

Essential Workers

John Saultz, MD

(Fam Med. 2020;52(7):469-70.)

doi: 10.22454/FamMed.2020.811229

Over the past 6 months, an epidemic unlike anything seen in a century has swept the world. While no nation has entirely escaped the carnage, thus far the United States has been the most severely affected. More Americans have already died in this epidemic than in the Vietnam War and the casualties are not a representative subset of our country; the impact is far worse on minority populations, the poor, and the elderly. The COVID-19 pandemic has highlighted some of the best attributes of the American character, but it has also brought our country's longstanding social, racial, and economic inequities into clear focus. Our day-to-day lives have been fundamentally altered and it seems unlikely that things will ever return to normal. Maybe that is not such a bad thing.

The pandemic has separated America into two groups: those who are deemed essential workers and those who have been asked to stay at home during the crisis. The essential workers are hailed as heroes. Their stories are shared on national television and quarantined citizens take to their windows to cheer them. Online concerts are dedicated to them. This is true for health care workers, but it is also true for many others including grocery workers, police, firefighters, first responders, and those tasked with supplying us with accurate and timely information. On the one hand, this appreciation is genuine and much appreciated. But there is also something deeply disturbing at work. Many essential workers have died from COVID-19 while privileged executives and managers have remained safely at home.¹ Congress rushes to deliver financial aid to businesses large and small, but thus far resists calls to help the state and local governments

that employ many of those deemed essential. When the pandemic finally abates, how long will it take before we again hear disparaging comments about the evils of big government, intolerable tax burdens, and greedy public employee unions?

Just like the country as a whole, American medicine is divided into essential and the non-essential workers. Elective surgeries are canceled. Many specialized health services have been put on hold during the crisis and physicians in highly remunerated specialties and administrative positions have spent the pandemic quarantined at home with the rest of the country. But other specialty groups have been working nonstop. Primary care, emergency medicine, hospitalists, intensive care medicine, mental health professionals, public health workers, and infectious disease specialists have been overwhelmed with work. The onslaught of sick and dying patients has inflicted a once-in-a-lifetime professional trauma on many of us. We are faced with fear and tragedy on a daily basis and we work in a setting of personal risk that few of us have experienced previously. And the hardest part of this experience is that patients die without family members present and with doctors and nurses hidden behind masks, gowns, and face shields, and unable to touch them. Funerals cannot be held. Grief is robbed of public outlet and is experienced in solitude rather than in community. It is as though death has become anonymous and grief itself is quarantined.

In this issue of *Family Medicine*, we feature three papers that all address the issue of medical student specialty choice. On the face of it, this might seem to have little to do with the COVID-19 pandemic. But these three papers

paint a clear picture of the inherent mendacity of our early 21st century system of medical education. They show us clearly how miserably our medical schools have failed to create the essential workforce our country needs. Evans and colleagues examine the prevalence of targeted admissions programs in 133 allopathic medical schools aimed at increasing the number of graduates who ultimately care for underserved populations.² Deutchman and colleagues propose a new metric to illustrate how badly medical schools are failing to produce primary care physicians based on the practice patterns of graduates after residency.³ Finally, Prunuske and colleagues examined the attitudes about primary care of graduates from 16 medical schools.⁴ These three papers present a picture of American medical education prior to the arrival of COVID-19. It was not a flattering picture then, and it is even more problematic now. None of these studies report findings that should surprise any reader of this journal.

Not long after the World Trade Center attack on September 11, 2001, a speaker at a rural health meeting in Oregon contrasted the scene that must have taken place in the stairwells of those buildings before they ultimately collapsed. He compared the people who were coming down the stairs to escape the unfolding disaster to those going up the stairs to confront it. Those evacuating the buildings were stock brokers, attorneys, investment bankers, and office workers in some of America's most successful companies. Those going up the stairs were police, firefighters, and emergency medical technicians. Some of these people survived. Many did not. But consider for a moment how our culture values these two groups. Consider their average incomes. Consider the disparity in social standing between them. And while we promised to never forget 9-11, consider how quickly the old social order returned as soon as everyone again felt safe.

During this pandemic, we have once again deemed some of the lowest paid among us to be essential while many of our more affluent neighbors remain safely home. This is actually fine. Heroes need people to save just as much as people need heroes to save them when a real threat arises. Of course, heroism is not limited to just essential workers. In fact, everyone is essential in his or her own way, a fact that becomes clearer each day as we wait for barbershops, churches, and restaurants to

reopen. Being quarantined during the pandemic does not mean that specialty care and elective surgery are unimportant. It just means these services can be safely delayed, but there certainly is disagreement about what is and is not essential. If you carefully study the protests being carried out by those who want to reopen the country quickly, it is not hard to understand the resentment from many of those deemed unessential.

At this time in history, we all need one another, essential and nonessential workers alike. This is as true in medicine and it is in society as a whole. The pandemic reminds us that essential work is valued in a crisis. This is fine. But it is not fine to go back to the old normal when the pandemic is over. During normal times, nonessential work generates more profit and esteem than essential work and this is both unjust and dangerous. Such a system disrespects the work being done now on the frontlines of the pandemic and leaves us unprepared for the next crisis. It is far too early to say whether COVID-19 will cause a permanent change in our social order. It is clear, however, that such change will not happen on its own. In the months ahead, we will surely hear calls to never forget COVID-19. But what are the lessons we will pledge not to forget? Will we attend to our porous public health, mental health, and primary care infrastructures? Will we confront the bloated excesses of our health care system and shore up depleted social services? Committing here and now to changing these systems is the only meaningful way to memorialize the work and sacrifice of today's heroes. And all of us, essential and nonessential alike, can be heroes in the work to come.

References

1. Khullar D. The essential workers filling New York's coronavirus wards. *The New Yorker*. May 1, 2020.
2. Evans DV, Jopson AD, Andrilla CHA, Longenecker RL, Patterson DG. Targeted medical school admissions: a strategic process for meeting our social mission. *Fam Med*. 2020; 52(7):474-482
3. Deutchman M, Macaluso F, Chao J, et al. Contributions of US medical schools to primary care (2003-2014): determining and predicting who really goes into primary care. *Fam Med*. 2020; 52(7):483-490.
4. Prunuske J, Kang H, Wendling A, Edwards-Johnson J, Phillips JP. Attitudes toward family medicine among students choosing other primary care specialties. *Fam Med*. 2020; 52(7):491-496.