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Behind the Mask: An Autoethnographic Approach to Understanding Healthcare Workers' Lived Experiences and Perceptions of Mental Health during the COVID-19 Pandemic

by

Megan Farrow

A Thesis

submitted in partial fulfillment

of the requirements for the degree of

Master of Public Health in the Department of Community and Public Health

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To the Graduate Faculty:

The members of the committee appointed to examine the thesis of MEGAN FARROW find it satisfactory and recommend that it be accepted.

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RE: Study Number IRB-FY2022-123 : An Autoethnographic Approach to Understanding Healthcare Workers' Lived Experiences and Perceptions of Mental Health during the COVID-19 Pandemic

Dear Ms. Farrow:

Thank you for your responses to a previous review of the study listed above. These responses are eligible for expedited review under OHRP (DHHS) and FDA guidelines. This is to confirm that I have approved your application.

Notify the HSC of any adverse events. Serious, unexpected adverse events must be reported in writing within 10 business days.

You may conduct your study as described in your application effective immediately. This study is not subject to renewal under current OHRP (DHHS) guidelines.

Please note that any changes to the study as approved must be promptly reported and approved. Some changes may be approved by expedited review; others require full board review. Contact Tom Bailey (208-282-2179; email humsubj@isu.edu) if you have any questions or require further information.

Sincerely,

Ralph Baergen, PhD, MPH, CIP
Human Subjects Chair

Dedication

In dedication to my loving and incredibly supportive family, including my children, Faith and Gavin, and my partner, Damon, whose encouragement has been unwavering, even at the most challenging points of this journey. As impossible as the dream seemed when it began, this last in a series of milestones has yielded something more significant than I could have ever anticipated.

I also dedicate this thesis to my fellow healthcare workers, my former colleagues, my peers, and my friends. Thank you for entrusting me with your stories, putting your confidence in me to safeguard the information you chose to share, and instilling in me a sense of responsibility to advocate for you through this research.

Finally, it is with the utmost regard that I dedicate this work to the many healthcare workers who risked both their lives and their sanity in the continued effort to care for their patients throughout the COVID-19 pandemic. My heart aches for those who lost their lives as a result.

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List of Abbreviations

ARRT	American Registry of Radiologic Technologists
CDC	Centers for Disease Control and Prevention
CT	Computed Tomography
CSC	Crisis Standards of Care
IDHW	Idaho Department of Health and Welfare
MRI	Magnetic Resonance Imaging
NAMI	National Alliance on Mental Illness
PTSD	Posttraumatic Stress Disorder
WHO	World Health Organization

Abstract

Background: Mental health status among medical professionals, especially in light of the recent COVID-19 health crisis, is a critical public health issue that warrants further investigation. Purpose: This study contributes to the knowledge base regarding the extent that mental health burdens have been exacerbated by COVID-19, and also broadens the understanding of the unique challenges faced by healthcare workers in southwest Idaho during crisis situations. Methods: Employing autoethnographic and semi-structured interview data collection methods allowed me to qualitatively analyze and interpret how my own lived experiences working through the pandemic as an MRI Technologist compared to the experiences of other frontline healthcare workers, based on a newly developed conceptual/analytical framework. Results: The results of this comparative autoethnography show that COVID-19, the hero discourse, and shifts in knowledge and power each had a profound impact on the paradigm of truth for many healthcare workers in southwest Idaho, myself included.

Key Words: Autoethnography, Healthcare, COVID-19, Mental Health, Medical Imaging, Idaho

Chapter 1: Introduction

Background

It is estimated that mental health conditions affect at least one in five healthcare workers, and these conditions commonly present as anxiety, depression, PTSD, and burnout (Muller, et al., 2020). The effects of these mental health burdens have been exacerbated by the COVID-19 health crisis. Dzua, et al. (2020), refer to these mental health burdens as "… moral distress (p. 513)", stating that the physical and emotional harm currently being experienced by healthcare workers can be considered a "… parallel pandemic (p. 513)" as rates of anxiety, depression, PTSD, and burnout continue to rise. Prior to the COVID-19 pandemic, burnout was still a very real public health concern, particularly among healthcare workers. The results of a 2018 study indicate that as many as 78% of physicians reported experiencing symptoms of professional burnout (Bednar, 2019). To date, however, there is very little data that addresses burnout and the unique challenges faced by non-physicians (Prasad, et al., 2021). Burnout, along with other mental health burdens, contributes to healthcare workers choosing to reduce the number of hours they work or leaving their profession altogether. Jha, et al. (2019), state that "the prevalence of physician burnout has reached critical levels (p. 2)". By 2025, the US Department of Health and Human Services predicts a shortage of up to 90,000 physicians, the impact of which will have an effect both on healthcare systems as a whole and on patients individually (Jha, et al., 2019). This number may increase as a result of the COVID-19 pandemic.

According to the Centers for Disease Control and Prevention (CDC, 2021b) and Gainer, et al. (2021), COVID-19 is defined as a new disease, one caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) that spreads easily and can cause symptoms ranging from mild to severe, and even result in death. The CDC reports that the median incubation period

is five days, with an estimated incubation period ranging from two to 14 days (2021). The COVID-19 virus is spread person-to-person via respiratory droplets that usually result from coughing or sneezing. Unfortunately, even asymptomatic individuals, or those with mild symptoms, can still carry and transmit the COVID-19 virus. Crowded medical departments, such as emergency departments (ED) or intensive care units (ICU), increase the possibility of short-range transmission. While the CDC (2021b) recommends that the general public maintain a physical distance of at least six feet between persons, this guideline is neither realistic nor obtainable for medical professionals treating patients. For frontline healthcare workers, personal risk of contracting this potentially deadly virus increases when providing care to patients who exhibit COVID-19 symptoms, or those with a confirmed positive test result (Gainer, et al., 2021; Shaukat, et al., 2020).

The coronavirus pandemic has forced healthcare workers to face unprecedented challenges that include an increased risk of infection or death resulting from frequent and/or prolonged exposure to COVID-19 (Shaukat, et al., 2020). The CDC reports that as of November 2021, the United States has seen a total of 46,268,465 cases of COVID-19, resulting in almost 750,000 deaths (749,876), since January 2020 (2021a). As of November 2021, when this research began, Idaho reported 295,999 total cases and 3,645 COVID-19 related deaths over that same time period (The New York Times, 2021). These large numbers are a matter of grave concern. Charney, et al. (2020), liken modern day hospitals to the "ground zeros (p. 900)" of the 2001 World Trade Center terrorist attacks. The authors discuss data they collected during interviews with first responders a decade after the 9/11 attacks. Their analysis paints a bleak picture for the level of fallout that can be expected in the healthcare setting once the worst of the pandemic has passed. In terms of the mental health and wellbeing of frontline healthcare

workers, higher rates of anxiety and depression, burnout, and PTSD resulting from psychological pressure and exhaustion are expected.

Statement of Problem

Mental health status among medical professionals, especially in light of the recent COVID-19 health crisis, is a critical public health issue that warrants further investigation. Healthcare professionals are often considered "… a hardy, resilient bunch…(p. 900)", meeting the unique physical and mental demands required for working under the challenging conditions inherent in the nature of their jobs (Charney, et al., 2020). Charney, et al., go on to say that healthcare professionals often sacrifice their own psychological well-being in their efforts to care for their patients. As a result, this demographic is significantly more likely to suffer from severe mental health symptoms compared to those with no direct patient contact, and are particularly vulnerable to anxiety, depression, PTSD, and burnout (Braquehais, et al., 2020). Gainer, et al. (2021), report that healthcare workers treating patients who exhibit COVID-19 symptoms, or those with a confirmed positive test result, increase their personal risk of contracting this potentially deadly virus. Frequent and/or prolonged exposure also increases their perceived risk of infecting close family and friends, adding to the existing stress and pressure of performing the necessary daily tasks required for their jobs. The dearth of information currently available on the unique challenges faced by healthcare workers in southwest Idaho, particularly during crisis situations, presents an opportunity to address an existing gap in knowledge.

Purpose

This study contributes to the knowledge base regarding the extent that mental health burdens have been exacerbated by COVID-19, and broadens the understanding of the unique

challenges faced by healthcare workers in southwest Idaho during crisis situations. It answers the following questions:

1. What are the perceptions held by healthcare professionals working in medical facilities in southwest Idaho regarding the effect of COVID-19 on their own mental health and the mental health of other medical professionals?

2. How do my own lived experiences working through the pandemic compare and contrast with the experiences of other healthcare professionals?

The first question aims to understand the lived experiences of healthcare professionals and their perceptions of mental health as a result of the COVID-19 pandemic. In order to achieve this, semi-structured interviews were conducted with frontline healthcare workers, giving them the opportunity to share their stories. The second question aims to qualitatively understand how my own lived experiences working as an MRI Technologist, and ultimately leaving the profession, during COVID-19 compare and contrast with the experiences of other medical professionals. Autoethnographic methods were implemented as a strategic means to deconstruct all contributing factors that led me to where I am, both personally and professionally. Through autoethnography, I was able to accurately describe my experiences during the pandemic as I perceived them. In order to effectively compare and contrast my own lived experiences with the lived experiences of other medical professionals, comparisons were made based on the theoretical constructs of phenomenology and power dynamics (Neubauer, Witkop, & Varpio, 2019). This provided opportunity to gain a thorough understanding of the phenomenon of COVID-19 in terms of "what" and "how" it was experienced by southwest Idaho healthcare professionals.

Significance of Study

Through the process of investigating the mental health status of healthcare workers in southwest Idaho in light of the COVID-19 pandemic, this study addressed an existing gap in knowledge, and proves useful in the areas of education, policy, and the development of future research projects. Speaking directly with healthcare professionals provides an opportunity to gain understanding on the prevailing thoughts and attitudes surrounding COVID-19 and mental health, and was paramount in understanding the toll this pandemic has taken on the mental health of southwest Idaho's healthcare workforce.

Using an autoethnographic approach to qualitatively analyze how southwest Idaho healthcare workers perceive mental health based on their experiences with the COVID-19 pandemic is likely the first of its kind. As a healthcare professional who just recently stepped out of my role as an MRI Technologist in the clinical setting due to burnout, I can personally attest to the need for exploring the impact of COVID-19 on the mental health of healthcare workers. I was employed by the largest trauma hospital in the Treasure Valley prior to the onset of the pandemic. In June of 2021, when my stress level hit a breaking point, I had a complete emotional meltdown. That breaking point prompted my decision for a career change. That breaking point also helped me determine where I wanted to focus my research efforts. That breaking point became the influencing factor in determining this research topic. Surely, I am not the only medical professional struggling with anxiety, depression, PTSD, and burnout? Recent evidence suggests that my experience is not unique (Prasad, et al., 2021). This document weaves between first and third person perspectives, in the effort to describe and make sense of both my own experiences and the experiences of study participants.

Chapter 2: Literature Review

To further understand the relationship between COVID-19 and the mental health of healthcare professionals in southwest Idaho, a review of literature was conducted. There is a substantial amount of research emerging on this topic. However, only a small number of these studies discuss the status of mental health among healthcare workers in the state of Idaho. There is a dearth of information specific to medical professionals working in medium-sized healthcare facilities (100 – 499 beds) located in southwest Idaho. Thus, this subject was explored using a wider lens, accounting for mental health among healthcare workers in the broader US workforce, as well as circumstances that were experienced by the state of Idaho in general. Focus was placed on staff that appears less commonly in scientific literature: respiratory therapists, medical imaging staff, nurses, nursing and medical assistants, etc. (Prasad, et al., 2021). This review highlights the mental health concerns that exist specifically for this demographic and investigates how these mental health conditions may have been exacerbated by COVID-19.

It is separated into four key topics as follows: mental health effects of COVID-19 on healthcare workers; COVID-19 in Idaho and its effects on the healthcare system; emotional dissonance and psychological adjustment; and theoretical framework, which encompasses power dynamics, the hero discourse, phenomenology, and autoethnography.

Mental Health Effects of COVID-19 on Healthcare Workers

The World Health Organization (WHO) describes *mental health* as an individual's state of mental wellbeing as determined by biological, environmental, and socioeconomic factors (2018). Mental health is an important component of an individual's overall health. Indeed, "… there is no health without mental health" (WHO, 2018). The absence of a diagnosed mental disorder is not necessarily indicative of a healthy mental state. WHO identifies several factors

that may contribute to poor mental health, including stressful work conditions, social exhaustion, rapid social change, and poor lifestyle choices. The negative impacts of the COVID-19 pandemic on the mental health of frontline healthcare workers have been profound as they relate to these factors (Abbasi, 2020; Carmassi, et al., 2020; Dutton, 2021c; Gainer, et al., 2021; Prasad, et al., 2021).

The National Alliance on Mental Illness (NAMI) use the phrases *mental health condition* and *mental illness* interchangeably (2021). Both are defined as conditions that affect thoughts, feelings, moods, and behaviors, usually resulting from multiple causes or events. According to NAMI, mental illness affects a reported one in five adults in the US each year, with 75% of lifetime mental illness beginning by the age of 24 (2021). Idaho ranks fourth in the nation for the percentage of the population that struggles with mental health conditions (St. Luke's, 2019). Unfortunately, St. Luke's (2019) also reports that there is a critical shortage of mental health providers in Idaho, resulting in roughly one quarter of the population (24.7%) being unable to obtain the mental health treatment and services they need.

As a healthcare professional, I am most familiar with the terms used to describe the mental health conditions that follow. While these may be the words I would select to describe my own experiences during COVID-19, I acknowledge that other members of the healthcare community may describe their experiences in a different way, and use different language to do so.

- *Anxiety*, one of the most common mental health conditions, causes feelings of intense fear or distress. Anxiety can present either through physical or emotional symptoms, or both (NAMI, 2021).

- *Depression*, which is a devastating mental health condition that can have a profound impact on an individual's ability to function on a daily basis (NAMI, 2021).
- *Posttraumatic Stress Disorder (PTSD)* is a mental health condition that develops in response to a traumatic event. Symptoms of PTSD often accompany other conditions, including anxiety and depression (NAMI, 2021).
- *Burnout* has been defined a number of different ways. Almen (2021) describes burnout as a state of "…physical fatigue, emotional exhaustion, and cognitive weariness (p2)". In the presence of these symptoms, individuals have been shown to have a diminished capacity for dealing with stress.

The rising prevalence of negative mental health outcomes among frontline healthcare workers over the last two decades is indicative of a public health crisis that existed long before COVID-19. One study found that as many as one in six reported suffering from stress-related symptoms after providing care to patients during disease epidemics (Carmassi, et al., 2020). The current pandemic has exacerbated the mental health burden of our frontline healthcare workers, particularly those who spend extended periods of time diagnosing, treating, or caring for patients with confirmed or suspected cases of COVID-19 (Carmassi, et al., 2020; Gainer, et al., 2021). For frontline healthcare workers, treating patients who exhibit COVID-19 symptoms, or those with a confirmed positive test result, increases their personal risk of contracting this potentially deadly virus. Frequent and/or prolonged exposure also increases their perceived risk of infecting close family and friends, adding to their mental health burdens (Gainer, et al., 2021).

In a recent JAMA interview (Abbasi, 2020) conducted with Eileen Barrett, MD, MPH, former deputy chief of medicine at New Mexico's Indian Health Service's Gallup Indian Medical Center, the Ebola outbreak was compared to the COVID-19 pandemic, and several

similarities emerged. Among them were the catastrophic natures of both illnesses, shortages of personal protective equipment (PPE), and supportive care protocols being substituted for actual treatment plans. Barrett identified one key factor contributing to physician stress during both crises: uncertainty. Uncertainty can be perpetuated through fears about the unknown (e.g. producing sensations similar to "…being on a beach before a tsunami (p. 2235)"), increasing numbers of cases, and concern over contracting or spreading the virus. All of these take a psychological toll on healthcare workers, resulting in negative mental health outcomes.

COVID-19 in Idaho and Its Effects on the Healthcare System

The Centers for Disease Control and Prevention (CDC) reported that as of November 2021, the United States had seen a total of 46,268,465 cases of COVID-19, resulting in almost 750,000 deaths (749,876), since January 2020 (2021a). Comparatively, as of November 2021, Idaho had reported 295,999 total cases and 3,645 COVID-19 related deaths (The New York Times, 2021). Of those, 82,536 and 42,949 cases were reported in Ada and Canyon Counties, which are two of the most populous counties in the state, resulting in 790 and 531 deaths, respectively (IDHW, 2021). As of November 2021, the Idaho Department of Health and Welfare (IDHW) (2021) reported that there have been 12,538 cases reported among Idaho's healthcare workers since March 2020. In May of 2021, the situation was dire, with only 53% of the state's eligible population being fully vaccinated. Idaho's unvaccinated population has contributed to the significant majority of COVID-19 hospitalizations (89.8%), admissions to the ICU (92.1%), and deaths (87.1%) since May 2021 (Matsuzawa & Van Hyning, 2021). According to Dr. Steven Nemerson, the Chief Clinical Officer for the Saint Alphonsus health system in Idaho, "We've lost the war. COVID is here to stay … because we can't vaccinate enough of the public to eradicate it (no page)" (Matsuzawa & Van Hyning, 2021).

By September 16, 2021, the IDHW activated the Crisis Standards of Care (CSC) statewide, just ten days after the CSC were implemented in northern Idaho (IDHW, 2021b). The drastic increase in the number of COVID-19 patients requiring hospitalization necessitated this action. According to Dutton (2021c), "hospitals had so many patients with COVID-19, the state gave them permission to downgrade medical care for everyone (no page)". An oversimplified explanation perhaps, but under the CSC guidelines, medical facilities have to prioritize care in order to save as many lives as realistically possible under the circumstances, and patients are triaged accordingly in order to do so (IDHW, 2021b).

For some, implementation of the CSC guidelines literally equate to life or death, as healthcare providers are faced with the unimaginable task of determining who receives a hospital bed, ventilator, or treatment, and who does not (Dutton, 2021c). Essentially, patients deemed to have a higher probability of survival are more likely to receive treatment over those who will likely not recover (IDHW, 2021b). Fortunately, as of November 22, 2021, CSCs were deactivated statewide as the positivity rate of COVID-19 cases began to decline (Stevenson, 2021).

As a medical professional, I feel a physical, gut-wrenching ache trying to imagine the added burden (i.e. stress, anxiety, depression, and guilt) these CSC guidelines likely placed on the physicians and medical staff who were now faced with making these impossible decisions, and executing them once a decision has been made. Dr. Nemerson acknowledged the psychological trauma that healthcare workers have endured since the onset of the pandemic nearly three years ago (Matsuzawa & Van Hyning, 2021), but acknowledgement does not lessen the burden. It should be explored whether or not CSCs did anything to alleviate mental and emotional fatigue.

Dutton (2021a) reported on several interviews that were conducted by the Idaho Capital Sun with more than a dozen healthcare workers in Idaho around the time of the fourth COVID-19 surge in the state. In September 2021, at the time the article was published, Idaho had seen an influx of COVID-19 related hospitalizations, reaching a seven-day average of 512, with only four ICU beds available out of 400 statewide (Lukpat, 2021). According to Dutton (2021a), many respondents described emotional breaks resulting in tears, either during a shift or shortly after. Several discussed the sheer volume of COVID-19 patients, many of whom were sick or dying due to their own vaccine hesitancy. Some discussed the disbelief and anger they were met with when they delivered information about a confirmed COVID-19 diagnosis to patients and their families. Dutton (2021b) described the problem as a scar that the pandemic is leaving on the residents of Idaho, particularly the state's healthcare workers, a "… scar that thickens with every 12-hour shift they spend trying to save people from COVID-19 (no page)".

Across the globe, healthcare workers have been championed as "heroes", likened to soldiers fighting on the frontlines against a deadly enemy (Charney, et al., 2020; Dutton, 2021), but to what end? The media has consistently ascribed heroism to frontline healthcare workers, effectively, and perhaps irrevocably, "… cementing an ideology that constitutes health care workers as the heroes in the war between COVID-19 and mankind (p. 344)" (Einboden, 2020). However, many healthcare workers, myself included, do not aspire to hero status. COVID-19 has caused very real devastation, trauma, and fear, and, for me, without an end in sight, the psychological and emotional outlook was bleak as hopelessness set in between January and June of 2021.

Emotional Dissonance and Psychological Adjustment

Faibane, et al. (2019), define *emotional dissonance* as the emotional conflict that arises in situations where an individual is expected to display a particular emotion or set of emotions as determined by their employer or organization, regardless of whether or not those emotions are consistent with how the individual actually feels. There is a correlation that exists between emotional dissonance and negative mental health outcomes, particularly among healthcare workers (Faibaine, et al., 2019). The expectation that an individual display anything other than sincere emotion causes tension, which can lead to exhaustion and burnout (Faibaine, et al., 2019; Ogutu, et al., 2021). Being subjected to the expectation of a "forced" emotional projection that is less than authentic can strip the individual of some of their personal power and autonomy (Ogutu, et al., 2021). With COVID-19, emotional dissonance becomes evident when the role of the individual is considered within the context of larger hospital culture. Healthcare workers continue to perform during every shift, long after emotional exhaustion, stress, and compassion fatigue have set in, in order to uphold the public perception that they will persevere in their heroic battle against COVID-19, despite the ever-increasing toll it takes on their physical and mental wellbeing (Einboden, 2020).

Amoura, et al. (2014), discuss the relationship that exists between a desire for control and the perception of control, and the impact this relationship has on psychological adjustment. *Psychological adjustment* is a response mechanism that allows an individual to adapt to and cope with factors outside of their control (Secer, Uias, & Karaman-Ozlu, 2020). Individuals who possess a high desire for control are motivated by the perception of control. The perception of control refers to the belief that an individual will be able to achieve a desired outcome by performing certain actions. Individuals who possess a high desire for control, coupled with a low

perception of control, as in the case of the COVID-19 pandemic, may experience negative psychological adjustment due to their inability to control their circumstances (Amoura, et al., 2014). Negative psychological adjustment may present as anxiety, depression, PTSD, stress, shock, grief, or other. (Secer, Uias, & Karaman-Ozlu, 2020).

Theoretical Framework

This literature review thoroughly explored the theoretical constructs of power dynamics, hero discourse, phenomenology, and autoethnography. The following sections highlight relevant findings. The discussion about power dynamics illustrates to what extent power, knowledge and truth can influence an individual within the larger context of their cultural group(s). Discourse, specifically the hero discourse, is investigated from the perspective of the frontline healthcare worker during the COVID-19 pandemic. Phenomenology is explored in relation to how the lived experiences of research participants can yield knowledge about a given phenomenon. The relevance and appropriateness of autoethnographic qualitative research design is also discussed in detail.

Power Dynamics and Hero Discourse

In the context used here, *power* does not equate to control in the sense of domination and subjugation (Negura, Plante, & Levesque, 2020). Instead, power dynamics are explored here based on the intricate connection that exists between power, knowledge and truth, gleaned from the work of Michel Foucault (Armstrong, 1985; Basumatary, 2020; Dumitrica, 2010; Mohammed, et al., 2021; Negura, Plante, & Levesque, 2020). In the following discussion I provide a personal example to explicate these terms and show how they dynamically interact.

First, power itself is exercised through a network of established social connections, moving fluidly through the network as opposed to remaining stationary (Rouse, 2005). When power is exercised, knowledge is created, and knowledge, in turn, regulates to what extent power can or should be exercised (Powell, 2015). Prior to the pandemic, I was confident in my role as an MRI Technologist. I had worked hard to get there. When I was offered a full time position in the hospital, I thought it was a dream come true, and for a while, that was the case. When the pandemic hit, working in a southwest Idaho hospital became a constant source of anxiety and stress. The stability I felt in my role was stripped away. The power exhibited by hospital administrators and management over me dictated that I had to continuously put myself in a dangerous situation, which instilled in me new knowledge about my personal and professional priorities. This new knowledge changed the dynamics of power. I quit. The decision to leave my role as a medical professional was liberating. This decision meant that those in positions of authority at the hospital could no longer exercise the same power over me.

Second, the dynamic between power and knowledge is such that one does not exist separate from the other, and the reflexive relationship between them "… ultimately determines the production of truth (Basumatary, 2020, p. 323)". When the COVID-19 pandemic hit, everything I "knew" about being an MRI tech was turned on its head. The expectation of my employer was that I continue working despite personal risk, which was a force of power that informed my knowledge that in order to keep my job and continue receiving a paycheck, I would knowingly, albeit somewhat begrudgingly, be required to walk into a dangerous situation every single shift. These forces of power I experienced had a lasting impact on my personal knowledge, and the reflexive relationship between the two altered what I knew to be true about a job I once loved. Love was quickly replaced by resentment. Those in positions of authority,

entrusted with making decisions and implementing policies, were fumbling in light of the fact that new information was emerging almost daily. Procedures that were in place during one shift would change, seemingly overnight, and be different by the next shift. I came to know that the future of my chosen profession would be drastically different than I ever could have anticipated. I thought I could rely on hospital leaders for answers, when in fact, no definitive answers were ever provided.

Further, it is through cultural relationships that we see power dynamics in action (Negura, Plante, & Levesque, 2020; Powell, 2015). The position one occupies within their cultural group determines, to some degree, the extent of the influence power will have over social interactions. Every individual has a "… symbolic role they play (p. 29)" within the larger context of culture (Negura, Plante, & Levesque, 2020). Groups of individuals working closely together within the hospital emulate sub-groups within a larger culture of medical professionals. For example, those of us in MRI formed one sub-group, with our own unique procedures and shared language that might not be used, or used as commonly, in another medical department. As a cultural group, we collectively adjusted to forces of power, which were exhibited in the form of frequent changes to policies and procedures. This was accomplished by shifting our knowledge of what was required for our roles as medical imaging professionals and the resulting social interactions. Some examples of this include: extra communication and preparation required when scanning a confirmed or suspected COVID-19 patient; and wearing additional PPE and determining ahead of time which tech would be "dirty", meaning that they would be in contact with the patient throughout the exam, doing their best not to contaminate anything else.

I distinctly remember my first exposure to a probable COVID-19 patient. In the early days of the pandemic, the social/cultural requirement that masks be worn by all patients at all

times had not been implemented yet. Effective patient care often required the technologist to be in close proximity to the patient (e.g. when starting IVs necessary for administering contrast during the exam). I was working close to one patient in particular, while starting an IV. As I was doing this, they were discussing how someone who lives in their home just tested positive for COVID. I was wearing a mask, the patient was not, and there had been much less than six feet of distance between us during this conversation. I felt very exposed in that moment, literally and metaphorically, but there was nothing that could be done about it. I had an ethical obligation to ensure that this patient received the medical care they needed, despite the fact that they had just inadvertently put several hospital employees, myself included, at risk for contracting a virus that we knew little about at that point. With this exposure came both knowledge and preemptive guilt that this patient interaction might result in one of my coworkers or my family, individuals with whom I have strong cultural relationships, possibly getting sick. I spent the rest of this shift maintaining as much physical distance as realistically possible from the rest of those working in my department. This was not an isolated incident, and as the pandemic progressed, so too did the frequency of instances such as these. However, I continued to do what was requested of me by hospital administrators and management, even as they struggled to find effective ways to combat a novel virus.

Finally, power and knowledge are connected through *discourse*, a social construct through which societal norms are influenced and regulated by those in positions of authority (Pitsoe & Letseka, 2013). It is through discourse that the formation of thoughts around a particular subject are established. Discourse also determines the "… written or spoken communication (p. 24)" used to discuss a particular subject (Pitsoe & Letseka, 2013), and it can be used as an instrument of power.

An example of this is the emergence of the discourse of heroism among healthcare workers (Einboden, 2020). The *hero discourse* addresses the rapid elevation of healthcare workers to the status of "hero", and the normalization of and desensitization to the elevated level of risk that accompanies that designation (Einboden, 2020; Mohammed, et al., 2021). Throughout the COVID-19 pandemic, thousands of frontline healthcare workers have faced increased risk of infection or death resulting from frequent and/or prolonged exposure to COVID-19 in their efforts to treat the millions of patients that have been affected by the virus worldwide (Muhammed, et al., 2021; Shaukat, et al., 2020).

In Idaho specifically, there have been 295,999 total cases and 3,645 COVID-19 related deaths reported as of November 2021 (The New York Times, 2021). Up to that date, when this review was conducted, there were few studies conducted on the hero discourse and, of those that were, only a small percentage have considered how the identities of the healthcare workers might have been affected in terms of their personal power, knowledge and truth (Muhammed, et al., 2021).

Einboden (2020) describes a painting done by an anonymous street artist, known only by the pseudonym Banksy (Image 1). The painting depicts a young child playing with his newest superhero doll, SuperNurse, while his older and more familiar toys sit forgotten, discarded in the trash bin behind him. According to Einboden (2020) there is a great deal of meaning in this deceptively simple image. The nurse wears both a theatrical mask and a surgical mask, simultaneously protecting herself and her identity. Her

Image 1: "SuperNurse" by Banksy (Gompertz, 2020)

uniform is that of a different era, reminiscent of those worn by nurses during periods of war. The red cross brazenly displayed across her chest, the only color present in the image, is symbolic of her bravery. The cape she wears signifies the superpowers to which the artist is alluding.

Einboden (2020) points out that while there is some appeal to the SuperNurse imagery and what it represents, it also "… makes [her] uncomfortable (p. 344)". As a healthcare professional, I concur with this sentiment. The hero discourse is indicative of an uneven distribution of power between those in positions of authority and those who are being subjugated (Mohammed, et al., 2021). Essentially, the exhibition of power is shaping cultural knowledge and enforcing the "truth" that healthcare workers have an obligation to step into the role of hero, continuing to boldly put themselves in harm's way for the greater good, as the battle against COVID-19 rages on (Einboden, 2020; Mohammed, et al., 2021). Personally, my perception is that the hero discourse has been disseminated by those hiding in their offices behind large desks, while those of us on the frontlines are continuously being asked to do more with less, as was evident during the PPE shortage. I acknowledge this perception may not be held by others, and I will be vigilant in keeping my own bias from leading those I interview. At the same time, I will set out to explore this dynamic.

It should further be noted that not all healthcare workers are fully in accord with the public perception of their hero status (Einboden, 2020; Mohammed, et al., 2021). The temporary boost in morale serves only to distract from the gravity of a very real situation. Einboden (2020) and Mohammed, et al. (2021), highlight several examples of healthcare

Image 2: Photo Credit Luigi Morris (Wallis, 2020)

workers voicing their dissent against the hero discourse. Many individuals have very clearly conveyed their feelings, both about the SuperNurse imagery and about those in positions of authority within the health system that have contributed to the public perception that has put them in this position (Image 2 & Image 3):

> "PLEASE DON'T CALL ME A HERO, I'M BEING MARTYRED AGAINST MY WILL (Einboden, 2020, p. 345)"
>
> "It makes it almost excusable, like we went to war and fought for you. But we went to war without a gun, and that's not what I was asking for (Muhammed, et al., 2021, p. 4)".
>
> "WE WILL Not Be your Bodybags! (Einboden, 2020, p. 345)".

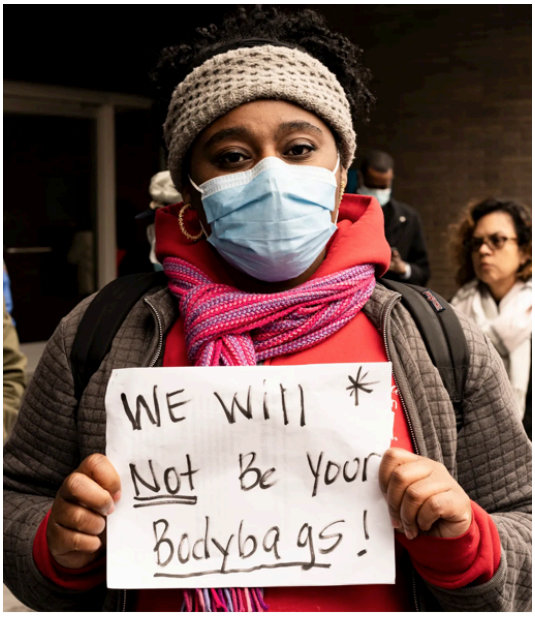

Image 3: Photo Credit Luigi Morris (Wallis, 2020)

Phenomenology

Phenomenology is a qualitative research strategy built on multiple philosophies hypothesizing that knowledge about a given phenomenon can be gained through an exploration of the lived experiences of the research participants in the context of real-world settings (Neubauer, Witkop & Varpio, 2019; Rodriguez & Smith, 2018). Rodriguez & Smith (2018) indicate that there are two distinct phenomenological approaches: descriptive and interpretive. The *descriptive phenomenological approach* seeks to gain understanding of the lived

experiences of the study participants, without the influence of any perceptions held by the researcher. The researcher ensures this through the process of 'bracketing'. Conversely, *interpretive phenomenology* seeks to interpret and describe the phenomenon, gaining understanding through the process of comparing the knowledge and experience of the study participant with that of the researcher. Interpretive phenomenology has proven effective in the delivery of relevant findings through the process of exploring the lived experiences of study participants in healthcare research (Rodriguez & Smith, 2018). This study will utilize interpretive phenomenological methods to better understand the phenomena of lived experiences of frontline healthcare workers employed in southwest Idaho hospitals throughout the COVID-19 pandemic.

When incorporating interpretive phenomenological methods into a qualitative research study, it is important to consider the *eidos*, or unique meaning, of the phenomenon being investigated (van Manen, 2017). Phenomenology is concerned with the way that phenomena manifests, thus researchers must interpret the lived experiences of the participants in the context of that phenomenological manifestation (Ramsook, 2018; van Manen, 2017). If we take a specific phenomenon, like hospital overcrowding during the COVID-19 pandemic, for example, Lindseth & Norberg (2004) explain the importance of healthcare workers reflecting on their lived experiences with such a stressful or challenging situation. Reflection provides an opportunity to gain understanding about the meaning that an overwhelming number of COVID-19 patients in the hospital has to healthcare workers. Once meaning is made of a lived experience, perceived knowledge about the subject emerges (Lindseth & Norberg, 2004).

Often, phenomenological data is collected through conversational or semi-structured interviewing, where the researcher and participant work together to investigate a given phenomenon (Lauterbach, 2018). Conversing with study participants through semi-structured

interviews encourages reflections on the phenomenon, delving into the lived experience through recalled memories (Lauterbach, 2018). Frechette, et al. (2020), define *lived experience* as a multidimensional phenomenon, based on both the experience itself, and the meaning assigned to the experience by the individual who lived it. The significance of a lived experience is determined through the process of interpretation, and "… what lasts once the experiencing is done (p. 3)" will vary person-to-person among a group of individuals (Frechette, et al., 2020).

A very compelling piece of phenomenological literature about a healthcare worker's experiences during the pandemic was written in the first person perspective by Erica J. Harris, MD, (2020) a practicing physician at Einstein Medical Center in Pennsylvania. Her words vividly capture her own experience, and the emotions behind her words resonate on a personal level and provide opportunity for comparison between her experience and mine. For example, she depicts leaving the hospital at the end of a long and grueling shift, which she describes with phrases like

> "… slowly removing my [PPE], taking care not to contaminate myself (p. 634)"
>
> "… [studying] the deep indentations across my nose (p. 634)", while uncomfortably questioning whether hers is the face of a hero,
>
> and being able to "… take a deep, unimpeded breath for the first time that day (p. 634)".

Autoethnography

Chang (2016) defines *autoethnography* as the process of "… searching for understanding of others (culture/society) through self (p. 49)". In order to understand the unique characteristics and benefits exclusive to autoethnography, it is essential to first understand the relationship of self within the larger context of culture. Human interactions, the relationships that exist among a

group of individuals functioning within a particular social structure, directly influence and are influenced by the cultural group to which one belongs. There is an element of connectivity, or sharedness, that is necessary for individuals to be classified as part of a cultural group. Some researchers hold the view that a particular culture exists outside and separate from groups of people that exist within that culture, which implies that the two are distinct entities – cultures and groups of people. Others contend that cultures exist in the minds of their members, and is established through collectively shared ideas, communications, and experiences of the individuals. Chang (2016) identifies "… culture as a product of interactions between self and others in a community of practice (p. 23)", where "… self is the starting point for cultural acquisition and transmission (p. 23)". The ability to gain understanding of a culture through self, employing autoethnographic methods, requires one to first acknowledge their place within the culture under investigation.

Autoethnographers are simultaneously the researchers and the research subjects, developing their understanding of culture through personal moments of significant impact experienced as members of the culture under investigation (Olmos-Lopez & Tusting, 2020). As both the researcher and a healthcare worker in this study, I share my own experiences, through writing. I grant readers access to my personal thoughts and reflections (Messinger, 2021). Exploring these experiences through the writing process provides researchers with "… a way of coming to know an experience better (Olmos-Lopez & Tusting, 2020, p. 265)".

It is noteworthy to mention that this literature review yielded no autoethnographic studies exploring the lived experience of an MRI Technologist working through the COVID-19 pandemic. However, autoethnography has proven effective in the study of sensitive topics. Philaretou & Allen (2006), for example, provide evidence that the use of autoethnographic

methods in the investigation of sensitive or "taboo (p. 66)" topics (i.e. mental health conditions, particularly among frontline healthcare workers) allows researchers the opportunity to answer questions that may prove difficult to answer utilizing more conventional methods. This can be attributed to the fact that the researcher, as a member of the culture under investigation, begins their research from a place of familiarity (Chang, 2016; Philaretou & Allen, 2006). Familiarity with the topic allows researchers to transcend the traditional conventions of scholarly writing, yielding content that is more personally engaging for readers (Chang, 2016; Messinger, 2021).

Philaretou & Allen (2006) also discuss the potential for autoethnographic methods to broaden sociocultural understandings of controversial or sensitive issues in three ways. First, they draw significantly higher interest due to the fact that the issues are controversial or sensitive. Second, they aid in dispelling misconceptions surrounding controversial or sensitive issues. Third, they establish a foundational understanding about the issues from which additional knowledge can be acquired. The authors warn, however, that researchers should be cognizant of the potential for emotional harm that may be caused by addressing issues of sensitive or controversial nature, and steps should be taken to mitigate that risk. Further, the process of seeking cultural understanding through exploration of personal life experiences can be taxing for researchers, as they may "… come face to face with certain negative aspects of self-concept that may be hard to acknowledge, understand, or accept (Philaretou & Allen, 2006, p. 71)". However, it is through the evocative nature of autoethnography that researchers are able to make sense of their personal "… struggle, passion, [and] embodied life (Wall, 2016, p. 2)".

Wall (2016) discusses the ever-increasing intrigue that surrounds autoethnography, and the extent to which it should be used in qualitative inquiry. There are some reservations regarding the validity of autoethnography as method, particularly for a graduate student working

on her thesis (Chang, 2016; Dumitrica, 2010). Dumitrica (2010) calls attention to the issues of the relative newness of autoethnography, its highly subjective nature, the rarity of employing this method in graduate research, and the probable difficulty the researcher will encounter defending the legitimacy of their work. Chang (2016) cautions against the following pitfalls: focusing excessively on self, separate from the cultural group; prioritizing narration over interpretation and analysis; and extracting primary data exclusively from memory, without employing methodical writing exercises to assist with recall. Dumitrica (2010) inquires about the self-indulgent nature of autoethnography, asking whether this research method places too much emphasis on the personal experiences and reflections of the researcher? I contend, along with Chang (2016), that autoethnography provides an opportunity for a more percipient analysis and interpretation of data, based on the intricate working knowledge researchers possess, which is drawn from their status as members of the cultural groups under investigation. Legitimacy for autoethnography as a qualitative research method can be established through analysis and interpretation that is both impactful and substantive, contributing to the understanding of a cultural phenomenon by exploring the lived experience of the researcher (Dumitrica, 2010), which happens through the process of "… connecting the personal to the cultural (Chang, 2016, p. 46)".

Chapter 3: Methods

Conceptual/Analytical Framework

The conceptual/analytical framework (Figure 1) presented here attempts to illustrate how the paradigm of truth, both for the researcher and the study participants, is affected by power dynamics, the hero discourse, and shifts in knowledge during the COVID-19 pandemic. At the center sits the paradigm of truth, or eidos. The *eidos* refers to the unique meaning of the phenomenon being investigated (van Manen, 2017). In this case, that phenomenon is COVID-19. Every member of the hospital community has their own truth regarding their experience working as a healthcare professional during the COVID-19 pandemic. Revolving around the center sits the phenomenon of COVID-19. The pandemic was an unprecedented crisis for many healthcare workers, and with it came confusion and chaos in the hospital environment. As such, it is important to understand the effect that COVID-19 has had on the paradigm of truth for healthcare workers in southwest Idaho. Hero discourse also revolves around the center. The hero discourse describes the exhibition of power through shared language and communication. This language has shaped cultural knowledge of the role of the healthcare worker during the pandemic. Hero discourse has enforced the "truth" that healthcare workers have an obligation to step into the role of hero, regardless of whether or not they have the desire to do so. In order to truly understand how this hero discourse has affected healthcare workers, it was important to analyze the effect of this discourse on the paradigm of truth. Shifts in knowledge and power also revolve around the center. Shifts in knowledge represent the effect of COVID-19 on what was known by healthcare workers prior to the pandemic, and what they have come to know since. It is important to understand how significantly knowledge has been affected. Shifts in power represent how power dynamics might have been influenced by COVID-19 (e.g. the power

exhibited by hospital administrators over medical professionals through rapidly enforcing new mask mandates, but initially allowing patients to decide whether or not they wanted to wear one). Also, it is through cultural relationships that we see power dynamics in action (Negura, Plante, & Levesque, 2020; Powell, 2015). For example, the position one occupies within the cultural hierarchy of a hospital determines, to some extent, the influence power will have. It is important to understand the layers of individuals enacting power, and to what extent, changing power dynamics might have influence on knowledge and truth. The interconnected and overlapping relationship between these phenomena eliminates the ability to determine which carries the most weight for an individual in their development of truth.

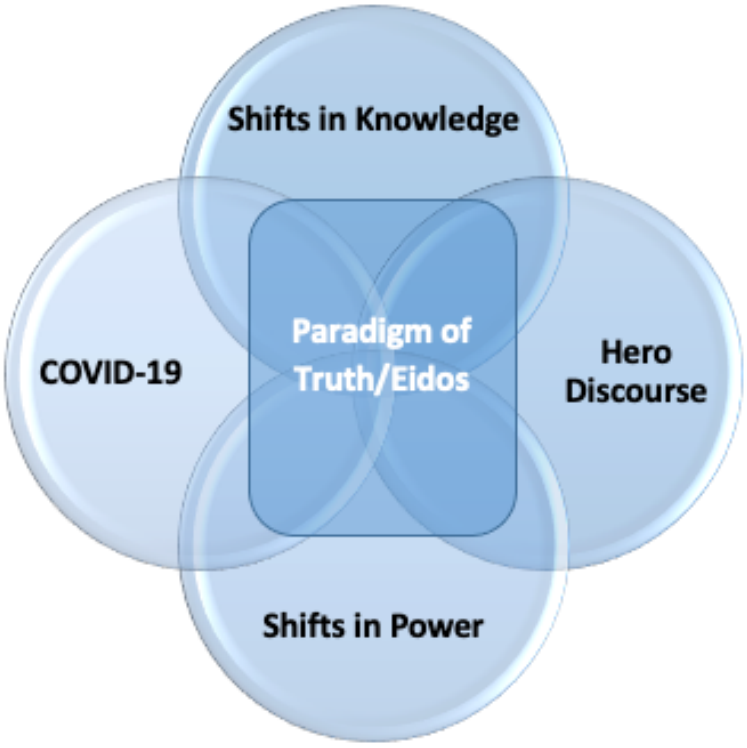

Figure 1: Conceptual and Analytical Framework representing the influence of knowledge, power, the hero discourse and the COVID-19 pandemic on the paradigm of truth.

Study Design

This study used a combination of autoethnography and semi-structured interviews to answer the following research questions:

1. What are the perceptions held by healthcare professionals working in medical facilities in southwest Idaho regarding the effect of COVID-19 on their own mental health and the mental health of other medical professionals?

2. How do my own lived experiences working through the pandemic compare and contrast with the experiences of other healthcare workers?

Using the newly developed conceptual and analytical framework detailed above, I qualitatively analyzed how my own lived experiences working through the pandemic as an MRI Technologist compared to the experiences of other frontline healthcare workers. To achieve this, nine (9) semi-structured interviews were conducted with healthcare workers, specifically those working in medical imaging, while concurrently exploring, analyzing, and interpreting my own lived experiences through autoethnography.

Semi-Structured Interviews

Study participants were purposely recruited for semi-structured interviews based on a predetermined set of criteria (i.e. frontline healthcare worker status, having had direct contact with confirmed or suspected COVID-19 patients, spanning the timeframe of the COVID-19 pandemic) (Creswell, et al., 2007). Nguyen, et al. (2020), refer to *frontline healthcare workers* as those with direct patient contact. For the purpose of this research, the population of frontline healthcare workers was more narrowly defined and included medical imaging staff working in medium-sized hospitals (100 – 499 beds) in southwest Idaho. The names of specific healthcare facilities have been omitted to maintain confidentiality for study participants. Priority was placed

on interviewing medical staff that appeared less commonly in scientific literature, specifically medical imaging staff (Prasad, et al., 2021). Semi-structured interviews were conducted with four medical imaging professionals from one hospital, including two technologists from magnetic resonance imaging (MRI); one from computed tomography (CT), and one from Xray; and five technologists from a second hospital, including four MRI Technologists, and one CT Technologist. Both hospitals were places where I previously worked.

Participants were selected based on whether or not they had direct contact with patients who exhibited symptoms of, or tested positive for, COVID-19 spanning the timeframe of the COVID-19 pandemic from January 2020 to present, which at the time of writing, was June 2022. Demographic information was collected at the conclusion of each interview, to include age, gender, race, ethnicity, professional licensure held (if any), and length of time in current position, in an effort to accurately describe the healthcare workers participating in this study. An interview guide was developed and piloted prior to use (Appendix A). The purpose of the guide was to serve as an outline for each interview, without the requirement that it be strictly adhered to (Lauterbach, 2018). Interview questions were formulated in such a way that participants were able to share their "… distinct experience, knowledge, and perspective (p. 16)" of the COVID-19 phenomenon (Ramsook, 2018). Questions were organized such that they overtly addressed the specific areas of the conceptual/analytical framework and began with the least sensitive moving towards most sensitive subjects.

Conversing with study participants through a semi-structured interview format encouraged reflection, allowing them to delve deeper into their lived experiences. Relevant topics were discussed in greater detail as they arose. Nine (9) semi-structured interviews were

necessary in order to reach saturation. *Saturation* refers to the point where no new information emerges (Creswell & Poth, 2018).

Considerations

Conducting semi-structured interviews required human subjects approval, which was sought from the Institutional Review Board (IRB) at Idaho State University and granted on January 14, 2022. As hospital channels were not used for recruitment purposes, it was not necessary to gain approval from the review boards at both hospitals before asking individuals to participate in this study (Creswell & Poth, 2018).

IRB approval was not required for the autoethnographic component of this study, as the primary focus was on my personal experiences. However, it was important for me to acknowledge the inclusion of others in the telling of my own story and to adhere to research practices that protected their privacy to the extent possible (Chang, 2016). The process of self-reflection through data collection, analysis, and interpretation caused strong emotional reactions for me. As such, I maintained my willingness to access available resources, including counseling services provided by Idaho State University, as necessary.

It was acknowledged that the topics being discussed could trigger strong emotional responses from interviewees. Each was informed that they were under no obligation to answer any question, even if they were in the middle of the interview, and that they were able to withdraw from the study at any time. A list of resources, including counseling services, was compiled and provided to study participants, if necessary, particularly if they expressed interest in speaking with a mental health professional (Appendix D). Doing so was valuable, because I was able to help one interviewee who asked for assistance. Also, participants were made aware

of this possibility and were provided with a copy of the informed consent document prior to the interview (Appendix C).

In an effort to adhere to COVID-19 safety guidelines and recommendations, interviews were conducted and recorded over Zoom, with all meetings being password protected such that only the researcher and interviewee had access. The Zoom platform allows participants the opportunity to have a face-to-face conversation without taking any unnecessary safety risks. The specific aims and purpose of the interview were disclosed to each participant ahead of time, and verbal consent to participate was recorded on Zoom from each individual prior to beginning the interview. The majority of the interviews took approximately one hour to complete. Each participant selected the time for the interview to be conducted, as shifts in the hospital can vary drastically. Each participant was asked to make sure they were conducting the interview in a safe, comfortable setting.

Autoethnography

In order to analyze how my own lived experiences working through the pandemic as an MRI Technologist compared to the experiences of other healthcare professionals (Chang, 2016), I deconstructed the contributing factors that led me to where I currently am, both personally and professionally. I employed autoethnographic data collection methods to achieve this. To ensure that my findings would be both impactful and substantive, I completed five writing exercises recommended by Chang (2016). These activities were not strictly engaged in in consecutive order. Activities were revisited, as necessitated by the emergence of relevant data, in order to add or adjust content.

Activity 1. I created a timeline outlining personal experiences as they occurred, over a specific period of time (i.e. the COVID-19 pandemic from January 2020 to June 2021) (Chang,

2016). This activity was completed between March and April of 2022. These experiences were aligned with the categories of the conceptual/analytical framework, where appropriate. Establishing a timeline assists researchers with personal memory recall, based on specific events. This proved useful in prompting an estimated five writing exercises, based on what appeared in the timeline, to gain information about personal experiences. An additional writing exercise ensued as data was gathered, in the form of a photo essay. Engaging in writing exercises as a reflective process takes time, thus I dedicated a minimum of 30 minutes of writing time to each reflective exercise. I specifically included a writing exercise that addressed the very point in time I decided to leave my career in medicine, and what I am doing professionally in the present.

Activity 2. I wrote a synopsis of my daily routine specific to my shifts in the hospital (Chang, 2016). I completed this between February and March of 2022. The synopsis also included rituals and activities pre- and post-shift, as these may have been influenced by, or may have influenced, changes at work. I detailed my daily routines both prior to COVID-19 and during, and explored both in detail. As a writing activity after the synopsis was created, I reflected on how it related to the framework. That is, I investigated how my daily routine might have been affected by power dynamics and the hero discourse during the COVID-19 pandemic, and how this might have impacted the paradigm of truth. As other concepts arose, they were documented for exploration.

Activity 3. I engaged in self-observation exercises called “occurrence recording” (Chang, 2016). In this type of activity, a researcher records personal thoughts and behaviors over a certain period of time, and then reflects on the occurrence of each. As a coping mechanism, I recorded many of my experiences during the COVID-19 pandemic after particularly challenging shifts in the hospital. I reviewed each of these by mentally and emotionally dropping myself into

the scenarios they described. I reflected on exactly what prompted me to write them in the first place. I dedicated at least 30 minutes of writing for each of 12 personal reflections. This process occurred over a period of four months, from February through May of 2022, to ensure that there was enough time for deep, critical analysis.

Activity 4. I engaged in a writing exercise designed to capture my personal responses to the same semi-structured interview questions that I asked others. I enlisted the help of a family member to read me the questions, and answered each through semi-structured interview format. Each question was reflected on before an answer was provided. This exercise occurred in February of 2022, prior to beginning semi-structured interviews with participants, in an effort to capture my sincere responses, without the influence of information gathered through participants' responses. Following completion of the interview, I spent approximately 30 minutes writing a reflection on the interview itself, and my thoughts and feelings on the responses provided.

Activity 5. I engaged in interactive self-observation, which allows the autoethnographer the opportunity to "… observe and record [their] cognitive, behavioral, and emotional state (Chang, 2016, p. 94)" during the process of data collection. At the conclusion of each semi-structured interview, I spent approximately 30 minutes recording my perspectives on the data collected, comparing my personal experiences with those of the study participants'. This practice was ongoing for the duration of the semi-structured interview process, from February through June 2022.

Although the autoethnographic process is not linear, there is a dynamic relationship that exists between the activities involved in data collection, where "… one activity informs and

builds upon another (Chang, 2016, p. 121)". There was a concentrated period of five months where I engaged in five reflective activities, as depicted in the timeline below (Figure 2).

	Jan	Feb	March	April	May	June	July	Aug
Autoethnography								
Build Timeline			X					
Timeline Reflection			X	X				
Build Synopsis of Daily Routine		X						
Routine Reflection		X	X					
Perform Self-Observation Exercises		X	X	X	X			
Self-Observation Reflection			X	X	X			
Record Personal Responses to Interview Questions		X						
Interactive Self-Observation following each Interview		X	X	X	X	X		
Interviews								
Human Subjects Approval	X							
Recruit Study Participants	X	X	X	X	X	X		
Conduct Interviews		X	X	X	X	X		
Transcribe Interviews		X	X	X	X	X		
Open Code (HyperResearch)						X		
Axial Code (HyperResearch)						X		
Follow-up Verifications				X	X	X		
Comprehensive Analysis								
Compare Personal Findings with Interviews using Framework					X	X		
Defense								
Thesis Defense							X	
Graduation								
Apply for Graduation					X			
Graduate								X

Figure 2: Timeline.

Data Analysis and Security

Figure 3 is a graphic representing the concurrent analysis of both autoethnographic and interview data.

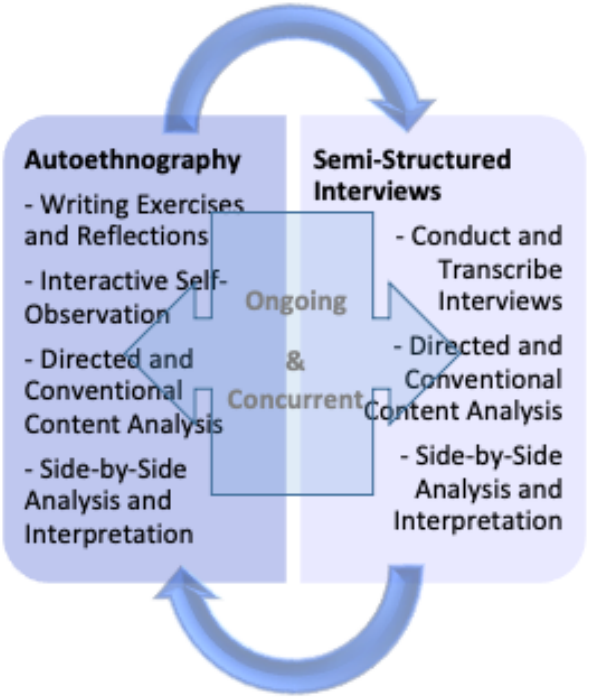

Figure 3: Proposed Qualitative Analysis Process

Autoethnographic data and recordings of completed interviews were stored securely in encrypted folders on a designated, password protected laptop computer. Each interviewee was assigned a pseudonym which was used in place of their name to ensure anonymity (Ramsook, 2018). The electronic recordings of completed interviews were transcribed using Otter.ai. This platform proved sufficient, thus a transcription service was not employed. Content analysis was conducted using HyperResearch for both autoethnographic data and the data collected through semi-structured interviews. This data was analyzed side-by-side so I could determine how my own lived experiences working through the pandemic as an MRI Technologist compared to the

experience of other frontline healthcare workers in the context of the conceptual/analytical framework. Throughout the entire data analysis process, I compared and contrasted myself to those I interviewed, applying a critical eye to the similarities and differences that emerged. Thus, data from autoethnographic analysis and data from interview analysis informed each other (Figure 3). As a way to show that what I saw was both reliable and valid, frequency reports of code categories were compared to text source root word searches to verify that results coincided. For example, the code 'PPE' appeared 60 times across all case files. To verify this finding, a search of text sources was conducted using the word 'mask', which yielded 167 returns, validating the significance of this data.

All data was coded using both directed and conventional content analysis techniques, following tenets of content analysis presented by Hsieh and Shannon (2005). First, directed content analysis served to validate the conceptual/analytical framework (Figure 1). All data was initially coded using only the following five codes, representative of the categories of the framework: COVID, Hero Discourse, Knowledge, Power, and/or Truth. A second round of coding used a conventional, inductive process through which I identified concepts, phenomena, and themes as they emerged. As they emerged, I assigned them to the categories of the conceptual/analytical framework that they most accurately represented: COVID-19, Hero Discourse, Shifts in Knowledge, Shifts in Power, and the Paradigm of Truth. Although there is a category for Truth, the codes it contains are based on the things that impacted the paradigm of truth, and will be explored further in Chapter 5. Through this emergent process, other findings were discovered. Specifically, an informative category of descriptive words revealed itself. Ultimately, seven code categories were identified, collectively containing 236 total codes. These

were paramount in understanding my personal experiences in the context of the conceptual/analytical framework. The coding process is represented in Figure 4, below.

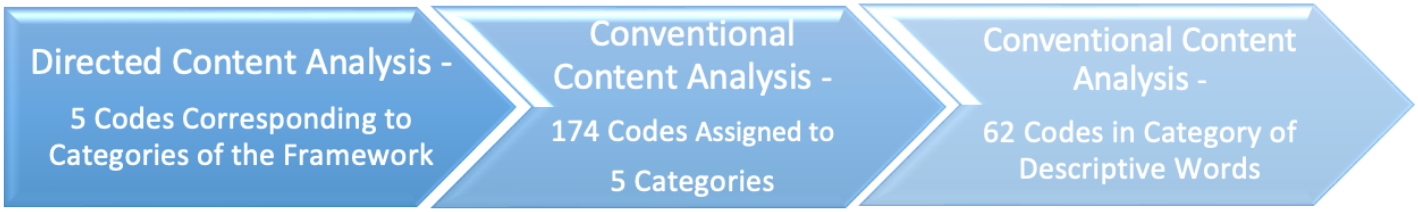

Figure 4: The Coding Process

Chapter 4: Results

This section details results obtained from autoethnographic data and data collected from semi-structured interviews, comparing and contrasting them along the way. It is separated into four sub-sections as follows: 1) a demographic description of study participants, myself included; 2) a brief description of the conceptual/analytical framework, complete with an updated graphic representing the relevant themes for each category; 3) a description of the three most salient themes for each category of the conceptual/analytical framework alongside photos from the aforementioned photo essay; and 4) an iterative, emergent theme of descriptive words not associated with the conceptual/analytical framework.

Demographics

Demographic information describing age, gender, race, ethnicity, education, professional licensure(s) held, length of time in current position, and intent to remain in the current profession was collected from each study participant following completion of the semi-structured interviews. The age of study participants ranged from 25 – 61 years old. Among the interviewees, there were five males, and four females. With the exception of two, all interviewees reported race and ethnicity as White and Caucasian, respectively. Every interviewee holds a Bachelor's degree, with one working towards a graduate level degree. All interviewees are registered with the American Registry of Radiologic Technologists (ARRT), holding licensure in at least one imaging modality, with the majority being registered in two or more. Length of time in current profession ranged from 4 – 32 years, with four interviewees having 10+ years of experience. Interestingly, length of time in current profession seemed to align with intent to remain in the profession. The four most seasoned technologists reported that they planned to remain in their current role, and the rest of the interviewees being "unsure" or

definitely not planning to remain in their profession. The implications of this discovery will be explored further in Chapter 5: Discussion.

Framework

The conceptual/analytical framework (Figure 1) attempts to illustrate how the paradigm of truth, both for myself and the study participants, was affected by power dynamics, the hero discourse, and shifts in knowledge during the COVID-19 pandemic. The interconnected and overlapping relationship between these phenomena eliminates the ability to determine which carries the most weight for an individual in their development of truth. After analysis of the data, I updated the conceptual/analytical framework to provide a visual representation of all salient themes for each category, as illustrated in Figure 5, below.

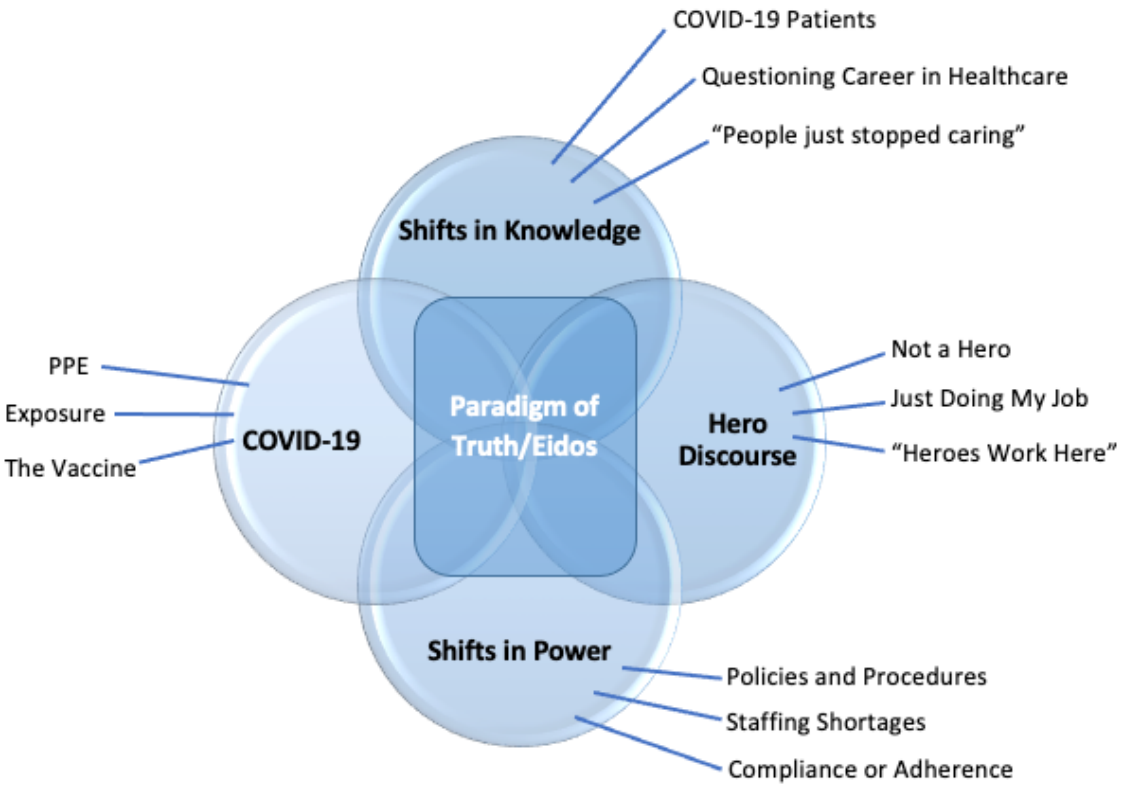

Figure 5: Conceptual and Analytical Framework representing salient themes for each category.

Salient themes from the Conceptual/Analytical Framework

The three most salient themes for each category of the conceptual/analytical framework are described in this sub-section. These themes have the potential to fall under more than one category, but here, I highlight how the themes relate to the categories to which they have been assigned, because they were the most relevant in these categories. An iterative, emergent theme of descriptive words is also be presented. This theme was not associated with the conceptual/analytical framework. Select photos from a collection captured from March of 2020 through June of 2021, recently explored through an autoethnographic lens in the form of a photo essay, are also included to emphasize salient themes, where appropriate. These findings are certainly not meant to be representative of an entire population, but rather a small number of medical imaging professionals in southwest Idaho.

Framework Category One: COVID-19

COVID-19 is one of the categories of the conceptual/analytical framework, as it is important understand the effect that it has had on the paradigm of truth for healthcare workers in southwest Idaho. Under this category, three predominant themes were identified: "Personal Protective Equipment (PPE)"; "Exposure", both the literal and the perceived risk of; and "the vaccine".

Theme One: Personal Protective Equipment (PPE)

The concept of PPE was referenced at least once in every interview, and mentioned multiple times across several of my personal self-reflective writing exercises. Study participants discussed PPE shortages, and the rapidly changing expectations surrounding the use of PPE. Limited availability, coupled with a lack of clarity surrounding the intended use of PPE, was a source of frustration for some, and resignation for others.

> “I think the biggest thing is you can't, things are changing so much, whether it's like policies on what you have to do with these patients, or even lack of policies, or, at first it was lack of equipment. But yet, you're supposed to wear all this protective equipment, and then there's a lack of it, oh, all of a sudden, this mask, you were only supposed to wear, you know, one per patient. Yeah, you can go 14 days with it.” (L1_MRI_02)

> “But the masks, we did end up having some supply issues where we came down to like, we only have like half of a box here. Like we need to make sure that we get some and I know that there was a scramble to get some and we ended up fortunately getting a hold of some and having that restock. But there was a point where I was like, Well, I'm not gonna have a mask anymore.” (L2_MRI_01)

After completing a timeline outlining my personal experiences as they occurred (Activity 1), I reflected on the timeline through another writing activity. The following is an excerpt of that reflection, capturing some of my thoughts and feelings on the theme of PPE:

> “In the hospital, stress was mounting. As a novel virus, no one was able to definitively say what we would be dealing with when treating patients with confirmed or suspected cases of COVID-19. There was very real concern over the personal protective equipment (PPE) shortage that was so prevalent in the news. Essential supplies (i.e. masks, gloves, gowns, hand sanitizer) were being stockpiled in preparation and becoming more difficult to acquire. Policies and procedures were being implemented and changed so frequently that it was difficult to keep up. Friends and family had a lot of questions about the COVID-

19 virus, and there was not a lot of information to share, at least initially. Having more questions than answers is a stressful place to exist."

Image 4: An evolving PPE journey. Image edited to omit facility. Photo by the author.

Theme Two: Exposure

The concept of exposure was discussed both as personal exposure to sick or symptomatic individuals, and as the risk of inadvertent exposure to family and/or friends. As the number of COVID-19 cases continued to rise in Idaho, so too did the risk of exposure for healthcare workers. As a healthcare professional working in a hospital, exposure to COVID-19 during every shift was imminent.

"But in all reality, we can't guarantee a safe, clean, waiting room, because people can say whatever they want to say. So it got to that point where that procedure I

felt it was, or policy, or whatever it is, was a joke. Because I go up, I grab a patient for something, and then lo and behold, they have COVID symptoms. And I was just, you know, not wearing the proper PPE and whatever [and] I just exposed myself for the 15th time today." (L1_XR_01)

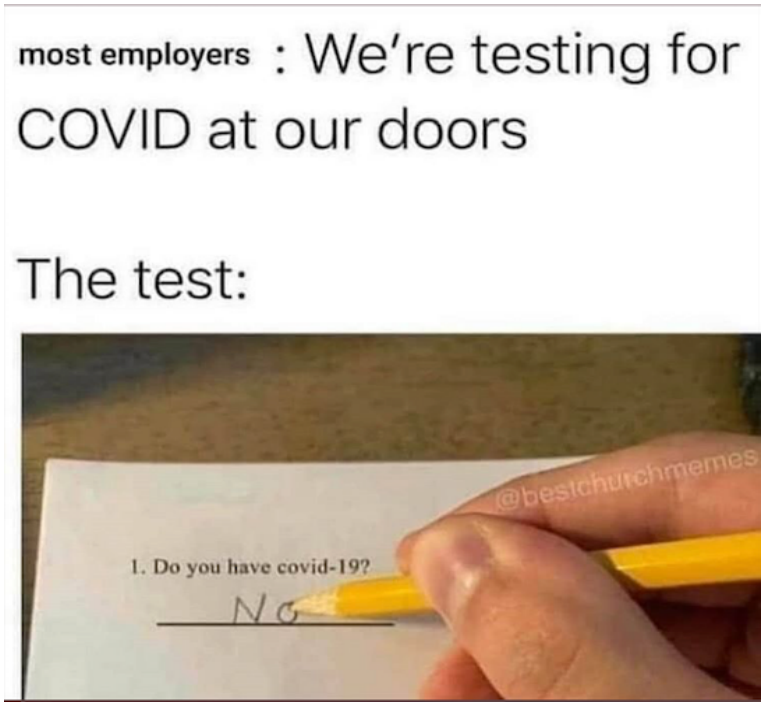

Image 5: Screenshot from a social media post by a fellow healthcare worker – July 2020

"I think sometimes a majority of society thinks that it's gone and that we don't need to worry about it. But as a health care worker, when you see how serious it is and what it can cause and that you know, you're a potential host who brings it home to your family. Mentally and emotionally, I mean, I just feel like I'm combating that every single day" (L1_CT_01)

"And you know, you hear people saying, 'Oh, COVID is not real COVID is not real'. And I'm like, I literally see it every day and how bad it is. And you're gonna sit here and say it's not." (L2_CT_01)

For myself personally, exposure was discussed both as an action, as in the risk of inadvertently exposing my family, and as a feeling. After completing a synopsis of my daily routine specific to my shifts in the hospital (Activity 2), I wrote the following reflection:

> "There were a lot of changes to my routine after COVID first appeared in Idaho, several months before the pandemic began inundating our healthcare system with very sick (and contagious) patients. It started with little things. Small changes, like making sure you had a mask in addition to everything else. I had a collection in my car that I would dig through before each shift to find the mask that had been worn least, or minimally, had the least wear and tear on it. Masks from home weren't allowed. Thus, I would wear the Amazon mask I purchased for myself from my car to the department, grateful for the protection I felt it afforded me. Once in the department, I would switch out my personal mask for the one provided and approved by the hospital. These were single use surgical masks that we were now required to wear for a full week unless "visibly soiled or damaged", per hospital policy, in response to the PPE shortage. After a week of use, these masks were thin, worn, and tattered, leaving me feeling more exposed than I had in the parking lot. With resolve, I would put the mask on my face knowing it would remain there for the next 12 hours. After each shift, I would leave the hospital's mask in my car, hanging from the rearview mirror. There were several reasons for this, which included: my show of support for the mask mandate, a badge of honor for myself as a healthcare worker, and hope that the UV rays from the sun would somehow help sanitize the mask before next shift. The more

COVID patients treated the shift prior, the more difficult it became to put the same mask on day after day."

As part of the self-observation exercises completed for reflection on the "occurrence recordings" of Activity 3, I mentally and emotionally dropped myself into a scenario discussing the theme of exposure, and wrote the following reflection:

"One of the biggest and perhaps most commonly misconstrued issues with COVID-19 is that it quits when you clock out and leave the hospital for the day. Out of sight, out of mind or some such nonsense. The reality is drastically different. It bleeds into every nook and cranny. Every facet of your life is somehow affected by this "hoax" of a disease. Your willingness to attend functions or events, get together and catch up with friends and family, and even leave your house becomes directly shackled to the number of times you were exposed that particular week. Either exposed directly or indirectly, the consequences are the same. Participating in your life makes you feel preemptive guilt. 'What if I inadvertently expose...?' 'What if I develop symptoms in a few days?' 'What if that patient was positive and nobody told us?' The list goes on and on..."

Theme Three: The Vaccine

The vaccine was a commonly-discussed concept, regardless of which side of the controversy personal opinions were held. For some, the vaccine helped to alleviate some anxiety and provided an added layer of protection against COVID-19. For others, it signified a loss of autonomy and control. Personally, I understand both sides, as I initially struggled with the decision to get vaccinated. Perhaps the most interesting perspective is that vaccination status

became a source of discrimination, particularly with quarantine and testing requirements following exposure, which is not a perspective I had previously considered.

> "And now that there's a vaccine that has taken a lot of anxiety away it was well, but there's still a lot of contention." (L1_MRI_01)

> "What do I get to do? What are the decisions I get to make as an individual versus the decisions I make as a healthcare person working in healthcare in a hospital? So a lot of your things that you're going to decide on, like, what matters to us, or this or that, or whatever, that gets taken away from you." (L2_MRI_01)

> "Because, you know, like, when [facility omitted] announced like their vaccination policy for COVID, there was a huge uproar. I get both sides. I get it. Some people super for it, some people super against it. It was new. I get it. But people were so discriminated against over a COVID vaccine." (L1_XR_01)

The following is an excerpt of a reflection on the timeline outlining my personal experiences as they occurred, completed for Activity 1, which captured some of my thoughts and feelings on the theme of the vaccine:

> "My initial response to the COVID-19 vaccine was hesitancy. Like many others, I was concerned about its safety and efficacy. These feelings were compounded by the ensuing chaos and inconsistency exhibited by management in the form of ever-changing policies and procedures. Conflicting narratives and misinformation continued to abound in the media. It was not a stretch to consider that we, healthcare workers, might actually be serving the role of guinea pigs in the vaccine rollout effort, as some reports suggested.

A coworker for whom I have great respect encouraged me to ignore the media and focus instead on the scientific literature. This was excellent advice in general, but proved especially helpful in easing my reservations about the vaccine. I made the appointment and graciously accepted the first of two vaccines, considering it additional armor in the effort to keep myself, my family, and my patients safe(r) during the pandemic."

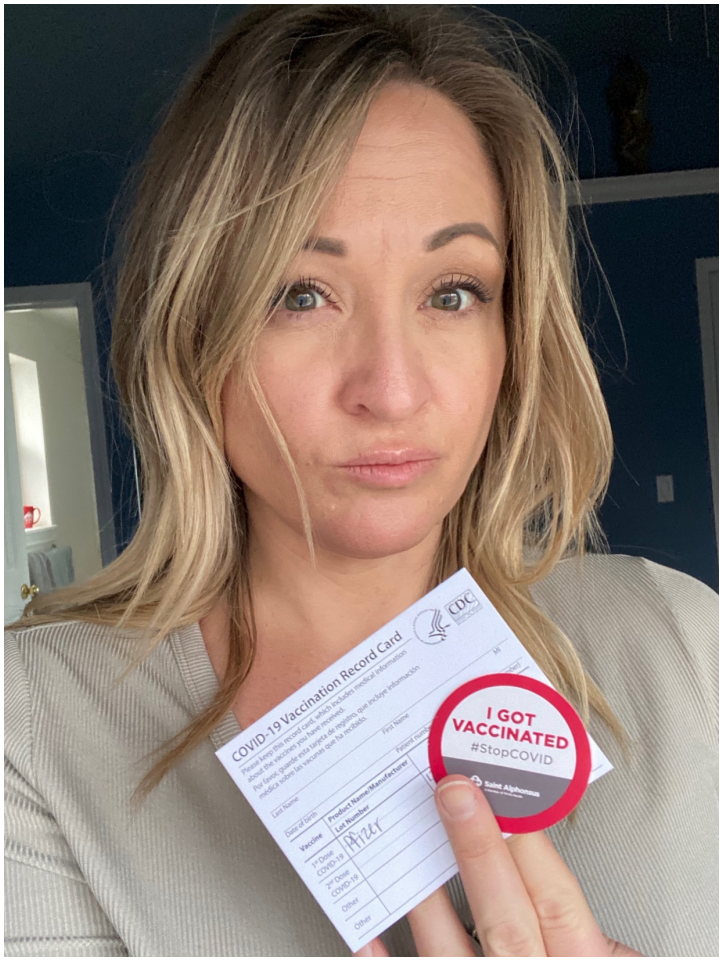

Image 6: First COVID-19 vaccination, Phase 1 of vaccination rollout – December 2020. My facial expression is one of defiance, as I was fully anticipating questions or criticism for my decision. Based on the response I'd witnessed surrounding mask mandates, I expected similar fallout for the vaccine. Photo by the author.

Framework Category Two: Hero Discourse

Hero discourse is another category of the conceptual/analytical framework. It is important to understand how this discourse has affected healthcare workers, and how the "hero" designation has impacted the paradigm of truth. Three predominant themes emerged, which include: "Not a Hero"; "Just doing my job"; and the impact of the "Heroes Work Here" messaging.

Theme One: Not a Hero

This concept was referenced by many study participants, none of whom overtly called themselves heroes. This is profound, as the hero discourse has enforced the "truth" that healthcare workers have an obligation to step into the role of hero, regardless of whether or not they have the desire to do so. I can relate, as I expressed the same myself more than once in my self-reflective writing exercises.

> "I just don't think it takes any type of special powers to do what we were doing. Obviously, special training, right. But I just think of hero as like a superhero or crime fighter or soldier. But I guess in essence, you know, we were risking our lives too. Yeah, I guess I just haven't sat down to really put a bunch of thought into that. I think that there's a lot of people that could do the exact same thing that I did every single day, if they had the training to." (L1_CT_01)

> "Okay, felt a little nice and stuff like that. But at the same time, I didn't really feel like I was deserving of it. I'm not a hero by any means. I'm just doing my job." (L1_MRI_02)

In the process of reflecting on my self-observation exercises (Activity 3), I wrote the following excerpt related to the theme of 'Not a Hero':

> "Healthcare workers have become heroes, but at what cost? We didn't ask for this, but if we don't continue to do our jobs, who will? Doing nothing is not an option. As difficult as it has been and will continue to be, this journey, my experience, the experiences of innumerable others, **needs** to be shared. Only then can healing, and change, truly begin."

Theme Two: Just doing my job

Similar to many healthcare workers not considering themselves heroes, several study participants stated that they were simply continuing to do their jobs, despite the ongoing pandemic.

> "I don't feel like I'm a hero doing what I'm doing. I feel like I'm doing my job and so it just seems like a little too much for me." (L1_MRI_02)

I expressed "just doing my job" slightly differently in my own writings, almost as a longing for caring and concern for healthcare workers. The following is an excerpt of one of the responses I provided to the semi-structured interview questions (Activity 4):

> "I feel like the community has kind of forgotten about the health care workers because they're tired of hearing about COVID. They're tired of hearing about numbers. They're tired of hearing about all of it. Right? And I think that what once was heroes work here is now oh, well, that's your job you signed up for it."

Theme Three: Heroes Work Here

The "Heroes Work Here" message, while seemingly well intentioned, might not have been as effective as anticipated for the healthcare workers it was meant to encourage. While each study participant was able to recall seeing this message outside of their respective healthcare facilities, when asked to describe how images of these signs made them feel, I was met with a

variety of responses. The imagery triggered a wide range of emotions, many of them negative. While some interviewees viewed the message as positive, many held thoughts similar to my own.

> "Um, it made me feel good. And it was nice to see that. But I still didn't feel like people thought it applied to us, if that makes sense." (L1_MRI_01)

> "I'm sorry, those stupid signs. 'Heroes Work Here' on health care workers. That was strictly just for the public. That was admin's way of making them look like they care for us. It was a way that oh, let's make this big statement to the public that we care about our health care workers, you know, 'health care workers work here' you know, but again, let's not give you proper PPE, let's put you in unhealthy work conditions." (L1_XR_01)

> "Because even though heroes work here, quote, unquote, they're not paid like heroes, and they will never be paid like heroes, or respected like heroes." (L2_MRI_04)

When reflecting on and providing answers to the semi-structured interview questions (Activity 4), I responded as follows on the theme of "Heroes Work Here":

> "Well, it's two-fold. Because if you remember where you were the first time you saw them, it was uplifting. It was encouraging. It was kind of like, keep going, we'll get through this, we have your back. Recognition for the job that you do was nice, because I feel like that was lacking. For almost the entire pandemic, there was not a lot of recognition or gratitude or appreciation. But seeing them now, in that same thread, it's kind of irritating, because you are drastically under

> appreciated. And you feel expendable. I mean, as long as there's somebody sitting in the chair to scan the patient. My impression is that they don't care if it's you or the next person they hire. And so I don't feel like a hero. I don't feel valued as a hero. I never aspired to be a hero. And it's frustrating to me that the sentiment from the community, the [person] who put those up outside the hospital was not mirrored inside the hospital from patients or management or the organization itself. I mean, we didn't get any kind of 'Thank you'. There was no incentive to continue to do it day after day. It was like do more with less."

Framework Category Three: Shifts in Knowledge

Shifts in knowledge represent the effect of COVID-19 on what was known by healthcare workers prior to the pandemic, and what they have come to know since. It is important to understand how significantly knowledge has been affected. Under this category, three predominant themes emerged, which include the evolution of feelings surrounding "COVID-19 patients"; "questioning a career in healthcare"; and the sentiment that "people just stopped caring about healthcare workers".

Theme One: COVID-19 Patients

The concept is related to the anticipation of treating a patient with confirmed or suspected COVID-19, and how those thoughts and feelings evolved as the pandemic progressed. Treating COVID-19 patients required modified protocols and additional preparation, at least initially. However, this seemed to quickly devolve into a "just another patient" mentality, as imaging departments were inundated with COVID-19 patients needing medical imaging. In the MRI department where I worked as a technologist, policy eventually dictated that exams be completed on patients, regardless of their COVID-19 status. After a certain point in the pandemic, it would

have been impossible to avoid scanning patients with COVID-19, some of whom were critically ill.

> "I think at first, when we figured out the severity of it, there was a little bit of increased anxiety. But then once everybody was just flooded with patients, it was every single patient, so it didn't matter." (L1_CT_01)

When I was reflecting on the responses I provided to the semi-structured interview questions (Activity 4), it occurred to me that while I never adopted the notion of "just another patient", my healthcare organization certainly did, as expressed in two separate excerpts, below.

> "Initially, it was just asked people if they'd been exposed, and then it moved to everybody has to wear a mask. We'd still have patients that didn't want to wear a mask. And then it was, if they're suspected COVID, we're not going to scan them. And then it was if they're suspected COVID, we'll wait til their test results come back, and then we'll decide if we're going to scan them. And then it was whether they're COVID or not, we don't care, we'll still scan them."

> "I mean, there was days where you felt like, oh, they have our backs, and there was days where it's like, I don't care if the patient has COVID, you're going to scan them anyway. And I don't care if you have kids at home, you're going to deal with COVID patients regardless, and I don't care if we're short staffed, you're still going to come to work and work a 12 hour shift and scan as many patients as are physically possible for you to scan. And mental health days are not a thing we're even going to talk about, and we're not going to do what we can to make things easier for you in any way. We're not going to make sure that you have support and equipment and all the things you need to do your job."

Theme Two: Questioning a Career in Healthcare

This theme was based on perceived levels of support, and influenced by animosity, distrust, and a loss of connectedness. Myself and several interviewees expressed animosity towards healthcare facility administration, management, and patients. Distrust was discussed as a feeling towards fellow healthcare workers and the healthcare system as a whole. “I continuously question my career decisions. If I chose the right path, if this is what I want to do, and my trust in health care wanes on a daily basis.” (L1_CT_01)

The loss of connectedness was felt and expressed by many of the study participants, myself included.

> “Now, everywhere you go, you don't get to see anybody's face, because you have to wear masks all the time, and you can't actually have a decent human interaction because nobody can see each other's face.” (L1_XR_01)

In the process of completing Activity 5, an interactive self-observation exercise exploring my thoughts and feelings following each semi-structured interview, I wrote the following reflection on the theme of questioning a career in healthcare:

> “I can vividly remember the scenarios described in this interview. Even though I am no longer working in a hospital setting, it is not difficult to recall how I felt and what I experienced when I was. I can hear the underlying pain in the voice and I can see the facial strain and changes in body language as we discuss some of these topics. My heart aches for my former colleague, my friend. I am reminded why the decision to leave was not made lightly. We all started out as a team, united in our desire to help people. COVID slowly stripped all that away. When you transition from being able to lean on your coworkers during a particularly

> grueling shift to having to learn how to navigate under the structure that is the pandemic, you lose a critical component of being a healthcare worker, one that is absolutely necessary for survival in this profession: a connection with people who not only understand but can relate to what you are going through. Without that, you are forced to navigate all of the thoughts, feelings, and emotions on your own."

Theme Three: People Just Stopped Caring About Healthcare Workers

When asked about perceived levels of support, both from healthcare organizations and from the community, responses varied. Some interviewees expressed feeling supported throughout the pandemic, while others felt that support was lacking. One explanation for this perceived lack of support discussed in several interviews is that the general public does not understand the responsibilities of healthcare workers. Lack of understanding seemed to correlate with a lack of care or concern, and statements such as "people just stopped caring about healthcare workers" emphasize this concept. This was a sentiment I shared.

> "They're very appreciative, they're very 'I'm just so grateful for you'. And then the next day you go work and people were horrible to you. [They] treat you like garbage… Once it stopped being so publicized, people stopped caring about health care workers and the sacrifices that we made." (L1_XR_01)

In the process of reflecting on the semi-structured interview questions (Activity 4), I wrote the following excerpt related to the theme of people losing care or concern for healthcare workers:

"It makes me sad that it's almost become an expectation that health care workers continue to do this job, even though they're putting themselves and their families at risk every time they step into the hospital. It makes me sad that the community that seemed like it was going to be rallying around all of us has kind of forgotten about us already. Yes, I too, am tired of reading it in the news. And I'm tired of hearing about it on the radio, and I'm tired of seeing it on Facebook and other social media. But it doesn't mean it's gone. People are still dying of COVID every single day and there are still healthcare workers going to work to make sure that that doesn't happen or doing what they can to try to slow it down or stop it if they can."

Image 7: COVID-19 cases and related deaths continue to rise, healthcare systems are overwhelmed, stress and anxiety worsens, and healthcare workers continue to risk illness and death, even as society refuses mask mandates and vaccinations. Photo by the author.

Framework Category Four: Shifts in Power

Shifts in power represent how power dynamics might have been influenced by COVID-19. It is important to understand the layers of individuals enacting power, and to what extent, changing power dynamics might have influenced knowledge and truth. Under this category of

the conceptual/analytical framework, three predominant themes emerged, which include "policies and procedures"; "staffing shortages"; and "compliance or adherence", or lack thereof.

Theme One: Policies and Procedures

This concept was discussed in every interview, with several study participants commenting on how frequently policies and procedures changed and the impact of those changes on their role in the hospital. This was a topic I discussed often in my autoethnographic writing exercises.

> "And then, um, even like our, you know, our directors of the medical places that we work in, they change their mind, every five seconds of what to do, what not to do, what's safe, what's not safe." (L1_XR_01)

> "Oh, it's constantly. It's been pretty steady recently. But, you know, the first part of the pandemic, it seemed like we always had a different, you know, directive or whatnot, like, day to day, week to week." (L2_MRI_03)

> "And it was, it was stressful, every time you had a COVID patient come down, it would take like, twice as long for the exam than it should have. And so the communication with all the different staff about the procedures, since it was constantly changing, that made it difficult, and then trying to remember all of the procedures, this is what we're doing now, this is how we handle this." (L1_MRI_01)

While reflecting on the semi-structured interview questions (Activity 4), I wrote the following excerpt related to the theme of ever-changing policies and procedures:

> “There was constant policy changes about what we do with COVID patients, how long we wait between scanning a COVID patient and scanning the next patient, how we handle bringing a COVID patient to the department. That changed almost it seemed like almost every shift, but for sure, every week when I would start because I worked Saturday, Sunday, Monday, by the time I would get there on Monday, what we had been doing the prior Monday has already changed.”

Theme Two: Staffing Shortages

This concept refers to staffing shortages as both a result of COVID-19 exposure and infection, and in situations where medical imaging professionals chose to step out of their roles in the hospital. Several times, this was discussed in conjunction with the topic of travels techs. It was implied that hiring travel techs was a management strategy designed to address staffing shortages, often evoking negative feelings among permanent staff.

> “And all of a sudden, we're understaffed, and we don't have enough people to like, cover the shifts, and we're moving people around, and we're messing up people's schedules, and no one's working their normal hours. And we're getting the schedule out a week at a time. Like it was just crazy.” (L1_MRI_01)

> “You're basically shamed for not picking up extra shifts and helping and you were the reason that we were short staffed because you wouldn't come in on your day off.” (L1_XR_01)

> “It's hard to want to back up the facilities when there was no incentive, but then they can hire traveling people and pay them three times the amount to be doing the same job I'm doing but I'm not worth that.” (L1_CT_01)

While I discussed changes to staffing structure, including shortages and technologists leaving the department or hospital, the topic of travel techs was not discussed in my personal reflective writing exercises. As part of the self-observation exercises completed for Activity 3, the recording personal thoughts and behaviors over a certain period of time and reflection on each, I wrote the following excerpt on the concept of "staffing shortages":

> "It is difficult to remember the specifics of the shift that prompted this piece of writing. However, it is relatively easy to recall why I was compelled to do so. By this time in the pandemic, I was the only tech working in the department on the weekends, as the staffing model had been adjusted in response to COVID-19. As a solo tech, I was responsible for balancing inpatient and outpatient exams, which required triaging appropriately based on urgency of the scan."

Theme Three: Compliance or Adherence

The inability to control the level of compliance or adherence to mandates and hospital policies, both on the part of patients and from other hospital staff, further illustrates the changing power dynamics resulting from COVID-19.

> "And oh, my God, one of our techs. Not even when the nurses are down here with the patient, not even that as soon as the patient got into the room, they would still take their mask off. Even though now you have six people in a 25 square foot space, they would still take their mask off as soon as they started working at their console. Constant every single fucking time. Even though the nurse right behind them, like five feet behind them, was venting about how 'my third patient died this week'." (L2_MRI_04)

In the process of completing Activity 1, a timeline outlining personal experiences, I wrote the following reflection on the theme of compliance or adherence:

> "Efforts on the part of hospital administrators to keep healthcare workers safe remained halfhearted at best. Those in positions of authority, entrusted with making decisions and implementing policies, were fumbling in light of the fact that new information was emerging almost daily. Procedures that were in place during one shift would change, seemingly overnight, and be different by the next shift. Healthcare workers were taking hits from every direction. It became impossible not to feel heartbroken and disheartened at the same time. It also became difficult not to feel frustrated with the healthcare organization and resentful towards those who were unwilling to comply with recommended safety protocols (i.e. patients, staff, and members of the community).
>
> It was difficult to explain my mental and emotional state to my family and friends, many of whom do not work in healthcare. Though my struggle was evident, I did not want to burden them with the details. It did not take long for compassion burnout to set in, particularly as mask mandates became politicized and several patients opted to be vocal about their views on the topic, occasionally to the point of disrupting care by refusing to comply with hospital policy. While the majority of patients understood this requirement and were willing to cooperate, several chose to argue the issue. This became particularly relevant in MRI, as many patients experience claustrophobia anyway, which was compounded when the expectation was that they would keep their mask on for the duration of the exam."

Descriptive Words

This category was both iterative and emergent, as the theme of descriptive words was discovered during the process of conventional content analysis. The language used to describe thoughts, feelings, and emotions quickly emerged as a theme, and was unique to the individual sharing their experience. My personal word choices differed from my peers, but there are similarities found in the meaning. Interestingly, or tragically, very few of these descriptive words has a positive connotation. Where one may have used the word *frustrated*, another would use the word *angry*. Some would say *expendable*, while others would use the words *disposable* or *replaceable*. Notably, the words *anxiety*, *frustrating*, *sad*, and *stress* were used most frequently. This data is presented in a frequency cloud below (Figure 6).

Figure 6: Descriptive Words Frequency Cloud

Chapter 5: Discussion

The purpose of this study was to gain understanding about how my own lived experiences working as an MRI Technologist, and ultimately leaving the profession, during the COVID-19 pandemic compared and contrasted with the experiences of other medical professionals. The primary goals were to 1) contribute to the knowledge base regarding the extent that mental health burdens have been exacerbated by COVID-19, and 2) broaden the understanding of the unique challenges faced by healthcare workers in southwest Idaho during crisis situations.

Using the conceptual/analytical framework as a guide helped me conduct semi-structured interviews that gave medical imaging professionals in southwest Idaho the opportunity to share their stories and helped me gain a more thorough understanding of COVID-19 in terms of "what" and "how" it was experienced by them. Also, use of the framework along with autoethnographic methods allowed me to comprehensively reflect upon and deconstruct pandemic-related factors that led me to where I am, both personally and professionally.

Our collective experiences are summarized here with an emphasis on: a) the most salient themes of the framework's outer constructs in relation to its core of "truth", b) the importance of descriptive words, c) interesting findings regarding demographics, and d) implications for healthcare workers in southwest Idaho.

Themes from Outer Constructs in Relation to Truth

The results of the themes related to the framework and the concept of truth have significant implications for how healthcare is implemented in the future. Truth, in this study, was conceptualized as the unique meaning given to a phenomenon by the individual who experienced it (van Manen, 2017). On a personal level, truth represents everything I endured as a healthcare

worker during the pandemic, every thought, feeling, and emotion. My experiences irreparably altered what I know to be true about working in healthcare.

COVID-19 (PPE, Exposure and the Vaccine)

Considering the paradigm of truth, the concept of PPE might be the moment when I, and several interviewees, began to lose confidence in management and in our respective healthcare facilities, both in their willingness and ability to keep staff safe as frontline healthcare workers during the pandemic. It is interesting that an item of PPE like a mask, once so readily available that it was taken for granted, could turn into an opposite truth replete with mounting stress for healthcare workers because of dwindling supplies. It turned into a flimsy excuse for a physical and metaphorical shield that armed healthcare workers *"with nothing but a paper mask and a plastic face shield."* The concept of PPE in the context of the COVID-19 pandemic had a profound impact on my personal paradigm of truth as a healthcare worker. For a period of time, there were no guarantees that I would have access to vital safety equipment necessary for me to do my job in a way that did not put me at increased risk, particularly as the number of COVID-19 cases began to climb rapidly in Idaho. As new information on the virus continued to emerge, so too did policy updates on PPE use. While I cannot fault my employer for the emergence of new COVID-19 information, I feel strongly that the method of delivery left plenty of room for improvement. Often sent as company-wide emails, these policy shifts began to feel callous and impersonal, particularly as PPE shortages were being reported in the same message, with firm reminders that staff were unable to supply their own protective equipment. My truth shifted, transitioning from a world of protection and confidence to a world of frailty, unpredictability, and anxiety. Several of the medical imaging professionals I spoke with seemed to feel the same.

Regarding exposure, this concept impacted the paradigm of truth in that for many of us, our jobs became a frequent source of exposure to a potentially deadly virus. Where priority was once placed on helping people, the reason many of us chose to enter healthcare in the first place, COVID-19 necessitated that priority shift to avoidance – avoidance of exposure, and eventually, as the pandemic progressed, avoidance of the thoughts and emotions that accompanied exposure, as *that* was *un*avoidable. Each interviewee worked with COVID+ patients, and exposure to COVID-19 during every shift was imminent. My truth shifted from navigating exposure to a number of different viruses periodically, to the knowledge that I would be exposed to a potentially deadly virus constantly. This knowledge led to the feeling of being vulnerably *exposed to exposure,* compounded with concerns about inadvertently exposing those I cared about the most. Many interviewees shared my concern about exposing family and friends after every shift in the hospital, altering their paradigm of truth as the pandemic raged on. No longer were we simply doing what could be done to provide care and promote healing, we had become a source of exposure ourselves, a vector for illness and possibly death.

Regarding the vaccine, for one interviewee with a unique perspective, it shifted their paradigm of truth in the sense that they came to understand that healthcare workers who opted not to get vaccinated might be subject to discrimination and adverse treatment from their peers. The situation described to me was one in which an unvaccinated healthcare worker was subject to different policies and procedures following a COVID-19 exposure, compared to those who had been vaccinated. Quarantine expectations differed, as did testing requirements and the expectations that had to be met in order for the healthcare worker to return to work. Suffering discrimination based on what some consider a personal choice would have a profound impact on the paradigm of truth for healthcare workers in that situation. For others, their truth shifted as a

result of the vaccine mandate, which equated to a loss of autonomy and control over their personal choices as they were faced with the decision to accept a vaccine or lose their jobs, particularly when these healthcare workers were not allowed to participate in this decision making process. Regarding the vaccine and the impact on my personal paradigm of truth, the vaccine provided an added layer of protection against COVID-19, which served to reduce some of the anxiety and stress I felt every time I entered the hospital.

Hero Discourse (Not a Hero, Just Doing my Job, and Heroes Work Here).

Being dubbed a "hero" had a profound impact on the paradigm of truth, particularly for those healthcare workers who had no desire to step into that role, despite the fact that the hero discourse, reinforced by healthcare organizations and the community, implies that they had an obligation to do so. 'Hero' was not a designation I aspired to, a sentiment shared by many interviewees. Many interviewees expressed that there was nothing heroic in the act of simply doing their jobs, implying that the job still needed to be done, despite the complications presented by the COVID-19 pandemic. For others, I got the sense that they wanted things to return to some semblance of 'normal', whatever that would look like when COVID became endemic, so that they could continue to do their jobs without the attention and pressure that came along with being a frontline healthcare worker navigating a pandemic. This resonated with me, as I am confident that I would have remained in healthcare for much longer, if not indefinitely, if COVID-19 had not happened. This concept has impacted the paradigm of truth such that healthcare workers had to relearn what exactly "just doing my job" meant. For me personally, my paradigm of truth was altered so drastically that I no longer work in healthcare, and "just doing my job" has come to mean something entirely different. My day-to-day existence no longer involves interacting with patients, rooting for their well-being and navigating the hectic

hospital environmental. Today, I wake up in the morning and pour myself a cup of coffee to enjoy while I get ready for the day, before beginning work from the comfort and safety of my home office for an organization that I am proud to be a part.

The “heroes work here” message impacted the paradigm of truth for many of us, in the sense that it created a divide between the healthcare worker and the healthcare organization. A sign out in front of one hospital, boldly proclaiming “heroes work here” did little to assist those navigating the chaos inside. I still wonder about the intention of the message, but I am confident that it did not have the purposed effect, both from my perspective and from the perspective of many of those I interviewed. Some found the message uplifting, almost like a boost in morale before heading into what would likely be a long, stressful shift in the hospital. Others held a more negative view. Many spoke of the message with little more than disdain, with one interviewee confiding that they had contemplated stomping on the signs on their way into and out of the hospital for every shift. Personally, this message shifted my truth from feeling appreciated to ultimately feeling resentful towards my healthcare facility and forgotten by the community we were working so diligently to treat, cure, and keep safe.

Shifts in Knowledge (COVID-19 Patients, Questioning a Career in Healthcare, and People Just Stopped Caring About Healthcare Workers)

Regarding COVID-19 patients, the paradigm of truth was impacted in that each of us had to adjust to a reality in which we would knowingly be treating patients with COVID-19. How that knowledge influenced truth was unique to each healthcare professional who participated in this study. Initially, treating patients with COVID-19 caused feelings of stress and anxiety among many study participants, largely due to the fact that little was known about the virus. As policies and procedures were adjusted in response to new and/or emerging information, so too

was the level of anxiety for treating COVID-19 patients, at least for some of us. For some interviewees, they came to know COVID-19 patients as "just another patient", as they seemingly settled in to a new normal. The remainder of study participants, myself included, were never able to completely dispel the anxiety and anticipation involved with knowingly treating a patient with COVID-19. As the pandemic progressed, so too did my feelings of anxiety about this concept. My truth shifted such that stress, which was initially intermittent following occasional COVID-19 exposures early in the pandemic, was replaced with constant stress that accompanied the expectation that all patients be scanned, regardless of their COVID-19 status, and knowing that a large percentage of them would likely be COVID+ as the pandemic progressed. I was on high alert, with no reprieve.

Considering the paradigm of truth, the COVID-19 pandemic has caused many medical professionals to question the future of their career in healthcare. For interviewees who professed that they still enjoyed the work they did and knowing that they had no intention of changing jobs, the paradigm of truth was altered only in so far as to affirm their desire to remain in healthcare, specifically in medical imaging. Interestingly, the healthcare workers I spoke with who possessed the knowledge that they were supported throughout the pandemic, both from their healthcare organization and from members of the community, were much more likely to acknowledge that they planned to remain in healthcare. The perceived knowledge of support, or lack thereof, had a profound impact on the paradigm of truth for the other medical imaging professionals I spoke with, many of whom were considering the possibility of a career outside of healthcare at the time of the interviews. I can attest to this, as my truth shifted from feeling supported to the knowledge that I was expendable, which contributed greatly to my decision to

ultimately step out of my role as an MRI Technologist, after months spent questioning my career in healthcare.

The notion that "*people just stopped caring about healthcare workers*" was a shift in knowledge that heavily impacted the paradigm of truth for many study participants. In response to the mandates being implemented at the federal level and attempting to be enforced locally, many of us felt that the community that had so recently professed support for us "healthcare heroes" began to turn on us as these mandates became politicized. Opinions on the topic of masking and the vaccine abounded, with many choosing to vocalize them. There is some overlap here with the "heroes work here' message. Knowledge shifted such that what began as a grand gesture of support for healthcare workers quickly devolved into something much worse. Patients were opinionated at best and argumentative or even hostile at worst in response to mandates that they either did not agree with or did not understand. Many interviewees, myself included, could recount a number of such situations. For many medical imaging professionals who felt that they were being "*treated like garbage*", when we were already challenged with showing up for the next shift no matter how grueling the last one was, the truth began to shift with the knowledge that ours had become a thankless job.

Shifts in Power (Policies and Procedures, Staffing Shortages, and Compliance or Adherence)

The paradigm of truth for myself and many healthcare workers was impacted as power shifted through frequent changes to policy and procedure. Commonalities between interviewee responses and my own thoughts and feelings include a clear delineation between pre-COVID and the ongoing pandemic, highlighting the reflexive relationship that exists between knowledge and power in the production of truth (Basumatary, 2020). Prior to the pandemic, policies and

procedures remained fairly constant, and each of us had a clear understanding of how these were expected to be implemented into our daily workflow. As the pandemic waged on, many of us had a difficult time adjusting to the frequently modified policies and procedures, which made it difficult to track changes from one shift to the next. I felt disempowered by this unpredictability, as did others. The impact of power on the paradigm of truth was compounded by a lack of consistency and clear communication from management, with the implementation of updated policies and procedures differing between departments, which added immensely to the chaos that was (is) COVID-19.

Regarding staffing shortages, the paradigm of truth shifted as management continued to exercise power through the expectation that healthcare workers "*do more with less"*, initially without the proper PPE and eventually without adequate staffing, stripping away the stability I once felt in my role. This shift in power had a lasting impact on what I and others knew to be true about the future of our chosen professions. The consensus seemed to be that the healthcare organizations prioritized profits over people, with the number of patients being imaged seemingly more important than the technologists doing the imaging. The expectation seemed to be that the same volume of patients be imaged or scanned, even as it became necessary for imaging departments to make adjustments for staffing shortages. My truth shifted from knowing that there would be adequate staffing for even distribution of the workload and to cushion some of the stress of the day to working solo. The knowledge that I would be working by myself as a result of staffing shortages led to feelings of increased stress, anxiety, and isolation. Eventually, I would be the only MRI technologist scheduled during a twelve hour weekend shift, and I was expected to match pre-COVID patient volumes, navigating both outpatient exams and inpatient imaging orders. The exhibition of this power over me instilled a new knowledge that left me

wondering who I could trust with my feelings, knowing that I would be unable to turn to my supervisors. Several interviewees felt the same.

The impact of power dynamics on the paradigm of truth was evident in the inability of healthcare workers to control the level of compliance or adherence to mandates and hospital policies, both on the part of patients and from other hospital staff. For some, this shift was caused by power being exercised through an unwillingness to comply on the part of their colleagues, which has led to feelings of distrust towards all other healthcare staff. For others, this shift occurred through the implementation of policies, procedures, and mandates, an exhibition of power without the willingness or ability on the part of the healthcare organization to enforce these changes, which ultimately led to feelings of distrust towards the healthcare system as a whole. Reflections on my own experiences highlight several examples of inconsistencies in compliance or adherence, even from one department to the next within the same healthcare facility. These inconsistencies further complicated what was often a challenging endeavor to complete a scan on a COVID-19 patient. Personally, my truth shifted as I began to be resentful of and carry animosity towards those that were unwilling to comply or chose to deny the severity of the virus altogether, with this display of power impacting my safety and sanity.

Descriptive Words

The language used by healthcare workers to describe their experiences during the COVID-19 pandemic is telling of the mental and emotional state each of us was in at the time. Although word choice differed, negative connotations remained fairly consistent. As I read through the interview transcripts and my own self-reflective writings, the weaving together of this collection of words produced an abstract canvas full of very real and raw emotion. Each of these stories is incredibly powerful, and whether the study participants realized it or not, the

words they used to tell their story allows a glimpse into their personal truth. Reflecting on this category, it is not difficult to recall, in vivid detail, the scenarios that were described to me, most of them negative. Considering COVID-19, being *positive* is also negative, something that many of us fought to avoid. Because of this, it is not surprising that so few positive words emerged to describe the personal experiences of healthcare workers during the pandemic.

Demographics

Idaho is predominantly rural, with several federal Health Professional Shortage Areas (HPSA) designations throughout much of the state, as indicated in Figure 7, below (IDHW, N.d.).

Figure 7: Adapted from HPSA in the State of Idaho (Accessed June 27, 2022 – IDHW, N.d.)

Regarding demographic data, this is significant. It was the older interviewees who stated that they would remain in the profession, while the younger interviewees expressed their desire to leave healthcare. For this study, this younger demographic is representative of more than half of the medical imaging professionals I spoke with. If young people are opting to leave, or deciding against pursuing a career in healthcare altogether, and older staff begin to age out, the health professional shortage will continue to worsen. COVID-19 had a negative impact on efforts to retain medical staff, further widening the gap in the number of medical professionals currently working and the number of additional medical professionals that are needed to address the provider shortage. As a result, the future of healthcare in the state of Idaho might be in trouble.

Conclusion

The results of this comparative autoethnography show that COVID-19, the hero discourse, and shifts in knowledge and power each had a profound impact on the paradigm of truth for many healthcare workers in southwest Idaho, myself included. Personally, my experiences irreparably altered what I know to be true about working in healthcare, ultimately leading to my decision to step out of my role as an MRI Technologist. My own experiences were largely similar to those of the medical imaging professionals I spoke with in semi-structured interviews.

The policies and practices that disempowered imaging technologists, which drove the uptake of new knowledge that was complicated by the controversial hero discourse relating to COVID-19, ultimately guided the decision-making processes of healthcare workers. When over half of those interviewed embraced a new truth that they could/would explore options of new careers, it is evident that we are in trouble! While personal truths before COVID-19 are unknown, clearly this pandemic has shaped the intentions of healthcare workers, and if they know they have intentions, they may be more likely to act. There are many theories that address the relationship between intention and action, including the Theory of Reasoned Action, the Theory of Planned Behavior, and the Integrated Behavior Model (Montano & Kasprzyk, 2015). There is opportunity to explore this connection and expand upon these ideas in future studies.

Throughout this process, I stayed attuned to the emotionality I experienced, allowing myself to respond and react the way I needed to in order to fully immerse myself in the data. Ultimately, data came from unexpected places. When I was searching for my own words, I would sometimes find relevance in a writing activity that I did not recall incorporating a

particular concept into. Bringing my own thoughts and feelings to the surface was not always an easy task, as it involved a new level of vulnerability, one that I was not always comfortable with.

Chang (2007) discusses zooming in and zooming out in the process of data analysis and interpretation, as a means to make sense of both the data and the lived experience, in the broader context of culture. When zooming in, emphasis is placed on details, the small fragments of a much larger set of data. Zooming out provides a "bird's-eye view" (p.129), allowing the autoethnographer to identify relationships, themes, and connections. "Until you give a meaningful structure to collected data, they may appear to be a 'messy' pile of fragmented bits" (Chang, 2007, p. 126). Making sense of the volume of data was an exercise in patience, dedication, and focus. However, it was through the process of self-reflection and exploration that I found clarity and closure.

Despite the mounting evidence that the mental health burdens that plague frontline healthcare workers have been exacerbated by the COVID-19 pandemic (Muller, et al., 2020), results of this study indicate that little is being done currently to alleviate those burdens. As a result of a shifting paradigm of truth, many medical imaging professionals have no intention of remaining in healthcare, and several are contemplating career changes in the near future. The COVID-19 pandemic may have irreversibly altered the landscape of healthcare, and will likely have far-reaching implications for our southwest Idaho hospitals.

As a means to address the mental health burdens of our frontline healthcare workers, which have been magnified by the COVID-19 pandemic, I make the following recommendations, based on both my personal experiences and the input of those I interview throughout the course of this study: 1) grant medical professionals the ability to both display and discuss their sincere thoughts, feelings, and emotions and validate them by taking these

seriously; 2) considering future disease epidemics, or as new diseases emerge and policies and procedures are adjusted in response, provide clear communication throughout the healthcare facility, ensuring thorough understanding and consistent implementation; 3) as new information emerges, communicate this information to medical staff, providing them with the education they need to continue to do their jobs without the stress that accompanies the unknown; and 4) to the extent possible, prepare for future outbreaks in such a way that healthcare workers feel that the effort is proactive instead of reactive, which serves to validate healthcare workers' importance to the organization and establish trust in the facilities' desire and ability to keep them safe.

The Crisis Standards of Care (CSC), which were activated in Idaho in September 2021, were not often mentioned. However, it should be explored whether or not CSC guidelines did anything to alleviate mental and emotional fatigue. There is also an opportunity to explore the COVID-19 pandemic from the perspective of management and administrators. Perhaps gaining understanding of their experiences, and resulting thoughts and feelings, might serve to bridge the expanding gap between healthcare workers and management, by establishing opportunities for effective communication and highlighting potential areas for improvement.

Limitations

As the researcher on this project, I was also a frontline healthcare worker who just recently stepped out of my role as an MRI Technologist in the clinical setting. It is acknowledged by some that lack of distance to subjects can induce bias, as researchers are also simultaneously the research subjects in autoethnography (Poerwandari, 2021). I have a personal connection to this subject, and remained hypervigilant to avoid any potential biases throughout the course of this research, analysis and interpretation.

Time was an acknowledged constraint of this research. Once human subjects approval was obtained, recruitment for participation in the semi-structured interviews began immediately. Recruitment proved more difficult than anticipated. However, nine (9) semi-structured interviews proved sufficient to reach saturation, as no new data was emerging (Creswell & Poth, 2018).

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Appendix A

DRAFT Semi-Structured Interview Questions

- How did you come to work in healthcare, here at XX hospital in XX capacity?

COVID-19

- How would you describe your professional role prior to the COVID-19 pandemic?
- What words would you use to describe your role now, in the midst of the ongoing pandemic?
- How prepared were you for COVID-19?
- What affect has the pandemic had on you mentally?
- What affect has the pandemic had on you emotionally?

Shifts in Power

- How were hospital policies and procedures adjusted in response to the pandemic?
- How did those adjustments affect your role within the hospital?
- What would you say about the level of preparedness of your healthcare organization?

Shifts in Knowledge

- How has the COVID-19 pandemic affected the way you think about being a healthcare worker?
- What affect has COVID-19 had on the way you feel about being a healthcare worker?

Hero Discourse

- How would you describe the level of support you received from your healthcare organization and members of the community?
- What words have people used to describe you as a healthcare worker?
- Do you remember seeing signs similar to these outside your hospital? (Image 4)
- How do these images make you feel?

- Based on your experiences, what could have been done differently?
- Do you have anything else that you would like to add that we have not covered?

Image 8: “Heroes work here” signs (O’Mara, 2020).

Appendix B

FINAL Semi-Structured Interview Questions

- How did you come to work in healthcare, specifically in medical imaging?

COVID-19

- How would you describe your professional role prior to the COVID-19 pandemic?
- What words would you use to describe your role now, in the midst of the ongoing pandemic?
- How prepared were you for COVID-19?
- What affect has the pandemic had on you mentally?
- What affect has the pandemic had on you emotionally?

Shifts in Power

- How were hospital policies and procedures adjusted in response to the pandemic? (Crisis Standards of Care?)
- How did those adjustments affect your role within the hospital?
- What would you say about the level of preparedness of your healthcare organization?

Shifts in Knowledge

- How has the COVID-19 pandemic affected the way you think about being a healthcare worker?
- What affect has COVID-19 had on the way you feel about being a healthcare worker?

Hero Discourse

- How would you describe the level of support you received from your healthcare organization and members of the community?
- What words have people used to describe you as a healthcare worker?
- Do you remember seeing signs similar to these outside your hospital? (Image 1, below)
- How do these images make you feel?

Closing

- Based on your experiences, what could have been done differently?
- Do you have anything else that you would like to add that we have not covered?
- Demographic Questions

- 

    - *Image 9*: “Heroes work here” signs (O’Mara, 2020).

Appendix C

Informed Consent

You volunteer to participate in an interview conducted by Megan Farrow, a graduate student researcher in the MPH program at Idaho State University.

You understand that the project is designed to better understand what effect the COVID-19 pandemic has had on the mental health burdens of frontline healthcare workers here in southwest Idaho.

1. Your participation in this project is voluntary.

2. You understand that sharing your opinions might be helpful for gaining understanding about mental health burdens and the unique challenges faced by healthcare workers in southwest Idaho during crisis situations. However, you understand that if you feel uncomfortable in any way during the interview, you have the right to decline to answer any question or to end the interview.

3. Participation involves being interviewed by an MPH graduate student from Idaho State University. The interview will last approximately 30-60 minutes. A Zoom recording of the interview and subsequent dialogue will be made. If you do not want to be recorded, you will not be able to participate in the study.

4. You understand that only the graduate student researcher and her faculty advisor will have access to the recorded interviews. These will be stored securely on a password protected laptop computer, in encrypted files, for a period of three years and will then be destroyed.

5. You understand that the graduate student researcher will not identify you by name in any reports using information obtained from this interview, and that your confidentiality as a participant in this study will remain secure.

6. You understand that this evaluation has been reviewed and approved by the Institutional Review Board (IRB) for Studies Involving Human Subjects at the University of Idaho.

7. You have read and understand the explanation provided to you. You have had all of your questions answered to your satisfaction, and \you voluntarily agree to participate in this study.

8. You understand that the topics being discussed might trigger strong emotional responses. A list of resources, including counseling services, has been compiled and will be provided to you, if necessary.

9. You have been given contact information for the graduate student researcher listed here.

Megan Farrow meganfarrow@isu.edu

VERBAL CONSENT GIVEN VIA ZOOM_____DATE:_____

Appendix D

Resources for Study Participants

2-1-1 Idaho Careline

- Call 211 or (800) 926-2588
- Text your zip code to 898-211
- Online resources are available at http://www.211.idaho.gov/ and https://211-idaho.communityos.org

The 2-1-1 Idaho Careline website provides an extensive list of community counseling resources, which can be accessed by clicking the following link. The search is conducted by zip code. Results can be explored by Agency, Program Location, or Service provided.

https://211-idaho.communityos.org/guided_search/render/ds/%7B%22service%5C%5Cservice_taxonomy%5C%5Cmodule_servicepost%22%3A%7B%22value%22%3A%5B%7B%22taxonomy_id%22%3A413190%7D%5D%2C%22operator%22%3A%5B%22contains_array%22%5D%7D%2C%22agency%5C%5Cagency_system%5C%5Cname%22%3A%7B%22value%22%3A%22VLTEST%22%2C%22operator%22%3A%5B%22notequals%22%5D%7D%7D?localHistory=WNqLPlX_0QBhfM4Jnql0mQ

Treasure Valley Mental Health Resources Directory, Provided by the Idaho Press

https://www.idahopress.com/news/local/treasure-valley-mental-health-resource-directory/article_d4ed41ca-c4dc-51c8-93d3-b7cd930a39be.html