have legal access to abortion care and if and when its physicians will be criminalized for providing what is considered to be the standard of care by multiple health-related organizations. This extraordinary change in the medico-legal landscape requires reevaluation of health profession codes of ethics related to clinician conscience. This article argues that these codes must now be expanded to address 2 newly critical areas: physician advocacy to make abortion illegal and affirmative protection for "conscientious provision" in hostile environments on par with protection of conscientious refusal.

Conscience After *Roe*

The US Supreme Court overturned *Roe v Wade* in June 2022, and now each state's legislature will decide if and when its citizens will have legal access to abortion care and if and when its physicians will be criminalized for providing what is considered to be the standard of care by multiple health-related organizations. This extraordinary change in the medico-legal landscape requires reevaluation of health profession codes of ethics related to clinician conscience.

Existing conscience provisions were developed when abortion was a constitutional right. Therefore, they focus on moments when a patient asks for reproductive care to which they have a legal right but which conflicts with an individual physician's personal morality. For example, the 1980 revision of the American Medical Association's (AMA's) Principles of Medical Ethics states: "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care."[1,2]

We do not dispute the premise of this principle and other ethics opinions,[3,4] which is that individual physicians can refuse to provide care that violates their personal morality in nonemergent situations. Instead, we argue that these codes must now be expanded to address 2 newly critical areas: physician advocacy to make abortion illegal and

affirmative protection for "conscientious provision" in hostile environments on par with the protection of conscientious refusal.

Physician Advocacy in Public Spheres

Role morality describes ethical standards specific to a professional role.[5] These standards are not imposed on people outside a given profession and can be different than the personal ethics of some within that profession. "Do I think abortion is ethical?" is a personal morality question relevant to whether physicians choose to participate in abortion care in their professional life and to how they choose to respond to an unwanted pregnancy in their personal life. Personal morality is the foundation of conscientious refusal, and no physician should be forced to perform an abortion if it conflicts with their individual beliefs. However, role morality is key to public action by physicians, both individually and collectively. "What is my duty to my patients as a physician on the topic of abortion?" and "What is my duty to other physicians?" are role morality questions that should guide physicians' activities in the public sphere to protect the legality and accessibility of abortion.

Advocacy. Physician advocacy in favor of abortion bans is an unethical misuse of professional privilege because it wields the institutional expertise of the profession in service of the personal conscience or morality of the individual physician. Instead, professional ethics should require physicians who think abortion is immoral to be "pro-choice and anti-abortion,"[6] because seeking to protect abortion's legality while personally opposing the act of abortion honors the commitment to the health and autonomy of a diverse population of people seeking medical help that is ethically required of physicians. State laws that ban or severely restrict abortion access are in direct conflict with accepted standards of care in medicine because they harm patient health, as well as patient autonomy and dignity.

Preservation of patient health. Established international medical organizations, such as the World Health Organization (WHO), recognize abortion as essential health care, and the WHO asserts that "multiple actions are needed at the legal, health system and community levels so that everyone who needs abortion care has access to it."[7] Additionally, 10 major US organizations representing practitioners and scholars in reproductive care (the American College of Obstetrics and Gynecology, the Society for Maternal and Fetal Health, the Society of OB/GYN Hospitalists, the American Society for Reproductive Medicine, the American Academy of Nursing, Nurse Practitioners in Women's Health, the Society of Family Planning, the American College of Nurse Midwives, and the Association of Women's Health, Obstetric and Neonatal Nurses) joined together to denounce the Supreme Court's retraction of constitutional protection for abortion care:

> This decision promises to severely limit many of our members' ability to provide high-quality, patient centered maternal health care, and it will certainly lead to unnecessary patient suffering and harm.... A broad medical consensus holds that abortion is an essential part of reproductive health care and that without access to abortion, people will face harmful and enduring repercussions.[8]

Bodily risks of pregnancy are undeniable, and they provide one reason that mainstream medical organizations support legal access to safe abortion. The United States is the only developed country with a rising maternal mortality rate,[9] which disproportionately affects Black patients.[10] However, the maternal mortality rate is significantly lower in states with policies protecting abortion access than in states restricting abortion access,[11] and legal restrictions on abortion will disproportionately affect people of color

and other marginalized populations.[12] This pattern is consistent with the finding that the risk of death from childbirth was approximately 14 times higher than the risk of death from abortion between 1998 and 2005.[13] The safety of abortion compared to childbirth is likely higher today. The maternal mortality ratio (MMR) used in this study was 8.8 deaths per 100 000 live births compared to 0.6 deaths per 100 000 reported legal abortions.[13] For 2018, the Centers for Disease Control and Prevention reported the MMR as 17.4 deaths per 100 000 live births compared to 0.41 deaths per 100 000 reported legal abortions.[12,14] Conversely, when following pregnant people seeking abortion, the Turnaway Study found decreased risk of physical or psychological harms for those able to obtain the abortion they desired.[15] Medical professionals must be concerned about the increased health risks a pregnant person faces when continuing a pregnancy, which is one reason the pregnant person's beliefs about the moral status of their embryo or fetus should be paramount. The medical community at large must protect the ability of a patient and clinician to acknowledge these known medical risks when grappling with the multifaceted dilemma of an undesired or complicated pregnancy during informed decision making and must protect access to full spectrum reproductive care.

Respect for patient autonomy. Abortion bans are a violation of patient autonomy. They foreclose patient moral decision making and ignore the personal conscience of many patients in our country's diverse population. One of the complexities of abortion is negotiating the concept of fetal personhood. There is no one understanding of fetal personhood—if it exists and, if so, when it begins—that the profession of medicine can gather behind. However, it can gather behind one decision maker—the pregnant person. Those who oppose abortion's legality sometimes position themselves as defenders of voiceless fetuses. Individuals can, and obviously do, disagree on what's "right" in terms of abortion using many different secular and religious moral frameworks. Yet we are all "former fetuses," with equal moral authority on the moral status of fetuses generally. And, like many Americans, the 59% of US abortion patients who already have children[16] can draw on their prior experience of pregnancy and parenting. The only person with unique insight into and authority to define the moral status of any individual fetus is the person in whom it lives and on whom so much of its life depends, both before and after birth.

The roughly 1 in 4 women in the United States who will have an abortion by the age of 45 have voted with their feet to tell us they believe abortion is morally neutral or morally good,[6,17] and individual physicians or physician groups advocating for abortion to be illegal are assuming the mantle of moral decision makers for these patients instead of medical advisors. Ethics codes should be clear that leveraging the credibility and social capital of the profession for self-interested ends is unethical because it harms both patients and the profession. Recognizing that moral authority for decision making lies with the pregnant person acknowledges the plurality of moral views concerning abortion and allows patients and clinicians to navigate this complicated space informed by the principle of respect for autonomy.

Respect for colleagues. Finally, abortion bans harm a physician's colleagues. Abortion is a complex and nuanced topic on which individual physicians hold a range of beliefs. In contrast to conscience codes that allow physicians to decline to provide legal health care, criminalizing the provision of health care that some physicians believe is morally good or morally required leaves them no option for navigating the conflict between law and personal morality. Instead, abortion bans force these physicians to choose between

committing a crime or violating both their affirmative conscience and their professional duty to protect patient autonomy and health and to provide evidence-based care to a morally diverse group of patients. Therefore, codes of medical ethics should be updated to state that, where abortion is illegal, breaking the law to provide care for reasons of conscience is not unethical.

Lack of respect for colleagues is also shown by failure to recognize the difference between personal morality and role morality, which could lead some physicians to advocate for abortion bans that impose their values on patients who have different and equally valid values. The distinction between personal morality and role morality should lead every specialty's professional organization to establish physicians' ethical obligation to support abortion's legality and accessibility regardless of their personal views on its morality and to establish that it is unethical for physicians to publicly advocate to make abortion care illegal.

Reciprocal Respect for Conscientious Provision

Advocacy for conscientious provision is not new,[18] but serious protection of it would be. There have never been laws that force a clinician to perform an abortion against their will. However, as family planning specialist and American studies scholar Lisa Harris notes: "the persistent failure to recognize abortion provision as 'conscientious' has resulted in laws that do not protect caregivers who are compelled by conscience to provide abortion services."[18] The important physician freedom identified by the AMA—to "choose whom to serve … and the environment in which to provide medical care"[1]—will be—and in some states already has been—stripped from many physicians who feel morally obligated to provide safe abortion care. Reciprocal respect requires that ethics codes on clinician conscience must include an understanding that clinicians have a right to provide care that is equal to the right to withhold it.[18] In addition, the American College of Obstetricians and Gynecologists' statement in opinion 385 that accommodation of clinician conscience must not harm patients by preventing them from accessing necessary health care must be underscored and added to other codes.[4] In this watershed moment for reproductive rights (and the lack thereof), it is imperative that the boundaries of physician conscience in individual patient-physician interactions be further clarified.

Finally, abuse of conscientious refusal must be eliminated in those states where abortion is legal, to which even more patients from outside jurisdictions will come seeking abortion care. Conscientious refusal is an important value when it is used as a "shield" to safeguard physicians from being forced to act in a way that would compromise their integrity.[4,6] But when the balance between physician and patient autonomy becomes unethically tipped toward physicians, that shield can transform into a "club" that causes patient harm.[6] Conscience as a shield includes refusing to perform or assist in an abortion procedure, and it protects the physician who genuinely believes an embryo or fetus is also "their patient." Exploiting conscience as a club betrays the fiduciary obligation of the clinical relationship through actions that obstruct patients' ability to get abortion care. These actions include providing incomplete or false counseling, refusing to refer to another clinician (whether in-state or out-of-state) capable of providing abortion services, and providing medical director services for crisis pregnancy centers that mislead patients. These behaviors harm patients by denying their moral agency.

Furthermore, when physicians delay or deny care, people are more likely to present to abortion facilities at a later gestational age, which can increase the risk of complications—or force them to undergo an undesired childbirth, which is associated with multiple short- and long-term adverse health outcomes.[15] Institutional and legislative policies that enable and support these unethical acts and that prevent reproductive health clinicians from providing full-spectrum, evidence-based reproductive health care to those who want it should be reevaluated and rewritten. Physicians must separate their fiduciary responsibilities to patients from their personal views about their decisions in order to ensure that patient care is not compromised by the privilege of conscientious refusal.

Conclusion

An exclusive focus on clinician conscience obscures that there are 2 consciences at stake in every patient-clinician encounter. For too long, an imbalance in favor of clinician conscience has burdened patients who suffered from care gaps created by physicians who express their personal opposition to abortion through their support of antiabortion legal, institutional, and pedagogical policies. This privileging of clinician over patient conscience also manifests in the public sphere when physicians leverage their social capital as physicians with legislators and voters to decrease the legal options pregnant people have for reproductive care. Instead of advocating their personal moral perspective in the public and professional spheres, physicians should advocate to preserve the moral agency of all patients.

When engaging in clinical care, physicians make an explicit agreement to put themselves in uncomfortable, vulnerable, ethically challenging spaces. Everyone must have the courage necessary to serve people in need and to recognize and rectify gaps in reproductive health care that are unfairly harming people capable of pregnancy. In this pivotal moment in reproductive health care in the United States, clarification of important boundaries around physician conscience should be codified within professional codes of ethics.

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