The challenges of combatting the COVID-19 global pandemic are vast and systemic. It has required the world to adapt how we work, learn, and communicate. In this new reality, Americans have been confronted with what it means to provide and to receive care. The U.S. now looks beyond professional medical caregivers (doctors, nurses, first responders, etc.) to include others who provide additional services of care. The fluid label of “essential worker” recognizes a wider range of equally important frontline service roles (trash collectors, grocery store workers, etc.). After elaborating on the history of the term “essential workers,” I move on to discuss those in the immediate periphery of the medical community (workers in personal or self-care industries and those in traditional or alternative medical sectors—among others) who have been sidelined as nonessential. This sparks many questions: who determines who is essential and when? Who provides care during these times? Whose jobs have been suspended and not recognized as acts of care? To explore those questions, I compare contemporary American trends to patterns discovered during my fieldwork in Shanghai. Three months in a Chinese Integrative Medicine Department revealed a phenomenon of reciprocal caregiving: patients provide food and support to doctors who practice excellent care. My analysis will reveal how caregiving in the U.S. can also be reciprocated under current circumstances by community members. I reveal how COVID-19 has re-defined how communities value care and disrupt understandings of how, by, and for whom care should be practiced.

Keywords
Essential workers, integrative care, reciprocity.

Introduction
Care is always central to our lives but even more so during a global pandemic. Crucial to the “constitution of personhood,” care often remains a “shifting” concept that lies at the intersection of daily practices, formalized relationships, moral obligations, and institutional structures (Buch, 2015, 280). Care in this context can be defined as a service provided to an individual or community that addresses a health need. These health needs or determinants span the physical, mental, socioeconomic, environmental, geographical, and so on. In this commentary, I will discuss how the dynamics of COVID-19 have shifted American understandings of care in three ways: (1) who can practice care, or who are deemed essential to this work, (2) how those on the receiving end of care have individually and collectively begun to reciprocate care, and (3) who is unable to practice care right now, or who is thought to be non-essential.

China, which has one of the most developed integrative medical systems in the world, offers insight into how the pandemic has expanded our understanding of care. This is because integrative care is an approach to care that centers the individual over the disease and considers all health determinants. Trends of reciprocity in Shanghai that mirror emerging mutual aid initiatives in the U.S. demonstrate the significance of integrative care.

Expansion of Essential Work
The idea of being essential has taken on different meanings throughout history. Before the discourse around COVID-19, the terms ‘essential work’ and ‘essential worker’ spiked in use during World War II. Wartime efforts not only mobilized the munitions, mining and agriculture sectors, but also
recruited women, people of color, and people with disabilities into the workforce, expanding the definition of essential work. Subsequently, economic and social structures—like national childcare—were in operation during the war to support these new demographics of essential workers (Graves 2020).

Similarly, previous norms about essential workers in American society have diversified during the COVID-19 global pandemic. Grocery store employees, trash collectors, bus drivers, food delivery workers, and others are now being grouped with professional caregivers. New categories of essential workers, created by U.S. state governments during the processes of shutdowns and re-openings, acknowledge the significance of seemingly mundane tasks in our society’s function and care.

However, this expansion raises certain questions: who are the estimated fifty-five million essential workers in the U.S.? Statistics provide part of this answer: women make up 76% of health care workers and 73% of government and community-based services providers; people of color represent 50% of laborers in food and agricultural industries. Approximately 70% of those fifty-five million essential workers do not have a college degree. 50% of those in industries labeled essential earn less than those who make up the nonessential workforce (McNicholas and Poydock 2020). These disadvantaged subpopulations have been newly recognized as essential so that they can continue to serve others—but they have always been essential. Why has it taken dangerous health risks for these workers to be recognized as inherently valuable to our care?

Additionally, it does not appear as though many institutions are inclined to critically evaluate the implications of being “essential” during a pandemic. There are gross deficits in protection measures and national support as these essential workers take on high risks. Praise of essential workers dangerously disguises the national government’s lacking pandemic response. Their unpreparedness will likely contribute to a higher essential worker death rate and an exacerbation of structural issues that already marginalize many such essential workers. We cannot afford to dissociate

**Reciprocity**

Where the government and private sector have fallen short in both providing care and supporting essential workers, others rose to the occasion. In acknowledgment of the overwhelming difficulties in providing care without adequate resources during a pandemic, citizens have taken it upon themselves to reciprocate with their own acts of care. They have donated fresh meals, collected personal protective equipment (PPE), raised money, and helped with childcare and education for essential workers. Many of these efforts were developed from the ground up, spearheaded by dedicated individuals without medical training. Although not formally labeled essential, these volunteers are able to target and address the myriad health determinants exposed and exacerbated by this pandemic, and to provide necessary services that otherwise would have fallen through the gaps.

This is a phenomenon similar to one I observed at my fieldsite in Shanghai—an acupuncture clinic embedded in a hospital at overcapacity. In general, doctor-patient relationships in China have been fraught with tension over the past decade due to a lack of mutual trust, overcrowded spaces, malpractice, and even violent confrontations. However, this crisis has been largely present in purely biomedical settings, which is more beholden to neoliberal and capitalist ideas of efficiency. This limits doctor-patient face time, hinders effective communication, and exacerbates power imbalances.

The integrative care clinic where I observed proved to be an exception. There, a single acupuncturist was often tasked with treating up to fifteen patients at once but still made sure to provide care that matched each individual’s needs. As recognition of his sincerity and dedication despite the challenges, his patients would bring him food, ensure he sat down every once in a while, asked after his family, and even fold his white coat. The ethics of integrative care prompted their actions: every individual, no matter their status, is human first. Additionally, in China, this integrative combination of biomedicine and Traditional Chinese Medicine (TCM) maintains that health should be comprehensive. In other words,
integrative care in China does what COVID-19 has further necessitated in the U.S.—evaluate all health determinants when providing care—and provides a look into models of care that are not strictly biomedical.

Specifically, there are two dimensions critical to integrative settings that are not as developed in biomedical discussions about care: (1) behaviors of care recipients towards caregivers and (2) interactions between two care recipients. In this acupuncture clinic, these dimensions took the form of daily care and community building. On a larger scale in the U.S. during COVID-19, we’ve seen the rise of pandemic-specific nonprofits and mutual aid organizations. However, mutual aid has usually been discussed only in terms of quantitative resources; I attempt to expand the concept into qualitative discussions of care.

To encompass these observations, I choose to use the term reciprocal care to describe the meaningful dynamics that arise when there is simultaneously a recognition of a need and the ability to respond to that need. While this term does not appear directly in existing literature, it is tied to ideas of care as a gift exchange: in exchange for care, the recipient responds by re-affirming the care in “equally human ways” (Kleinman 2015). The exchange facilitates an intimate network of reciprocity. Gift exchange still occupies a vibrant space in anthropological discourse, but classical theory provides foundational insight into reciprocal care dynamics. Expanding on Marcel Mauss’ *The Gift*, Claude Lévi-Strauss (1987) names these as (1) the obligation to give, (2) the obligation to receive, and (3) the obligation to reciprocate. Mauss (1990) pays relatively little attention to the obligation to give, which is the only one of the three that is not entirely dependent on a preceding action (to receive and to reciprocate imply a different actor initiating the giving). Nonetheless, the obligation to give is critical to understanding reciprocal care in this discussion.

In Shanghai, the origin of the first gift is the acupuncturist’s provision of integrative treatment and care. He is in part obligated to give because it is his job and in part motivated to give because of his empathy for other humans. Patients may conflate his moral and financial obligations to provide care, leading to them reciprocating his care. Additionally, when patients reciprocate, they compound his obligation to give: if he does not meet their expectations, patients will move on to another doctor, as is common in Shanghai. In the U.S., mutual aid appears to be the result of empathy, guilt, and a sense of responsibility, but determining the exact motivations behind such community efforts would require deeper fieldwork. Regardless, the observed result of reciprocal care—perceived better care and stronger community—may prompt professional caregivers to re-evaluate the one-way care relationships typical of biomedical settings. COVID-19 gives us the opportunity to shift towards caregiving work that is integrative, quotidian, and community-based.

**THE EXCLUDED AS NONESSENTIAL WORK**

Logistically, the division between essential and unessential was based on what is “practical.” This differentiation draws a line between various types of work to steer populations through the pandemic: it was decided that there are those whose work is critical to maintaining life and those whose work is not. Therefore, personal care services (defined by state governments as being related to massage, nails, esthetics, cosmetology, TCM including acupuncture, health and fitness, and so on) were suspended. From the perspective of an anthropologist, the division is more problematic—the confines of essential care can never be completely clear because they differ between perspectives and contexts (Buch 2015). To artificially delineate who is essential can be damaging, particularly for workers already at the periphery of professional medical care. Ultimately, it can limit giving and receiving care.

All such divisions are made from the perspective of a particular worldview. In the biomedical industry, one result of this dichotomy is the aforementioned exclusion of TCM clinics. Although these clinics are run by licensed practitioners, they were forced to close their in-person operations at the beginning of the pandemic and limit their services to online consultations and delivery of medicines (if applicable). Some individuals...
would argue that these TCM services are indeed essential to maintaining their lives, physically and mentally. When TCM practitioners are restricted in providing care, how does this erode the practitioners’ personhood and positionalities in American society? It is possible that as a result of being deemed unessential TCM clinic workers and patients—already outside of mainstream medical care in the U.S.—might contend with increasing alienation and xenophobia.

Then there are other services - like haircuts and nail treatments - that appear less necessary or more selfish to desire during a pandemic. However, many believe differently: thousands have been willing to gather and protest for their right to access these services. While seemingly superficial, things like hair are tied to identity, culture, and freedom - elements that can powerfully inspire resistance (Abad-Santos 2020). That leads to subsequent unwillingness to adhere to important public health measures like physical distancing and quarantines. The misalignment of individual values with state mandates can be insightful for formulating future public health policies. While the pandemic necessitated a hierarchy of care to limit COVID-19 transmission, we should not forget or diminish the implications and consequences of these divisions.

CONCLUSION

COVID-19 has shifted our understandings of how we should both provide and receive care. As the division between essential and nonessential workers can create tension, it is paramount we uncover systemic conditions that divide how our society can provide and receive care and remind ourselves to think about the relative nature of “being essential.” Ideas about care that underlie (or contest) such a division reveal the competing values of American citizens. These dissonances help demonstrate the priorities of both those who create the division and those who are impacted by it. Reciprocal care may be a solution for many of the issues of these times, as well as after we are no longer battling COVID-19. Perhaps, as in the hospital in Shanghai, reciprocity could be a sustainable practice of community building. The long-term impacts of the changing dynamics of care remain to be seen. For now, discussion about them provides a glimpse into the division and provision of care in the U.S. today.

WORKS CITED


