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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?

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### 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<sup>1</sup>**

*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<sup>2</sup>**

### 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,<sup>3</sup> 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*.<sup>4</sup>

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,<sup>5</sup> 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.<sup>6</sup> 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<sup>7</sup>—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.<sup>8</sup> Our COVID economy then caused the 400's wealth to soar a further 40% to \$4.5 trillion in less than 18 months.<sup>9</sup> Meanwhile, nearly half of American families have told researchers that they lack even a modest \$400 in ready savings in case of financial emergency.<sup>10</sup>

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<sup>11</sup>—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.<sup>12</sup> At the same time, a majority of Americans polled considered nurses (and implicitly caregivers earning lower wages) underpaid.<sup>12</sup>

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,<sup>13</sup> with Kaiser's walkout of thousands of workers being the most visible so far of such actions across the country.<sup>13</sup> 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.<sup>14</sup> 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.<sup>15</sup> 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."<sup>16</sup> 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.<sup>17</sup> 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.<sup>17</sup> 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<sup>18</sup> 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."<sup>2</sup> 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.<sup>19</sup>

## References

1. King berates medical care given Negroes. *Oshkosh Daily Northwestern*. March 26, 1966:3. Accessed April 21, 2022. <https://www.newspapers.com/clip/12049661/oshkosh-daily-northwestern-32666/>
2. American Medical Association. AMA Principles of Medical Ethics. *Code of Medical Ethics*. Accessed April 21, 2022. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf>
3. Williams B. *Making Sense of Humanity: And Other Philosophical Papers, 1982-1993*. Cambridge University Press; 1995.
4. Väyrynen P. Thick ethical concepts. Stanford Encyclopedia of Philosophy Archive. September 21, 2016. Revised February 9, 2021. Accessed February 22, 2022. <https://plato.stanford.edu/archives/spr2021/entries/thick-ethical-concepts/>
5. Kavya B, Abraham R. Global COVID-19 deaths hit 5 million as Delta variant sweeps the world. *Reuters*. October 22, 2021. Accessed July 11, 2022. <https://www.reuters.com/world/global-covid-19-deaths-hit-5-million-delta-variant-sweeps-world-2021-10-02/>
6. Horowitz JM, Igielnik R, Kochhar R. Trends in income and wealth inequality. Pew Research Center. January 9, 2020. Accessed February 22, 2022. <https://www.pewresearch.org/social-trends/2020/01/09/trends-in-income-and-wealth-inequality/>
7. COVID money tracker. Committee for a Responsible Federal Budget. Updated May 23, 2022. Accessed May 27, 2022. <https://www.covidmoneytracker.org/>
8. Kirsch N. The 3 richest Americans hold more wealth than bottom 50% of the country, study finds. *Forbes*. November 9, 2017. Accessed February 22, 2022. <https://www.forbes.com/sites/noahkirsch/2017/11/09/the-3-richest->

[americans-hold-more-wealth-than-bottom-50-of-country-study-finds/?sh=5f7f448c3cf8](#)

9. Dolan KA. The 2021 *Forbes* 400 list of Americans: facts and figures. *Forbes*. October 5, 2022. Accessed February 22, 2022. <https://www.forbes.com/sites/kerryadolan/2021/10/05/the-2021-forbes-400-list-of-richest-americans-facts-and-figures/?sh=26a404e534e9>
10. Grover M. What a \$400 emergency expense tells us about the economy. Federal Reserve Bank of Minneapolis. June 11, 2021. Accessed February 22, 2022. <https://www.minneapolisfed.org/article/2021/what-a-400-dollar-emergency-expense-tells-us-about-the-economy>
11. Miller S. Big companies are raising wages for lowest-paid workers. SHRM. October 7, 2021. Accessed January 6, 2022. <https://www.shrm.org/resourcesandtools/hr-topics/compensation/pages/big-companies-are-raising-wages-for-lowest-paid-workers.aspx>
12. Swanson E, Murphy T. High trust in doctors, nurses in US, AP-NORC poll finds. Associated Press-NORC Center for Public Affairs Research. August 10, 2021. [https://apnorc.org/high-trust-in-doctors-nurses-in-us-ap-norc-poll-finds/#:~:text=WASHINGTON%20\(AP\)%20%E2%80%94%20Most%20Americans,new%20information%20about%20the%20vaccines](https://apnorc.org/high-trust-in-doctors-nurses-in-us-ap-norc-poll-finds/#:~:text=WASHINGTON%20(AP)%20%E2%80%94%20Most%20Americans,new%20information%20about%20the%20vaccines)
13. Doan L. Nearly half of 140,000 who went on strike in 2021 work in health care. *CBS News*. February 22, 2022. Accessed April 21, 2022. <https://www.cbsnews.com/news/health-care-workers-strike-2021/>
14. Employment projections: 2020-2030 summary. News release. US Bureau of Labor Statistics; September 8, 2021. Accessed April 21, 2022. <https://www.bls.gov/news.release/ecopro.nr0.htm>
15. Protecting the Right to Organize Act of 2021, HR 842, 117th Cong (2021). Accessed February 22, 2022. <https://www.congress.gov/bill/117th-congress/house-bill/842>
16. Alfon B, Hughes M; SmithAmundsen, LLC. Health care workers and labor unions: the COVID “bump” and the new administration’s efforts to unionize more workers. *JD Supra*. April 28, 2021. Accessed January 6, 2022. <https://www.jdsupra.com/legalnews/health-care-workers-and-labor-unions-1469557/>
17. Kinder M. Essential but undervalued: millions of health care workers aren’t getting the pay or respect they deserve in the COVID-19 pandemic. Brookings Institution. May 28, 2020. Accessed February 22, 2022. <https://www.brookings.edu/research/essential-but-undervalued-millions-of-health-care-workers-arent-getting-the-pay-or-respect-they-deserve-in-the-covid-19-pandemic/>
18. Muhlestein B. Health care jobs are a political barrier to health reform. *Health Affairs Forefront*. May 25, 2022. Accessed May 27, 2022. <https://www.healthaffairs.org/doi/10.1377/forefront.20220524.257311>
19. Blendon RJ, Benson JM, Schneider EC. The future of health care policy in a partisan United States—insights from public opinion polls. *JAMA*. 2021;325(13):1253-1254.

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The author(s) had no conflicts of interest to disclose.

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