California health care worker explains how COVID-19 catastrophe has been fueled by the drive for profit

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The WSWS encourages health care workers to speak out on the disastrous conditions which are now overwhelming health care systems due the reopening and "herd immunity" policies pursued by the ruling class in countries around the world. Click here to send comments and letters for publication.

I'm a hospital worker in California. I'm writing to share the conditions, pre- and post-pandemic, at the hospital we work at.

It's a small hospital that serves several suburban, commuter communities. Most of the people who live here commute out of town to work, and likewise, most of the hospital workers, clinical and nonclinical alike, have to commute a good distance to get here. We are not a trauma center; severe car crash injuries and the like are transported to other hospitals. Nominally we are not-for-profit, but you know how that really goes.

One year our interim CEO was paid over $400,000. I don't have the numbers on the current CEO at the moment. The hospital hires all sorts of "consulting" companies to better squeeze money out of patient care: our physicians are pressured to cut down inpatient admission stays to only one day, instead of two or three, because that's "wasteful."

Before the pandemic, we were understaffed and underequipped in all departments. Every flu season, the administration hires travelers, because they refuse to staff us adequately the rest of the year. Night crews are always skeleton crews. One pharmacy tech all alone at night; decreased staffing in ICU (intensive care unit) so patients in the ED (emergency department) are transferred upstairs only on morning shift change, when there's actually nurses to attend them. There's only one radiation tech at night to x-ray and CT all the patients in the hospital. On weekend nights there's only one phlebotomist and one lab tech, as opposed to the one offset and two lab techs on weekday nights. The admitting (read: registration and billing) department is chronically understaffed, and they are constantly pressured to collect more from patients with very specific phrasing to psychologically corner patients into paying as much as possible up front. The ED at night is almost always short, especially when no one's able to cover callouts. When the unit secretary calls out, one of the clinical workers, usually a tech, takes over.

Right before flu season a couple years ago, administration fired a dozen nurses and all the monitor techs; some of these guys had been here for over a decade. That left the remaining workers in the wards to pick up the slack and monitor the heart rhythms of up to 50+ patients. The parasites who play the stock market have sophisticated automated trading software to make *microsecond* decisions based on the smallest market fluctuations, and we just have one schmuck trying to keep two eyes on dozens of heart rhythms. Come flu season, administration realized they made a poor decision, and extended job offers to all the nurses they fired. Most, if not all of them, said no, having found jobs somewhere else. So, we brought in travelers, as usual.

Security is always understaffed, so when we have psych holds awaiting transfer to actual psychiatric facilities, it's often a *clinical* worker watching the one patient. A tech or nurse is pulled away from all other patient care for the entirety of their shift to make sure a suicidal ten-year-old girl—and we get a lot of those—does not attempt self-harm.

About our rad techs. They image not only the emergency, surgery, and inpatient patients, but also outpatients! Two ducks running around an entire hospital, going from code, to surgery, to STAT ICU, to emergency department patients, and having to somehow, eventually, get to the patients who have actually scheduled their outpatient radiology procedures. "I got here at 10, I had an appointment at 10!" (It's 11:40, now.) "I'm sorry, I know you came here on time for your appointment, but we were called to the ICU, then we had to assist so-and-so surgeon…" That's right—the hospital schedules outpatient without actually having clinical staff to attend them for their appointments.

And you know how the hospital dealt with that?

They closed one of our outpatient centers. Sold it to RadNet. [Ed. note: RadNet is the largest outpatient imaging service in the United States, it reported net revenue of $1.2 billion in 2019.] Officially, the hospital is entering into a "partnership" with RadNet, who'll give a percentage of profits to the hospital in exchange for being the exclusive service provider for the patients who go to the center. As for RadNet's modus operandi: Imagine the mafia seizing control of all the doctor's offices in a city, briefly offering the poor doctor a 10 percent cut of the profits before closing the joint down quicker than Speedy Gonzales running for queso Oaxaca and funneling every single patient in the city to a centralized Dr. Giancana's office. That's what RadNet does with radiology and imaging centers. They'll close that outpatient center and patients will have to travel further just to get the care they need. By the way, anyone working at that outpatient center who isn't a rad tech is out of a job now.

We don't have a phone operator at night, so admitting department workers, the people who are trying to update your records, register your bed placement when you get admitted so the nurses can actually chart on you, and argue with your insurance company about medical necessity of inpatient stays gets to monitor all the hospital alarm panels, call codes, and take phone calls. EVS (environmental services; housekeeping) is always scrambling to clean the rooms.

Our two Bioquells (decontamination equipment) for the whole hospital are always breaking down, one or the other. Management keeps "repairing" them instead of replacing them. It takes four hours to finish Bioquelling a room, and if multiple rooms that housed *C. diff* patients need to be decontaminated whilst one of the machines is out of commission, it can be a long time before a room is actually ready for use. Our EKG machines have now seen eight years of use and are the most frequently used pieces of equipment in the entire hospital. The fax printers

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are always acting up, and we're always joking about going *Office Space* on them. That might strike you as funny—and it is—but our anarchic health care infrastructure is such that faxes are the *only* way we can exchange medical records with other providers, e.g., obtaining the medical history of a Kaiser patient, or sending clinical data to a pediatric hospital taking a child we can't care for. And keep in mind the times when the hospitals we're trying to communicate with have problems with *their* fax machines, too. We used to have a dedicated on-call biomedical engineer to make emergency repairs to our clinical equipment, but last year they outsourced that to some center that never sends a guy at night. If something breaks at night, it's just going to have to wait till day shift to be addressed.

This kind of horrific understaffing and underequipping isn't exclusive to us, and we're far from the worst. On December 8, I spoke to a traveler radtech from this huge 10-storey hospital that looks like a Marriott hotel. They had only ONE ancient portable x-ray machine for the whole hospital, to cover all ten floors. And they're a trauma center! The hospital acquired more machines only in late November two weeks before our conversation, after said traveler "politely raised her concerns"—during a pandemic.

So: Those were our working conditions *before* the pandemic. Over a year since SARS-Cov-2 emerged, our staffing issues have only been exacerbated. Patients are waiting 42+ hours for their ICU beds. Sometimes the telemetry admissions are stuck in the ED for so long that they spend the entirety of their admission in the ED, never making it to the telemetry department where they were supposed to have been. This causes trouble for the ED nurses, because the process in our software to discharge a patient from the floor is different from the process to discharge from ED. They don't know how to go about it. We're now doubling up patients in their rooms, and our basement is ready to take a surge. Why didn't we put patients in the basement before doubling them up on a room? I would guess (short) staffing—it is "easier" to keep one eye attending two patients in the same room, rather than hiring more nurses to look after patients in an ad hoc ward. We have a small "disaster tent" outside. Our first large one, in the parking lot, actually blew up in the first month it was set up due to an electrical issue.

Our clinical staff are starting to break. The hospitalists, the admitting physicians are not intensivists (ICU doctors). But circumstances have forced them to act in the capacity of one, especially at night—when the intensivist is on call, not on campus. One of our nightshift hospitalists broke down in tears two weeks ago, when someone asked her how one of the patients we recently admitted was faring. "I don't know. I don't remember how many people have died." She called out after that night and hasn't been back since. Regional management, meanwhile, likes to come make rounds during day shift to yell at workers for not using PPE we don't have. "Why aren't you using a face shield?! You're in direct patient contact!" You didn't give us face shields!

The on-call chaplain sometimes calls us in advance, now. "Is anyone in need of services?"

The toll on the paramedics is heavy. They have to don and doff all their PPE and decontaminate the rig (ambulance) between each patient. The local nursing homes are death traps. Those places were already horrific sites of neglect and abuse before the pandemic—we had an old lady, once we removed her pants, rose an actual cloud of human dust we couldn't see through. She hadn't been bathed in months. Now we get multiple runs (ambulances) from the same nursing home in the same night, and often the same crew going back for more patients. The staff at these residential care facilities are often found cowering in the corner. They don't want to touch death. Their patients arrive blue. One of our ED physicians actually complained: "Why did you bring us a corpse?" The paramedics cry when they're not too busy or tired to cry.

Last month, we got patients from over 200 miles away, transported by air, because the hospitals in their areas were all on diversion—they couldn't take any more ambulances, they had to go somewhere else. This month, we're on diversion most nights. I don't know where those patients go. Obviously, they're not going to LA (Los Angeles). On the nights where every single hospital in the county is on diversion, that actually cancels it out, in an absurd way—there's no place for these patients to go, so we might as well take them. Have them sit in the ambulance until a bed somewhere in the ED opens up.

Our hospital is now using over four times the amount of oxygen we use normally. This is freezing the pipes, and pressure is running low. The alarm for this goes off literally every second or less. The hospital operators have taped the "acknowledge" button down to mute the sirens. I don't know how that system is supposed to support the surge of patients we're expecting to serve without doubled up rooms.

And I hate to say this to people, because it's horrific and the last thing you want to think about during a pandemic, but being in a fully staffed, safely ratioed ICU, if you can find one—doesn't guarantee you a decent quality of care. The quality of our intensivists—our hospitalists and ED physicians, exasperated, joke: "We're not intensivists! And neither are our intensivists."—is pretty poor. We operate in a relatively calm, affluent area, and we aren't a trauma center, so our ICU doesn't get as much experience as say, the ones in major metropolitan areas like Los Angeles. A couple of the intensivists on our panel are always pulling away the ED physicians to help intubate every single patient they get—they can't do it themselves. There's a lot of resentment in the ED because of that. So, if our ED physician is busy tubing a guy upstairs, then there's no doc to see whatever new person the ambulance has brought in—and they might need to be tubed, too.

The last thing I want to talk about—and this is going to kill more people than most realize—are all the medical bills. Yeah, you survived COVID-19, maybe even without any of the nasty long-term sequelae we're seeing in the long-haulers. (In my case, it took me three months after clearing the virus before I could do a couple of star jumps without wheezing.) But I *guarantee* you that a lot of these people are going to wish they didn't survive. These bills are going to crush entire families, especially the ones without insurance. I've already seen an uninsured patient die from trying to avoid medical bills, not coming in for difficulty breathing for so long that their heart, overcompensating and overtaxed, failed. He was a father with a wife and kids. They and the extended family were sobbing outside the hospital in the cold winter air.

One night in the ICU in my hospital is $25,000. Does not include diagnostics (e.g., x-ray & bloodwork), anaesthesiologists, respiratory therapy, intensivist. That's only the room. Most people transfer from the ED to ICU—so there's an additional emergency room bill on top of that. Cost of an ER can vary, but if you're placed under isolation, expect $5,000 to include all the sterile supplies in the room (e.g., crash cart) that must be thrown out and cannot be reused for other patients. The ED physician also has a separate bill. Meals are separate expenses, too. (Of course, if you're intubated, you don't have to pay for a meal.) In a busy hospital, maybe half the meals in the ED don't ever make it to the patients; the nurses are too busy to hand-deliver them after they arrive upstairs from the cafeteria. A lot of patients pay for meals they don't eat.

The ambulances are run by private companies and have their own bills. In Los Angeles County, an Advanced Life Support ride can cost up to $2,500. Basic Life Support can cost up to $1,700. Does not include cost of ancillary services (e.g., respiratory therapist, additional $2,800). And this is just ground transportation—I don't know the rates for aerial transport, like our patients with the 200-mile helicopter ride.

At our hospital, no one is getting hazard pay, and they completely cut the yearly raises for non-clinical workers. Our new benefits for this year, vision, dental, and medical, are garbage. I'm part-time due to my disability, and that means I have to pay double for medical benefits that have been slashed by more than half for 2021, and those are just the

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biweekly premiums, not the out-of-pocket portion I owe when I actually see a doctor. I was already stretching my medication last year, and now I have to think about spreading them thinner—right as my health is starting to deteriorate, when it's best to start any preventive interventions before things worsen and/or become permanent. I've stopped seeing my cardiologist. My visual processing is starting to go, I caved in and bought a white cane on New Year's Eve, and now I have to think about what the hell I'm supposed to do if I go completely blind. My fiancé's dead and my biological relatives generally don't want anything to do with me as a genderqueer person. If I go legally blind, I'll probably just kill myself, because disability benefits don't even cover half rent for a stoveless studio apartment in California. With or without a pandemic, this is what capitalism has to offer workers.

All of us are bracing for the Christmas party and New Year's Eve party cases. We're hoping that not too many people partied—but that doesn't matter, so long as workplaces are still open, and people are being threatened with utter destitution if they don't go out and drudge for Wall Street.

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