EMOTIONAL LABORS:

ORGANIZING LONG-TERM CARE WORKERS IN CHICAGO

DURING THE COVID-19 PANDEMIC

by

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Submitted in partial fulfillment of the requirements for the degree of

BACHELOR OF ARTS IN PUBLIC POLICY and SOCIOLOGY

at THE UNIVERSITY OF CHICAGO

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April 18, 2022

**Abstract**

The COVID-19 pandemic has labeled care workers as "essential," raising questions about the distance between the social lauding of the profession and the felt value by these workers who, in the United States, number many women of color. This paper qualitatively evaluates the content of eleven oral histories and one interview by nurses and nursing assistants to consider whether and how these workers negotiate their marginal identities at individual and collective levels to agitate for change. I merge individual-level identity literature on gendered and racialized approaches to labor with social movement theory about union efficacy and collective power-building. I find that, even as care workers do not invoke their marginal identities as the primary contributing stressor to their experience of work during COVID-19, these workers and the labor unions that represent them emphasize their personal vulnerability to the pandemic's effects yet collective strength in opposition to managerial bodies. The outcomes of this project iterate the need for continued sociological investigation of all types of care workers' experiences of work, as socio-economic stratification within their profession and their lives at large continues.

## Acknowledgements

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**Introduction**

"The American healthcare system is broken" is a common refrain—one often repeated by politicians, patients, doctors, and the public at large. The coronavirus (COVID-19) pandemic of the past two years has upended the management and administration of health care in the United States, drawing attention to its capacities and shortcomings. Maybe more importantly, the pandemic has brought a shift in how care workers—in hospitals, in schools, in homes—are described in public discourse. Their work is "essential"—which, now, equates the idea of front-line work with being socially and societally valuable.

This paper will deal with the idea of "care work"—broadly defined over bodies of scholarship as any work, paid or unpaid, that pursues processes of care for a person or people (Hochschild 1983). However, not all care work is created equal: labor that is done by people at the identity margins carries with it a different weight. I will first explore the existing literature on how care work is gendered and racialized, then explicate the proven utility of labor unions in representing care workers despite historical challenges to organizing in the United States. I will seek to bridge these fields by identifying existing work on COVID-19, arguing that the pandemic has been an opportune moment to bring attention to care workers' narratives as they seek to improve their working conditions.

Often irrespective of their patient populations' demographics, nursing assistants and technicians in the United States are majority women of color, documented or not (Frye 2020). This project seeks to answer the question of how care workers negotiate their marginal gender and racial identities when performing care work—in other words, whether being women of color has affected their personal experiences of performing work during COVID-19. I extended this question by asking how the labor unions that represent Chicago's care workers invoke those

identities at a collective level to agitate for material and social changes to working conditions and treatment. I found through qualitative analysis of oral histories and union websites that, while care workers largely de-emphasized their own individual identities when discussing burnout and the toll of COVID-19 on their experiences of work, they as a collective class of workers and as union members do more to stress the vulnerability of their job positions as inextricable from their identities.

**Theoretical Framework**

I first explore the bodies of literature on how care work has become increasingly gendered and racialized—in the sense that more and more gender and racial minorities perform this work, but also that this work has been essentialized as unseen, unclean, and unsupported because of the people who do it. I then zoom out to look at perspectives on labor unions, as they have historically been the gateway from workers facing their individual stresses alone to sharing in those struggles as a collective. The last section touches on how and why COVID-19 is a historical moment to be bridging the individual and collective struggles of the healthcare labor movement. By focusing on COVID-19 in this project, I contribute to the further exploration needed of how to use the industry's current social visibility to rectify individual and institutional issues care workers face.

*The Gendering and Racializing of Care Work*

Care work can be framed as not only as the physical act of accommodating a patient's needs to improve their health situation, but also the psychological and emotional angles care workers must pursue. Many scholars have established different sub-categorizations of care work that I draw on in this project. In her seminal work *The Managed Heart* (1983)*,* Arlie Russell

Hochschild synthesizes the concept of "emotional labor," a phrase that has deeply shaped what it means for women in particular to perform work in any sort of service or care occupation. She found in her scholarship that service employees—flight attendants being one notable example—intentionally masked personal emotion in order to project feelings of support and cordiality for customers. Hochschild argues that, by withholding their own true emotions every day at work, these workers' mental and emotional health deteriorated. My project hypothesizes that the same is true today in the case of care workers—and that the tragedy surrounding COVID-19 has changed how and when people display their emotions in a healthcare setting.

Incorporating some elements of "emotional labor" into their analysis, historian Eileen Boris and sociologist Rhacel Salazar Parreñas (2010) anthologize various studies to define the concept of "intimate labor" as any physical and emotional work involving the human body. By connecting health care, other bodily care, sex work, and more under this umbrella term, they make novel connections about the stigmatization of both performing and needing bodily labor. This anthology of scholarship directly led into Boris and Jennifer Klein's (2012) "devaluation thesis," which argues that, because of the perceived "dirtiness" of the work, not enough attention or value is paid to home health care work. The result is that workers performing "dirty labor" are stigmatized as well. The basic irony, however, is that more and more care work must be taken on by those most devalued in this hierarchy—workers that are truly essential. My project relies heavily on these connections between health care, mental health, and the body to explore how care workers negotiate their identities as unseen and even "unclean" in their work—while simultaneously being so crucial to the functioning of the healthcare system.

These concepts of emotional and intimate labor by no means stand apart from workers' identities in the United States; on the contrary, these phenomena are highly gendered and

racialized, and more and more of this care work is performed by women of color. Boris and Klein trace the historical trend of wives and mothers initially performing care work within the home setting, then to their outsourcing of such work to home health aides—who were and are primarily women of color—and finally to facilities beyond the home setting. Within those latter settings, which include nursing homes and hospitals, nurses are mostly women and nursing assistants are largely women of color. Centering both the work experiences of nurses and nursing assistants in long-term care facilities, and their (mis)treatment based on their identities as women and people of color, is a holistic and intersectional approach that has gained traction in recent decades and is one I seek to pick up in this project.

Conducting this scholarship on care workers at all was, until recently, under-valued as an avenue for those individuals to tell their stories. This valuation, exemplified by pieces such as Timothy Diamond's groundbreaking *Making Grey Gold* (1992), comes from the notion that not only are care workers facing issues such as poor pay and neglect, but also that the people they care for—vulnerable, elderly populations—deserve attention as well. The closeness Diamond garnered with his patients and coworkers alike, in his role working somewhat covertly as a nursing assistant, allowed their narratives of issues in the care space to shine through. Another potential stressor identified by previous scholarship is the high emotional investment of care work, something which comes through greatly in this project in how care workers speak about day-to-day and institutional stressors. This high emotionality may come from the fact that, in a long-term health care relationship, care workers and patients can develop a bond that mirrors and substitutes family structures. For example, as young female nurses perform care work for elderly patients, they can become like daughter figures (Dodson and Zincavage 2007). Such a closeness can allow for easy communication about care needs between patient and nurse; on the other

hand, it may informalize the patient-care worker relationship so much to the point where one party—particularly the patient, as María de la Luz Ibarra (2010) found—feels more entitled to abrasive responses when a problem arises. Rather than focus on the behaviors of patients in this project, I will explore how the care workers in question negotiate such emotionality and bond-forming amidst the high stress health environments created and exacerbated by COVID-19.

*Organizing the Health Care Workplace*

Discussion of how health care workers organize themselves communally is predicated on the established idea that labor unions are one way that workers can collectively agitate for their demands and make material gains. Many studies have established union efficacy in such a manner, specifying that there are indeed differences in organizing outcomes depending on the dynamics of the industries and economies in question. In other words, it is not a question whether unions have made material gains for workers in some industries in the face of globalized corporate power; rather, the variation comes in how effective organizing tactics can be across unions and industries depending on the circumstances (Satrya and Parasuraman 2011). With the COVID-19 pandemic as a change point for the healthcare industry and its laborers, there was and is theoretically greater appetite for material changes on behalf of service employees and frontline workers. However, I argue that the felt value of labor during COVID-19 to workers may be quite different, especially as focus on pandemic-related, short-term issues necessitates prioritization over the visibility of long-term structural issues.

In the United States, it is important to note the historical difficulty people working in the issue area of labor organizing have had in uniting with other social justice movements. Women and people of color have faced historical exclusion from unions in many industries, requiring them to form their own locals and foster (often lesser) bargaining power separate from men

(Helmbold and Schofield 1989; Halpern 1997). As a result, even as some unions are presently well-integrated into social movements, the problem of exclusion has led to organized labor's reputation as "conservative" in broad strokes (Crain and Matheny 2001). The premise of unions themselves, even, has been countered in critical disability studies scholarship, which has critiqued ideas of productivity and ability in the capitalist and "medical model" senses (Davis 2013). By dint of this project's focus on long-term care workers, its scope moves away from those narratives of patients experiencing said workers' labor. It is important to highlight scholarship of activists and thinkers who center the particular experiences of those elderly and/or disabled people who are "objects of care" not explicated thoroughly enough in this project (Wang 2018).

To counter historical exclusion of women of color in both practice of organized labor and from theoretical study, this project argues for increased attention paid to those organizing efforts achieved by said women in recent union history—since they do higher proportions of care work in the long-term care setting than ever before. However, with Boris and Klein's "devaluation thesis" as a backdrop, it is important to explore why such workers are harder to organize—not just given their identities, but also with their precarious employment positions. On a basic level, long-term care work is more essential than ever before, yet wholly unseen and intimate—leading to high-stress work with little social and economic valuation felt by workers. Mignon Duffy (2007) traces this development through history, with a specific focus on the service sector. She explains how most every example of a "dirty work" job has trended to being fewer men and more or the same amounts of women—and more women of color—conducting such work. She takes care to emphasize, though, the precarious nature of this work, where economic devaluation comes not only from the increasing workload and expectations of emotional labor—but also

from the inability of care workers and service employees to garner generational wealth in their sectors.

This issue is particularly salient in Chicago, home to a wide range of people of all backgrounds, suggesting that labor unions in the present day should incorporate justice principles particular to the identities of their members. My project explores this question with reliance on prior scholarship about both healthcare union efficacy in other cities, and to the conditions similar to those in which Chicago's laborers are living and working. Steven Lopez (2004) traces the history of Pittsburgh's steel industry and labor force—which, when steel jobs disappeared, was increasingly replaced with huge movement into the service sector. He explicates how effective steel organizing was; as service jobs are more and more "gig-ified," however, SEIU as the union that represents this growing industry in Pittsburgh has employed new bargaining and organizing tactics to mobilize and retain workers.

Gabriel Winant (2021) also traces the de-industrialization of Pittsburgh to explain how care workers were both needed to take care of the aging worker population and replenish the workforce. He specifically focuses on the massive profits garnered by major hospitals and private nursing home chains as health care became the dominant industry. Despite this growth, workers' pay had stagnated, and quality of working conditions worsened. Membership in union locals allowed for worker protections, though, and have made great strides in advocating for workers' rights. These authors' intersectional, ethnographic approaches to scholarship that I seek to pick up in this project demonstrate the utility of centering personal accounts of workers in agitating for solutions. These narratives highlight the ups and downs of union organizing, especially in the face of monopolized healthcare corporations that hire anti-union experts to squash organizing. Labor unions as the collective bargaining units for care workers and other

sorts of service workers are demonstrably effective in agitating for their demands despite these broader, historical anti-union efforts and sentiments present in the United States. This project takes that as fact, especially when unions actively incorporate questions of identity and social justice into their organizing principles.

*Identity and Occupational Communality during COVID-19*

I explore how, with such individual- and collective-level occupational stresses as introduced above, long-term care workers invoke and mobilize their identities in organizing for better conditions and outcomes for themselves and their patients. Existing social movements literature has already demonstrated the opportunities that an event such as the onset of COVID-19 brought and could bring to the goal of making structural change. David Meyer (2004) aggregates various studies exploring "political opportunity," thought of as the ideal situations for social movements' leaders to take further steps to pursue change. In the case of labor unions and health care, a global disease pandemic such as COVID-19 was and is a breaking point: it both creates dire new problems to organize around and exposes structural issues yet to be fixed. More specifically, it has exposed—at least at times—the particular issues of long-term care workers at the tenuous bottom of the healthcare hierarchy. My project explores to what extent those issues are meaningfully responded to—by managerial bodies in charge of decision-making, but also by the social order in charge of affirming the importance of care workers' needs.

As this project also emphasizes the conditions of facilities that care for diverse patient bodies, it is important to highlight scholarship that focuses on how racial health disparities in patient populations inform how care workers approach physical and emotional aspects of care. If health outcomes are different for majority-minority patient bodies, as reiterated by Laura Samuel and her coauthors (2021), and their care workers are likely to be women of color as detailed

above, this project seeks to explore how workers respond to those patients' particular needs or provide solutions for management bodies to enact. Kimberly Beiting and coauthors (2021) found this as well, arguing that underserved patient populations—who are susceptible to worse outcomes from COVID-19 due to historically worse qualities of care—need particular attention that is distinct from their white, wealthy counterparts. Their study's product of a clinical management plan actively reflects the physical and emotional care needs specific to these patient populations, and it was made in a manner that does not essentialize the differences between racial categories. My project focuses on care workers specifically, and thus patient health outcomes are useful information but not the primary unit of analysis. The framework of patient sensitivity in uniting workers, however, is crucial to this project in understanding the sorts of demands labor unions lead with and how they invoke patient protection as their motivation for their actions.

This project will touch on the extent to which healthcare union locals align themselves with concurrent social movements. I specifically focus on facilities that have patient populations particularly vulnerable to the effects of COVID-19, as Chicago's hospitals and nursing homes often are. The newness of this project comes in demonstrating the conditions of working in and organizing around those issues specific to COVID-19, and how those issues build upon existing problems care worker unions have picked up previously.

**Data**

My project primarily consists of data from two sources: oral histories from care workers in hospitals and nursing homes in Chicago, and content analysis of labor union websites and communications.

The oral histories were conducted in the fall of 2020 and winter of 2021 for two different University of Chicago mixed undergraduate and graduate courses: "United States Labor History," and "Capitalism, Gender, and Intimate Life," respectively. Each interview is about an hour long, with 11 total factoring into my analysis. The oral histories cover workers self-identifying as nurses, nursing assistants (CNAs), and patient care technicians (PCTs). While all interviewees were recorded as identifying as women, only some transcripts shared workers' racial identities. This is a limitation of my knowledge of the data: while there is evidence of some racial diversity of the sample in that at least two of each of white, Black, and Latina women are represented in the oral histories, I cannot speak to all eleven women's experiences of their racial identities.

Although each oral history project was conducted by a different student in the classes, interviewees were asked similar questions to one another. Questions addressed subject matters such as what a typical day at work before versus during COVID-19 was like, their experiences with labor unions, and how they react to the term "essential worker." Interviewees were asked various follow-up questions to particular answers, and also had the chance to speak freely at the end of their interview time. Additionally, I conducted one interview with a white, mid-30s hospital physician working in general health and end-of-life care that is analyzed. Questions for that interview similarly asked about her day-to-day rhythm of work, both before and during COVID-19, and whether she felt her identity played a role in determining her experiences of work. With these sorts of questions, I sought to glean whether she incurred stress during COVID-19 specifically as it related to her marginal identity as a woman—and whether this compounded what I had hypothesized to be a stressor of being a woman working with predominantly male bosses. All workers' identities have been anonymized: I will only include

the date where available or broad time period (Fall 2020 or Winter 2021) in which they were interviewed for reference.

This project also refers to raw data of staffing levels and nursing home ratings within Chicago and in Illinois more broadly. I have also referenced COVID-19 case and death numbers in Chicago: while these figures are not explicitly represented in this project, they allowed me to more precisely reference which "waves" of COVID-19 care workers spoke about in the oral histories. These data came from reports out of the Illinois Department of Healthcare and Family Services (HFS), which has been studying COVID-19 trends in the state and aggregating concrete solutions for nursing home reform. Additionally, content review of press releases and blog posts of websites of unions that represent health care workers in the city—the Service Employees International Union – Healthcare (SEIU), the American Federation of State, County and Municipal Employees Council 31 (AFSCME), and the National Nurses Organizing Committee (NNOC) as an affiliate of National Nurses United (NNU)—has contributed to analysis of activist rhetoric around the issues health care workers have faced during COVID-19 and worker-demanded solutions for improving their work environments. With firsthand accounts of care workers proliferating during COVID-19, I will expand on the understanding of how the healthcare landscape and organizing its workers at racial and gender identity margins specifically has changed or stayed the same with the pandemic.

Oral history is crucial as a data collection and preservation method to explore this topic because this project necessitates present-day perspectives on the internal lives of interviewees. Archival research allows for background on the subject matter in Illinois and Chicago specifically, in providing prior perspectives on nursing homes and their care workers as it related to historical patterns of home or hospital residency and outcomes. With such data as the oral

histories and content analysis of union statements and rhetoric as all mentioned above, a comparative study of the changes and consistencies in problems care workers have faced may emerge.

**Analysis**

The oral histories used in this project were all transcribed on Otter.ai and stored securely on Box. The interview I conducted is an hour long and took place on Zoom; it was also transcribed on Otter.ai. Coding of variables and trends found in the oral histories was conducted manually and sectioned into relevant topics for analysis. Online or archival content—such as websites, news articles, and datasets—were coded in a similar manner, with attention to finding code categories concurrent to the oral history codes for grouped analysis of the two types of data.

Three major categories of analysis and results emerged from the codes of oral histories and the website contents used. First, the oral histories and accounts of workers represented in union communications yielded broad patterns of the personal experiences of work and the particular issues of burnout, exhaustion, and frustration that care workers faced. The second code pattern that emerged was that of how care workers' perspectives on work-related issues come into conflict with or up against those desires of managerial bodies at their hospitals or nursing homes. This emerged from their discussions of working conditions and particular interactions they or their coworkers had with their health administrators. This leads into the final major code grouping—solutions to care work-related problems—which is bolstered by the content analysis of union rhetoric. This contributes to my larger discussion about COVID-19's implications on the nature of care work, and it yields policy recommendations for Chicago's and Illinois's health administrations as well.

**Results**

Through analyses of the oral histories and the content of union websites, I seek to demonstrate how Chicago's care workers describe work stressors in individual and institutional terms. The first section explores the former: how long-term care workers describe the personal burnout and physical or emotional stress that has come particularly from working during COVID-19. I found that care workers focused less on how their own personal identity affected their work, but rather that worry about their patients' well-beings was the primary stressor that compounded their own.

In the second section, I explicate how these workers personally experience conflict with management at their facilities—specifically, the disconnect between how increased social attention to health care professions has not led to tangible improvements by management in their safety and work conditions. Especially during COVID-19, many care workers eschewed the social praise conferred by the term "essential worker," because the value it implies is not materially or emotionally felt when performing care work. This lack of felt value compels or further justifies labor union membership or action for these care workers.

This leads into the third section of my results, explaining how Chicago's healthcare labor unions as organizations more actively use rhetoric of workers' identity marginality in order to explicate how that compounds the stressors explained by individual care workers. While COVID-19 has necessitated that tangible, next-step goals put forth by labor unions be met, these unions concurrently invoke the long course of worker agitations to expose structural problems in health care.

*Stressors on Care Workers' Physical and Emotional Capacities*

I first argue that overcrowding and staff overworking plagues many healthcare settings across the city of Chicago, and the particular stressors brought on by COVID-19 exacerbated that for care workers and the broader public alike. Those existing stressors of working in long-term care facilities or caring for older patients in hospitals—their vulnerability to comorbidities with age being one that was referenced in the oral histories[1]—were amplified with the highly contagious nature of COVID-19 that forced most types of facilities to restrict outside visitors, lock down residents, and minimize staff-to-patient contact as much as possible. This nurse in particular emphasized the hypervigilant measures she took to try and minimize contact between COVID-positive and COVID-negative patients, or hospital patients and their families when she left shift:

> It's a lot of mental work. Yeah, like, did I wash my hands? What did I touch with this glove that's dirty? Like, did I just touch my face? … And then you're always keeping count of your coworkers, like, who's not here today who called in sick? Like, are they sick? Do they have COVID?[2]

This nurse's account demonstrates a constant need to be aware of her own and her coworkers' movements—to the point of a sort of peer-to-peer surveillance. This was shared by those interviewees working in hospitals, for the COVID-19 isolation floors began to encroach on those previously non-COVID spaces when patient capacities were met or exceeded.

Existing stressors plus this hypervigilance during the COVID-19 pandemic have caused burnout—defined not only as overworking causing a feeling of being drained, but "mental distance" from one's job and growing negative attitudes towards work one once liked or loved. Burnout can also cause a lack of motivation to perform thorough work; in the case of long-term care workers, that necessarily refers to both physical and emotional labor being compromised.

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[1] Oral history, 2/12/2021
[2] Oral history, 11/6/2020

One CNA in a Chicago nursing home explained the difference between broader social anxiety

about the pandemic, and the stress particular to long-term care settings:

> I'd be sitting in the nurse's station and hearing all these CNAs talk about people
> they know with COVID… It was just a different sort of anxiety that I would
> experience… It was really hard to explain to people, like, I never really got a
> bubble… I feel like I needed a day to hype myself up for going to the nursing home.
> And then I was at the nursing home and then I need day to calm down after the
> nursing home.[3]

This nursing assistant distinguishes between society's larger anxieties about COVID-19—still

tangible, yet more abstract—and her own constant anxiety as a care worker whose patients and

whose self are more vulnerable because of the conditions of her healthcare setting. The language

of burnout was also used more explicitly in other examples. In the interview I conducted, I asked

the question to the physician at a large Chicago hospital of how her ability to perform or respond

to the emotional demands of care work changed during COVID-19. I particularly asked this

considering that she had said having relationships with patients and their families was one of her

favorite parts of being a doctor:

> This was told to me by a different doctor: everyone who comes to the doctor either
> is there because someone told them to be there, or because they're suffering… If
> they're suffering, that's a lot of things that people need from you. They're looking
> at you. And when you're burned out and feel powerless… that's really hard… I have
> in the past separated myself. Because those requests for help are too hard when
> you're feeling powerless.[4]

These examples of the types of pleas she as an essential worker faces in performing care work—

"I am dying" or "someone I love is dying" were two that she named—must be responded to.

However, beyond what materially could or could not be done for those patients, this doctor was

also psychologically and emotionally unprepared to respond to those individuals and families

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[3] Oral history, 3/12/2021
[4] Interview, 11/5/2021

dealing with sickness and death at an acute level during COVID-19. The personal stress of the

patient—coming from their illness, or their financial situation, or their isolation from family—is

necessarily put on their care worker. While this is a phenomenon that pre-dates COVID-19, as

established in emotional labor literature, it is actively worse during the pandemic—to the point

of near inability to function on the part of the physician.

      With the repetition of such issues and burnouts, as the physician notes here, she has no

choice but to emotionally distance, or "separate," herself from building relationships with

patients. This is in contrast to the natural instinct to care that she alluded to in other discussions

of individual connections to patients and families. Another nurse in a hospital had a similar

account from a colleague managing an end-of-life case. The emotional distance this worker

experiences is shared by the speaker, who herself makes explicit the change in emotional

capacity and closeness that were available before COVID-19 compared to now:

> And [the nurse] had to translate and tell this woman that her husband is going to
> die, that we can't let her go in and see him. And that she can stand at the door and
> look through the glass window and say goodbye. That was one of the hardest things,
> I think, to witness… [since] a lot of the patients who we get really close to, we have
> cared for for a long time. It starts to feel very cold. I don't think anyone ever intends
> it to be that way… It's horrible. It's horrible. That's not the way we want things to
> go. And that's not the way that things used to be.[5]

This sort of case came to define the tragedies of COVID-19 and isolation in social discourse, and

this is one nurse who, even with emotional distance pursued, had to process these intense

emotions from an objectively distressing and sad situation. Blunting her own feelings in order to

be less affected by tragedy yet continue working, therefore, leads the nurse referenced in this

quotation to feel guilty for not being able to be totally emotionally present. She makes clear that

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[5] Oral history, 2/12/2021

this is neither the aim of the job of care workers, nor their wish when performing work—

exemplified by the nurse speaking saying "that's not the way we want things to go."

One former CNA who now works as a blood-drawing technician also talked about

balancing forced efficiency and the care work she desperately wants to do—and was well trained

to do as a CNA specifically:

> I'm told I can't stay and make very much conversation with the patients because
> I'm losing time in getting to other patients… It's a hard habit to break… so I still
> do [it]. It may [just] be 'I hope you're doing okay today,' or 'Is there anything else
> before I go?'… So, it's a weird balancing act, because I have to make sure I'm
> doing everything safely… but I also have to do it in a way that's quick and efficient,
> without harming anybody.[6]

This care worker explains that, by nature of her newer, non-CNA job, but also because of

overcrowding in hospitals and facilities due to COVID-19, she has less opportunity to connect

with her patients on a more meaningful level. What is lost when these connections are not made,

this answer asserts in and of itself, is better care—since the physical act of care is not the whole

act of providing health care, and much is lost without as much emotional care as before COVID-

19.

As is implicit from how little it was brought up in particular connection to the questions

eliciting responses about burnout, it may be said that feelings of exhaustion were not necessarily

felt to be amplified by or specific to the workers' gender or racial identities. For these care

workers, the jump in caseloads and overtime hours worked led to more burnout than any

potential prejudices based on gender or racial identity. Any personal circumstances experienced

outside of the workplace may vary in emotionality across identity lines, but I did not find with

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[6] Oral history, 3/3/2021

this particular project's scope that such identity-based negotiation was prominent in the accounts of care workers in health settings.

It may thus be argued that more pressing problem for female care workers (either white or of color) as health professionals was that they felt like personal agents, representative of and responsible for the failures incurred by overcrowding of COVID-19 floors or by visitors' inabilities to see their loved ones. So, rather than identity figuring as the primary compounding stressor, other aspects take prominence in the day-to-day for individual care workers. Conflicts with managerial bodies thus arise when patients' and workers' needs go unmet.

*Conflicts with Management over Unmet Patients and Workers' Needs*

Some of the personal stressors highlighted above are caused by factors particular to the unprecedented nature of COVID-19—and as I found through my analysis, few workers incorporated issues of personal identity in their responses to those stressors. However, other issues can be contextualized in historical management-worker conflict patterns characteristic of facilities with unionized workers. I argue from this that bodies of working people tactically invoke patient circumstances—and even patients' marginality—in addition to the invocation of workers' marginality to agitate for better protections for both groups.

In order to situate why particular conflicts have arisen between workers and their bosses, it is important to explain the working conditions particular to hospitals and nursing homes in Chicago that are exacerbated by the physical and emotional care needs specific to COVID-19. The issues of burnout and lesser quality of care arise more prominently at high-Medicaid facilities—where staffs of nurses and nursing assistants, the latter of whom are majority women of color, experience high turnover and little institutional support. This has been made apparent in Illinois by analyses conducted by the Department of Healthcare and Family Services (HFS), who

have studied the state of nursing homes in Illinois during COVID-19 and suggested potential measures for improvement. One of the HFS reports, presented to the Illinois General Assembly in late September 2021, draws the connection between patient demographics and working conditions for care workers during 2020 (Eagleson, Allison, and Cunningham 2021). As with most states, Illinois at different times during the COVID-19 pandemic has been a hotspot of cases and deaths. At the same time, "Illinois accounts for 47 of the bottom 100 facilities in the country as measured by nurse staffing performance" using Staff Time and Resource Intensity Verification (STRIVE) metrics, a set of performance targets based on a nationwide study of nursing conducted in 2007 (Eagleson et al. 2021:2).

This concentration of facility issues is also highly racialized. In Illinois, rather than all nursing homes serving a roughly equal proportion of the racial makeup of the state or cities themselves, some facilities serve entirely white clientele—about 16% in the state—or majority non-white patients—also about 16% (Eagleson et al. 2021:45). In Chicago, more 4- and 5-star-rated nursing homes (overall rating includes quality of care, health inspection rating, and staffing) are located on the North Side of the city, an overall wealthier and whiter region (U.S. Centers for Medicare and Medicaid Services (CMS) 2021). More 1- and 2-star-rated nursing homes are located on the South and West Sides of Chicago; said facilities have more racially mixed sets of clienteles, but they are ones with larger proportions of Black and Latinx residents in addition to white residents who are in lower socio-economic brackets (CMS 2021). One nurse in a major Chicago hospital that sees patients mainly from the West Side of the city highlighted their positionality as "underserved" individuals. She also contextualized the city's racialized segregation—and varying health outcomes as a result of it—as not unique to Chicago:

> We stood up for our patients and the kind of care that they deserve. Because that was our main goal, is to give safe and appropriate care to the people we take care of, and that's a majority underserved, Black and Brown, lower socioeconomic status people. That also describes the people who are suffering most from COVID in the hospital, in the city, in the state, in the country. So, it was opportune that COVID was kind of on the downtrend at that time that we went on strike.[7]

This care worker highlights that not only do the problems of racial inequities plague health infrastructures in Chicago or even at a city level—but they can be felt at a national level as well. Paying attention to national trends or trends of COVID-19 in other states is something that care workers situated as part of their experiences of work and life during the first year of the pandemic. What this care worker understands to be the reality for her patients is great inequity in how people of color and poorer people experience health care—inequity that is represented quantitatively in the September 2021 HFS report.

The authors of the report aggregated the facts of intersecting inequities in their analysis—finding that patient racial demographics also correspond to Medicaid dependency rates. Those facilities are thus plagued with problems, such as overcrowding and resource misallocation, as measured by STRIVE metrics. All of these data together point to demonstrably worse care for residents, who themselves or their family members then provide personal accounts to contribute to poorer facility ratings (CMS 2021). The cyclical nature of such issues may help explain some (though certainly not all) instances of reported code violations typically found in worse-rated facilities.

The HFS report thus argues that the staff at skilled nursing facilities faced stressors in greater measure than most (if not all) other states because of this cycle of problems. Drawing correlations between patient demographics, facility conditions, and staffing levels is essential to

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[7] Oral history, 11/6/2020

understanding the broader argument that quality of care is not wholly a function of staff

capability, but it is also about the conditions in which these unsupported laborers work. This

context about Chicago and Illinois serves as a backdrop for the personal accounts of workers in

these facilities, in how they imagine the struggles of their patients as concurrent with their own

as largely women of racial minorities.

The workers' accounts documented in the oral histories aligned their shared minority

status with their patients, qualifying the quantitative data in the HFS report that shows the same

idea. One nursing assistant explained how affected her coworkers were who had contracted

COVID-19:

> I have co-workers who got [COVID-19] who have had to leave bedside nursing, because they get so winded. And their sleep is affected and all these other things. The fact that it affects people more with underlying conditions … who are those people more likely to be? Poor, Black, Latina. [This system] is not set up to be a thing that works for anyone … the people who do make it out and are okay, that's luck and privilege.[8]

She highlights that the patients whom nursing assistants and technicians have historically treated

are usually poorer and/or of color—and so are these care workers who similarly grapple with

issues of their social position. The workers' lack of "luck and privilege" that this nurse names as

necessary to navigate the American healthcare system mirrors the "underserved" language used

to describe patient populations in the previous quotation.

Every oral history interviewee brought up the disproportionate bottom-loading of work

onto CNAs and care technicians—emphasizing their marginal identities as underpaid women,

often women of color, who do most of the work to keep healthcare facilities running. One nurse,

speaking at the time when vaccines against COVID-19 were becoming available for those

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[8] Oral history, 2/12/2021

working in health care, sought to center the experiences of care workers at the identity margins

who are also lower on the healthcare hierarchy:

> In my mind, it's obvious that you want to vaccinate people who are providing care first… And I think this kind of gets back to… who is considered essential. Patient care technicians are a lower paid group. Many of the PCTs I work with are women of color, people of color, and people who are trying to go to nursing school, but they have to keep pushing it back because it's expensive.[9]

She introduces the term "essential" here—explicitly stating the notion that PCTs, despite being

some of the most invisible workers in the healthcare system, provide more care and give more

attention to patients than even she and her fellow nursing leads do. She also notes that many

nursing assistants at her hospital likely want to pursue nursing school—to get more training, and

to get better positions at their hospital or elsewhere—but that it is too expensive for them now

and may be precluded by COVID-19.

This nurse appreciates that at least health care workers had early access to vaccination

against the coronavirus in Chicago, but she then wonders, "Is [vaccine priority] being offered to

people who cook the food? … One of the only [workers] to die who worked at [our hospital] was

a custodian."[10] Naming not only PCTs and care workers, but also "behind-the-scenes" staff such

as custodians and cooks at her hospital, this nurse sought to highlight the stressors of being of a

shared marginal identity on top of having to take on much more work with no guarantee of

protection. In this sense, she elaborates on her own concept of "essential work," specifically by

centering those service workers whose demographic makeup and socio-economic status as

lower-level workers should be spurring increased protections from management.

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[9] Oral history, 2/12/2021
[10] Oral history, 2/12/2021

Care workers during COVID-19 have come into social and emotional conflicts with their bosses—and the American public at large—for lauding their work as "essential" without making meaningful changes to a healthcare system which workers and consumers alike view as broken. If interviewees agreed that their work was frontline and most necessary during a health crisis such as COVID-19, they also stressed repeatedly that, at the end of the day, the work they do is still their job that they feel need not be specially highlighted because of the pandemic. A former CNA in a nursing home, who is now a blood technician at a Chicago hospital, framed this idea by highlighting a wish for better wages—but also naming the feelings she associates with a label such as "essential":

> But yeah, with all this talk of essential workers and 'thanks for doing what you're doing'…it's like, okay, if you're thankful for what we're doing, why don't you fight for better wages? I mean, I feel like it's one of those things that's a blanket term to make people feel important, when we're only just doing our jobs.[11]

This refrain was repeated by many interviewees— "we're just doing our jobs"—when asked about what being "essential" or "heroic" means to them. Beyond a neutral attitude or acceptance of such a label, some care workers expressed their frustration with the hypocrisy that such a valuation carries for them. One nurse at University of Illinois at Chicago's (UIC) hospital assessed such a label as evidence that their management sought to economically and socially profit off of the increased social attention being paid to lower-level workers:

> I don't see what we're doing as any different [from pre-COVID], and I don't see us as heroes, either. I see us as good people who want to just do their job and do it with the right equipment to be safe. But the fact that hospitals were capitalizing on, for good publicity, and calling us heroes was so condescending to me. And, because, it was very clearly being used for their own benefit, rather than to actually take action to protect us.[12]

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[11] Oral history, 3/3/2021
[12] Oral history, 11/6/2020

This nurse argues that the label of "essential worker" itself actually obscures to the broader public the conflict she and her fellow unionized workers have faced with management at her hospital. Rather than have hospital and nursing home managerial bodies profess support for their health care workers by providing one-off break room parties or by merely calling them "essential," these workers express their frustration with these shallow solutions and agitate for sustained, concrete support ones instead.

This individual frustration—and this hinting at their own personal visions for healthcare reform—is what drives care workers together to actualize their solutions. These workers face problems—either their own, or ones they see when empathizing across jobs within the healthcare system—that make organizing with a labor union, even after potential hesitancy to do so, more attractive. Workers specifically point to conflicts with their facilities' management bodies as the reason that demand-generating under the label of a union—and walkouts and strikes for those demands—have arisen in the first place. Some interviewees were a part of the walkout that took place at the UIC hospital in September 2020; others talked about the efforts at Rush University to organize a union; still others as SEIU employees spoke generally about appetites for striking and direct actions at their facilities as well.

Some of the richest pieces about direct actions to highlight in this project are those instances wherein workers point to their pride in being a union worker for the increased sense of protection and support they felt specifically as marginalized people. Many workers' accounts illustrated here begin with their justifications of why they are already in or want to be in a union. One nursing assistant sought to dispel what she argues is a mythical, untrue idea about the purpose or scope of labor unions:

> Our demands are so non-extravagant if you were to actually look at it. I think the public maybe thinks, 'oh they just want more money' or what have you, but a lot of what we fight for is not just about the money.[13]

She makes clear that better pay for health care workers, especially those lower-level ones who have the most interaction with patients, by no means stands apart from running demands that have existed since before COVID-19.

Better pay also by no means comes first in some of the organizing that has taken place in Chicago's health facilities. The same nursing assistant goes on to explain that, before even being able to agitate for material remunerations, her union had to ensure that if replacement workers were called, that those workers employed by the facility would not be threatened based on their immigration status:

> One of the [demands] was [for the hospital to not use] deportation as a disciplinary action. They were discriminatory because, for instance, some of our workers were here on a certain visa… [our supervisor was] threatening deportation as a disciplinary action.[14]

While the legality of the threat does not necessarily hold in this particular circumstance, the threat itself is unquestionably frightening to workers hearing it used against themselves or their colleagues. This nursing assistant's experience demonstrates that, without unions stepping in to first protect against racialized attacks on people's livelihoods, after which they may then go on to agitate for material solutions to issues like ample pay or personal equipment, threats to workers would likely have gone unnoticed or at least undefended by a coalition of people.

Other workers also alluded to this stress about replacement by agency—or non-union—nurses and nursing technicians during their strikes. One nurse implored at the end of her

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[13] Oral history, Fall 2020
[14] Oral history, Fall 2020

interview for nurses and nursing assistants to consider a union as a way of representing collective

interests:

> I want… [our strike] to be an example for other unions and especially nurses who are a majority in this country not unionized… I want them to know that they are safer with a union, both in their practice and in their job security, and even though it's a very scary thing to sign that union card and to stand up against your employer… you have the support of your colleagues and your organization behind you whenever you have an issue.[15]

Rather than place blame on those replacement nurses, this care worker kept the focus on

managerial actions as causing the problems she has experienced. This places the onus on

employers and corporate power to take responsibility for the problems these workers see.

Drawing together the problems of working conditions, overstaffing, and de-sensitivity to patient

needs that they experience at an individual level, care workers in Chicago feel they can come

together as collectives in their unions to address their management bodies as a united force.

*Invoking Identity at the Organizational Level*

These oral histories and accounts of working conditions demonstrate that care workers

often de-emphasize their marginal identities in favor of centering how their burnout affects their

ability to care for vulnerable patients. However, I argue that they then as union members

personally find utility in rhetorically invoking their shared struggle in order to organize worker

interests and unite in opposition to those interests of healthcare management bodies. Proposed

policies by workers themselves have focused on recognizing the separate stressors nurses versus

owners or administrators face, and it is important to center those needs of workers in order to

remediate lower quality of care that has accompanied the COVID-19 pandemic. The mitigation

strategies workers used in their organizing to counteract these stresses, I argue, are the exact

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[15] Oral history, 11/6/2020

tactics that governmental bodies and managerial systems should heed in order to ameliorate

worker and patient conditions in Chicago's healthcare facilities.

Nurses organizing under SEIU's Chicago union local have used language that stresses the

urgency of the pandemic, specifically linking it to the idea that—especially with the possibility

of future disease pandemics—everyone at some point in their life will need care work performed

on their behalf (Givens 2021). In other words, nurses specifically invoke their care for their

patients as the very reason they walk out of their jobs—since better conditions at work, and care

that is sensitive to all people, improve both the workers and the patients' lives. One nurse on the

South Side of Chicago, referencing a few hospitals that provide care for many elderly patients

being up for closure by the city, highlighted the cost of such proposals:

> It's definitely more stress, just the way the government has responded. In particular
> they've talked about trying to close Mercy Hospital, and shut down the emergency
> room for Provident… Where are all of those patients going to go if they close those
> two? Taking those away is a disservice to the community…To say Black Lives
> Matter and then go right into their communities and reduce services which are
> actually utilized, makes me question a lot.[16]

This invocation of the Black Lives Matter movement exemplifies how these workers envision

the connection between social movements, labor unions, and the health and well-being of

marginalized communities. It supplements the idea that, when workers are not cared for or seen

by health administrations—and when understaffing has only been exacerbated in that time—their

work is less productive and actions such as strikes are a necessary outcome (Gooch 2021).

Indeed, a nurse in the Cook County Health system representing the NNOC explained their strike

of June 2021 as being a last resort. She affirmed then that "we [as a union] do not want to strike,

we want to be at the bedside, but it is time for Cook County to create a plan to hire nurses to care

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[16] Oral history, Fall 2020

for our community" (Gooch 2021). This idea emphasizes the vital purposes of unions to their

members—to protect workers no matter their identity, but also to advocate for the patients of

these care workers who the latter seek to uplift and defend. At an individual level, facing the

burnout that long-term care work during COVID-19 has produced can only be healed by the care

workers themselves so much. Most remediation has been left undone at an institutional level to

support workers in the aggregate; the urgency of union rhetoric itself asserts that

recommendations from workers should be taken seriously.

While nurses in many hospitals and facilities in Illinois received what was known as

hazard pay during the "first wave" of COVID-19—categorized in this project as lasting from

winter through summer of 2020—most administrators stagnated wages or stopped that practice

in favor of retaining paid time off if a worker contracted the virus. The oral history interviewees

were appreciative of the existence of hazard pay but took issue with the fact that once it ended,

wages bottomed out again—especially for the already lowest-paid workers of color—despite

increased COVID-19 case numbers. One nurse specifically pointed out the unfairness felt by

contract staff when physicians are paid higher bonuses or have hazard pay for longer:

> I honestly just think [the appreciation bonus] was a cop-out at the time, because
> there was a lot of pressure for hazard pay and things of that nature. While I'll take
> any bonus, that's great. But my problem [is] with the amount of government funding
> and things that this hospital received, and the bonuses that they gave to their
> physicians.[17]

This nurse is clear that she is not simply protesting the temporary nature of hazard pay: the

obfuscation of hospital funds and favoring of those better-paid care workers who do less "dirty

work" or emotional labor is what is unacceptable. Even then, the introduction of COVID-19

vaccines (to health care workers, then vulnerable populations, then younger populations who

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[17] Oral history, Winter 2021

would be potential visitors to healthcare facilities) meant that protections for workers beyond early vaccine access were lifted in many places in Illinois, including Chicago, with a "return to normal." This meant that hazard pay, which if not already over, ended unceremoniously for many workers across the city. This fact has spurred union workers along to agitate for more financial boosts in the short and long terms.

Workers and the unions that represent them have suggested wage raises as a blanket, quick-to-implement solution in their recommendations. More specific proposed solutions— dependent on the primary problems a given facility faces—are more money spent towards retention efforts, supplemental trainings, and in-occupation therapies or supports for workers facing burnout. While demands along these lines pre-dated the pandemic, specific restitutions were advocated for once federal monies began to be distributed to states under COVID-19 emergency policy. SEIU demanded that, with the $75 million in federal funding allocated to nursing homes to supplement worker wages, those funds' movements be made transparent and increased wages acted upon (Bach 2021). AFSCME, too, advocated for vaccine mandates for its workers and patients, and better federal funding distribution across facilities and specified based on specific staffing or resource needs (AFSCME Council 31, 2021). These solutions, as detailed in blog posts and resolutions derived from union meetings, specifically articulate how agitating for improved working conditions benefits both workers and patients.

It is important to note how many care workers represented in the policy recommendations or direct actions detailed on union websites see their job not just as an occupation they do to pay (some of) the bills—they love being able to perform care work. When time spent with patients or quality shared moments are lost due to overworking and less face-to-face time, long-term care workers lose the ability to perform their often-favorite part of their job. Despite the travails of

doing such involved emotional labor, one reason many of the oral history interviewees became

care workers is because they deeply desire to ameliorate the inequities in care that they see. One

nurse explained how cases where patients emerge from hospital after variable ups and downs in

their health are the most victorious and gratifying:

> With COVID, we have actually seen some people that we thought for sure were …
> not getting out of here alive. And not only did they leave alive, but we've actually
> gotten updates that… they went to rehab… and actually went home to resume their
> lives. So that is pretty incredible. We don't see it a lot. But you know what, those
> small wins are a big win.[18]

In many cases, workers do much lost emotional patient care off the clock—taking unpaid, extra

time to meet and talk with patients about topics beyond their physical needs. Angelica Campos, a

home care worker in a Chicago suburb in Indiana speaking on behalf of SEIU, told the *Chicago*

*Tribune* why, despite extra time being taken, this work needs—and why she desperately wants

it—to be done:

> How can you walk away from someone who relies on you so much? How can you
> say, 'My shift is over,' when all of the sudden they fall after you clock out?
> Everyone who does this job says, 'We don't do it for the money. We do it because
> we love them.' Even though they tell us not to fall in love with our clients, how can
> we not see them as family? (Kukulka 2021).

The benefits that this extra time brings to patients may seem intangible and thus unimportant for

healthcare administrations—because it is part of the unseen labor that care workers do all the

time. Rather than being done off the clock, though, this work should be possible during work

hours—which are overfilled with lack of COVID-19 safety or equipment, fewer per-patient

hours, and emotional stress or high-pressure health situations. Campos and SEIU at large took

this rhetoric to a rally around proposing legislative change through the Build Back Better Act,

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[18] Oral history, 2/28/2021

which was introduced to and passed in November 2021 by the U.S. House of Representatives
(Kukulka 2021).

Healthcare labor unions in Chicago frame such solutions as inherently oppositional to not
only the goals of facility management seeking to turn their own profit, but also to the larger
statewide health department (IDPH). SEIU as an organization, in their press release on
transparency, argue that IDPH have either misallocated federal funding for healthcare facilities
or purposely obscured the amounts of money available and their intended uses (Bach 2021). A
housekeeper, Ozzmon Dumas, at an SEIU-affiliated nursing home in Chicago called Symphony,
spoke on behalf of their care and service workers to agitate for transparency:

> Union nursing home workers have been playing a crucial role in holding the
> industry accountable. Symphony, you received $1.5 million dollars from the
> government that was for direct COVID-19 relief, and I haven't seen a single dime
> of it. Where's our money? (Bach 2021).

Not only do Dumas and other workers invoke this obscure movement of money to ask for better
pay, but they as a collective also argue that they know better where those dollars could go to
implement their proposed solutions. This calling-out stems from workers' lived experience
knowing that those federal dollars are not simply to improve healthcare administration. They
rather argue that the money should be used to support patient care—directly, to patients' tangible
quality of residency, and indirectly, through workers' improved conditions.

This collective rhetoric, as it mirrors social movements in other industries organizing for
workers' gains or consumer protections, allows for the intersectional alignment of movements
that these Chicago unions have pursued. Healthcare unions representing these care workers have
done more, especially during COVID-19, to emphasize the strength of having a multi-gender,
multi-racial coalition—and to highlight how those workers at the identity margins are better

protected in unions because of increased wages and job security. President Greg Kelley of SEIU said, at the passage of the federal Build Back Better infrastructure bill:

> With Build Back Better, we have a unique opportunity to right the historic wrongs that have excluded people of color, and Black women in particular, from the types of investments that have benefited other industries. We cannot have an equitable recovery unless we fix our broken care economy so home care workers can earn a living wage, and seniors can age with dignity (Waltmire 2021).

Making explicit that many long-term care workers and other administrative and health professionals are Black women and women of color, Kelley and other SEIU leads emphasize how people at the gender and racial margins have already experienced harm in other areas of life—and that they deserve quality jobs to support them financially and emotionally. The union argues that workplace and identity stressors mutually reinforce one another—and that proper allocation of federal and state monies for their wage increases or staffing retention would help assuage both types of stressors for workers and patients alike.

Proposed solutions to health care's biggest structural problems come from both individual workers' experiences of performing their labor and from the organizational level of the unions that represent them. It is a question of whether managerial bodies would heed those solutions without breaking points such as strikes arriving first. Regardless of this fact and the extent to which hospital and nursing home management corporations listen to or do not listen to these worker-generated solutions, policymakers at the city, state, and federal levels on their end should continue to work towards transparent resource allocation and better policies for broader issues that affect workers.

## Conclusion

This project set out to answer the question of how long-term care workers in Chicago think about their own marginal identities—as women, or women of color—during the COVID-

19 pandemic. I also explored how this thinking translates to particular demands made in the context of labor union organizing, and how those unions at an organizational level invoke questions of identity in their conflicts and resolutions. Through analyzing eleven oral histories, one interview, and union communications—all qualitatively coded—I first found that on a personal level, care workers associated burnout and compromised emotional labor more with the particular circumstances around COVID-19 as a novel situation rather than primarily with their personal identities. In processing emotions of frustration at working conditions and sadness at the losses they saw, these care workers de-emphasized their own individual identities and stressed more their compromised feeling of agency in the health care system. This idea about burnout as being relatively unattached to identity for some workers connects to the next finding about the concept of "essential worker." The term confers a praise that the care workers eschewed—again, as they saw themselves less as individuals at work than as components of a whole—in favor of spotlighting the avenues for change in the health care system they sought to see enacted.

These findings about individual-level experiences of care workers during COVID-19 contributed to my further analysis of how these workers collectivized their struggle by organizing with their unions. If I found that individuals focused less on their identities as marginal, then workers speaking about their fellow vulnerable employees and the unions that represent them actively highlighted such marginality and precarity in order to bolster their own advocacies for change. This project thus bolsters the notion that, while labor unions are effective tools under which workers organize, their efficacies are inextricable from the characteristics of managerial pushback that define their particular sector.

Unions must also grapple with the fact that, as they seek to represent workers at the margins of racial, gender, and socio-economic identity, managerial corporate structures and the

public at large may not socially and societally value them. In this sense, social attention to health care has made COVID-19 an opportune time to agitate for change, but the long course of structural problems in health care were and are only aggravated by the pandemic and divert attention away from old problems to focus on present ones.

Future work on this topic with the methods used in this project could include even more interviews with care workers, particularly care workers across the state of Illinois to perhaps address how the questions of safety, identity, and organizing differ in urban versus rural communities. Additionally, as the data for this project ends around the time of mass vaccination of the Chicago population, more work with these methods of examining the individual and collective experiences of care workers should be done to account for the continued presence and evolution of COVID-19.

Health care is not just the physical act of caring for a person: it is also every emotion transmitted between a patient and those that care for them. While that relationship may suffer because of mistreatment on either side, it is important to continue centering the narratives of patients and care workers alike in order to investigate how we as a humanity may improve that exchange. Every person will need care—physical and emotional—in their lifetime, and it is important that they and the people responsible for that care may do so with dignity and respect.

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