

# DISTRESSED WORK

## Chronic Imperatives and Distress in Covid-19 Critical Care

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At the height of the Covid pandemic, the distress critical care workers experienced was so chronic, intense, and pervasive that it constituted a new kind of problem. As shown in interviews and observant participation conducted in an intensive care unit, the perceived obligations of health care professionals and the structural contexts of work generated emotional, physical, and moral burdens that damaged critical care workers' understanding of their work and contributed to the health care sector's labor dilemmas.

**I**n the wake of Covid-19, health care in the United States is undergoing a widespread transformation linked to a crisis of work.<sup>1</sup> Health care workers are working at or beyond their capacity and are frequently described as exhausted, overworked, underpaid, and suffering from moral distress.<sup>2</sup> The concurrent intensification and isolation of health care work have led many workers to leave permanent jobs for higher-paying temporary assignments or to leave the health care workforce entirely.<sup>3</sup> In an October 2021 survey of critical care nurses, 92 percent believed that the pandemic will shorten their

Neelima Navuluri, Harris S. Solomon, Charles W. Hargett, and Peter S. Kussin, "Distressed Work: Chronic Imperatives and Distress in Covid-19 Critical Care," *Hastings Center Report* 53, no. 1 (2023): 33-45. DOI: 10.1002/hast.1458

careers, and 66 percent had considered leaving nursing.<sup>4</sup> One in three clinicians are considering leaving their current role by 2024, and 71 percent of U.S. clinicians believe that their roles in health care have changed for the worse.<sup>5</sup> The health care system is an overstretched and underresourced labor structure, and the people who constitute it feel increasingly detached from their roles as workers.

A good deal of scholarship on health care work has highlighted the problem of moral distress—the experience, that is, of knowing what should be done but not being able to do it. Strategies to address moral distress were employed prior to and have been used during the Covid-19 pandemic.<sup>6</sup> Yet commonly recommended techniques, such as debriefing about difficult cases, have largely focused on addressing

individual moral distress surrounding specific events, such as unexpected or traumatic deaths, or especially challenging patients. The ethnographic study we present here is rooted in the view that the pandemic-driven crisis in health care—which includes but stretches beyond individual moral crises—demands a better scope for understanding work. At stake in this crisis are some of the structural foundations of health care work: who is willing to work within its roles, with what kinds of moral commitments, and under which operational conditions and limits.

Our study emerges from multiple stages of the pandemic and examines the lives and labors of critical care workers in an intensive care unit (ICU) where three of us, Neelima Navuluri, Charles Hargett, and Peter Kussin, are physicians. We argue that the distress experienced during Covid-19 is markedly different in its chronicity, intensity, and collectivity from usual cases of distress. This difference compels a closer look at the multiple and complex meanings of work. Health care systems were not designed or equipped to respond to the constant and pervasive structural distress created by Covid-19. Since the early days of the pandemic, the structure of health care work itself has operated as a core site of distress. With “structure” and “structural,” we refer to the various social, political, economic, and experiential processes and power relations that shape health care work.

To address the current crisis in health care, it is necessary to look at how health care workers’ roles, occupations, and vocations experience strain and transformation. This involves identifying the changes in labor practices and then viewing them in relation to the institutional and public responses to the changes. We call this experience of strain and transformation “distressed work” to convey the inseparability of moral commitments to care work and the everyday conditions of that work in pandemic contexts. With its con-

nection to the term “moral distress,” “distressed work” binds together the meaning making linked to health care work with the structural instabilities of that work in practice. During the Covid-19 pandemic, not only were many health care workers routinely unable to care for their patients in the way they thought they should, but seismic changes in the structure of health care work dramatically altered their identification with their job roles. Attention to processes of work under distress reveals how the pandemic accelerated inequalities in health care, how it shifted the social contract between institutions and workers, and how workers themselves contend with the moral underpinning of the work they continue to do.

Distressed work is a necessarily imperfect analytic. We settle on this term partly to capture the varied uses of “work” as both a discrete and systemic term. The term “work” can point to a singular event, such as an ICU shift. “Distressed work,” then, may seem to describe something fleeting (such as a tough overnight shift that ends and resolves). It can alternatively signify something more permanent and systemic. While the term “work” may seem generic, for us, it points to differences in labor conditions, such as waged and salaried modes of compensation. It can also speak to workers’ identification with a professional role, such as when someone says, “I work as a respiratory therapist.” Work as an analytic can involve economic dynamics such as the effects on hospital profits and expenses when the needs for shift coverage by clinicians change in response to surging numbers of patients in a specific time and place. Work is also spatial, as it marks out the workplace. Perhaps most importantly, work is a social analytic. It can be carried home, can galvanize individual identities within a community, and can build communities among workers who share similar experiences.

Distressed work, then, is necessarily a process and is multiscalar because health care work itself is both

individual and relational. It is also dynamic. Structures of work during the pandemic changed dramatically over an extremely short time amidst highly volatile situations. Because of this dynamism, though, we believe that distressed work can also be a site for positive change when problems are identified. When scaled up for use in considering a cadre of workers or a hospital unit as a workplace, the analytic can reveal how chronic institutional instabilities affect both individuals and systems and how these instabilities might be remedied.

To illuminate the complexities of what the analytic captures, we turn to specific, firsthand accounts of health care workers who describe how fear, isolation, responsibilities to be a good citizen, and alienation from care work reconfigured their relationships with work, their personal life, and society. These accounts cover a range of experiences of distress from outlier situations to the banalities of work activities in terms that are both moral and structural. We assess what these firsthand reports tell us about why and how some people continue to work through an ongoing crisis and an institutionally forced separation between care and work. We also reflect on how, for some workers, these conditions are no longer tenable. What has emerged from the pandemic is a steep increase in the toll that health care work takes on workers without institutional recognition of that toll. This constitutes the crisis of distressed work.

To better understand the contours of this crisis, we mobilize insights from the anthropology of work and apply them to a health care setting. In recent research that considers the labor dimensions of the climate crisis, scholars have shown, for example, how there remains a dangerous and misguided faith in the durability of the human capacity to work.<sup>7</sup> This research describes how instabilities of work pose threats to personal and collective ethical positions. Such instabilities are also potential sites of solutions because they may hold

clues for surviving ongoing ecological disaster. We employ a similar focus on instabilities to a health care setting, which workers characterize as transformed for the long term and as distressing, in order to understand the precarity of the health care system more broadly.

The respondents in our study detailed distressed work in various contexts, all of which share the friction of moral imperatives to keep working in the face of persistent distress. To be sure, moral imperatives to carry out health care work and their distressing consequences are not new, and provider distress has occurred in other pandemic and disaster contexts.<sup>8</sup> However, a key difference we observed entails tensions between, on the one hand, the obligations people believe health care professions to have, individual ethics, moral positioning, and labor structures and, on the other hand, actual work practices.<sup>9</sup> While scholarship continues to emerge on moral distress during the pandemic, the precise nature of distress's daily drivers and accelerants remains underexplored.<sup>10</sup> A labor-focused analysis, such as the one based in distressed work that we employ here, can provide important details on the nature of these factors. While our analysis focuses on ICU labor in a U.S. hospital, the analysis may be extended to address overwork, undercompensation, quality of care, and social suffering in health and can address what has been described as the “next normal” of health care's future.<sup>11</sup>

The three of us who are clinicians (with experience as medical faculty members ranging from three years to three decades) approached ethnographic work as a matter of *observant participation*; we continued in our roles as physicians in the ICU while being ethnographers of the ICU.<sup>13</sup> This dual commitment allowed for observations in all locations of patient care in the ICU and the hospital. It also created opportunities to link respondents' narratives and vignettes to their own lived experiences

with patients and their families.<sup>14</sup> From observations of interactions between workers, evolving technologies, patients, and families, it was possible to glean important insights about labor practices in relation to spatiality and community. Navuluri, Hargett, and Kussin could observe how people grappled with the constantly changing conditions and how the use of space and interactions with other workers changed over time, often in unexpected and novel ways. As a medical anthropologist, Harris Solomon, who had previous experi-

paraphrase as “just doing my job” and “get in the room.” As they elaborated on the chronic distress of that work, common themes emerged that we call “isolation,” “loss of community,” “visitation,” and “end of life.”

### **Moral Imperatives: “Just Doing My Job” and “Get in the Room”**

Research on moral imperatives for health care work affirms that health care workers approach the complex everyday ethical, financial, and resource-care needs of patients

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ence in intensive care settings, did not conduct observant participation due to visitation restrictions; he provides an important counterbalancing perspective.

The majority of participants in the study were female, were White, and had worked in their job role for a mean of eight years. There was equal distribution of nurses and physicians and a proportional representation of respiratory therapists, pharmacists, and supply-chain and environmental-service workers. This sample enabled us to explore varied dimensions of labor within the hospital and identify variations between and within groups. In what follows, we combine analysis of participant observations and coded interviews to detail how distressed work emerged in particular contexts. (See table 1 and the “Research Methodology” box for more on the participants and the study's design.) Respondents expressed their sense of moral imperatives to work in similar terms that we

through individually and professionally honed moral positions.<sup>15</sup> Expressing perspectives that are consonant with these findings, our study participants communicated that they believed a fundamental driver of their choice to work in health care, and critical care specifically, to be a deeply held commitment to care for people during the most difficult times of their lives. Given this enduring commitment, which transcends even the worst situations, it is no surprise that ICU workers have repeatedly emphasized that caring for Covid-19 patients is their job and professional duty.<sup>16</sup> However, some workers that we interviewed described a key tension: while critical care was their calling, it was also their means of compensation and livelihood. They contextualized this commitment and its entailments in terms of spatial divisions within the ICU during times of uncertainty and unclear risk. At stake is the sustainability of moral

commitments to work in a system under profound transformation.

At the beginning of the study in July of 2020, national dialogues about health care work centered on the idea of health care heroes—individuals going to great lengths in the face of uncertain risk to help others.<sup>17</sup> However, many of the health care workers we spoke with shared a relatively consistent message about working during Covid: they were doing their job, fulfilling a duty they had signed up for long before SARS-CoV-2 even existed.

A resident trainee who worked in the ICU for several weeks in 2020 remarked, “It just felt like my job ... . It was my normal ... . There were going to be critical illnesses regardless of whether Covid was there ... . I felt like I was just doing the job.” This feeling was shared across job roles. A nursing assistant stated, “I make a difference because, first of all, I do my job ... . I don’t care if they ask me, Covid, non-Covid, whatever. I like to do my job ... . [T]hey can count on me ... . I’m gonna show up.” However, fulfilling this duty was not as simple and straightforward throughout the

pandemic or for every individual. We asked a physician pandemic-response leader what allowed him to keep doing the work. “Don’t we sort of sign up for this at some point?” he responded. “This is our job, isn’t it?” For this physician, health care work was a commitment, and they knew that, by its very nature, ICU work could be unpredictable, could be daunting, and may lead a physician past a certain threshold of tolerability. This struggle was noted by another physician who stated, “[W]e see this as our duty and responsibility, and we are pretty good about fulfilling our duty, and maybe that means we burn out too.”

These responses illustrate how ICU workers see their actions as a response to a moral imperative, something that compels them to go to their jobs. Some mentioned that this derives partly from the philosophical underpinnings of medicine and nursing, such as the Hippocratic Oath and Florence Nightingale Pledge. Respondents highlighted how moral imperatives are not universal, may become problematic over time, and may even become a burden. They also foregrounded the important distinction between heroism and professionalism, a difference that Joseph Fins notes “is necessary to maintain the basic functioning of health care systems when they are stressed by catastrophic events.”<sup>18</sup>

Yet, even as respondents articulated a professional commitment, they recognized that they did not necessarily sign up to be pandemic workers, work characterized by inequitable compensation. For example, one respondent described a tension in the hospital work structure during the early months of the pandemic: units deemed nonessential dramatically decreased their patient loads or shut down temporarily, while the labor of the ICU dramatically increased, yet compensation for both groups remained the same. “I wish,” the respondent explained, “that people would have realized the MICU [medical ICU] nurses are going through

## RESEARCH METHODOLOGY

The data we present here were collected between July 2020 and December 2021 at an academic, quaternary referral hospital in the Southeastern United States. The study was approved by the university’s institutional review board. We sought a purposive sample of fifty-seven individuals to participate in our study. Participants were recruited via emails sent out by their designated leadership inviting participation. Staff members were asked to contact us if they were interested in participating. Participants’ demographics are described in table 1.

Our fieldwork used two complementary ethnographic approaches: semi-structured interviews and participant observation. After obtaining informed consent, we conducted semistructured interviews (n = 69), averaging one hour, with health care workers; for these interviews, twelve participants were interviewed twice, at different phases of the Covid-19 pandemic. Interviews were conducted by at least two investigators, either virtually using videoconferencing or in person in private conference rooms adjacent to the ICU. The investigator who serves as a faculty member with direct involvement in trainee evaluation (Hargett) did not conduct interviews with resident trainees. Interview guides were adapted over time, with early interviews probing experiences at the start of the pandemic; the potentially changing forms of social communication with peers, patients, and families; and the ways in which individuals adapted both at work and at home. Later interviews also asked about these matters and also probed similarities and differences in work across various waves of the pandemic, the impacts of vaccine uptake, and the challenges of workforce shortages. Interviews were audio- and video-recorded. Audio files were transcribed, and deidentified transcripts were uploaded to and analyzed using Dedoose.

We employed thematic analysis.<sup>12</sup> Interview questions and coding were conducted using a prespecified interview guide and coding tree. Modifications were made based on ongoing study findings. Weekly coding team meetings entailed writing coding memos for each interview, discussing those memos, and establishing coding concurrence. This work enabled a broader and consistent perspective on coded vignettes, quotations, and key terms. These meetings also enabled us to draw connections between interviews, identify strengths and weaknesses in sample representation, and adjust accordingly.

**Table 1.**  
**Demographic Characteristics of Interview Participants**

<i>Characteristic</i>	<i>Total participants (N = 57)</i>
<b>Sex</b>	
Male	24 (42.1%)
Female	33 (57.9%)
<b>Self-identified race or ethnicity<sup>1</sup></b>	
White or Caucasian	44 (78.6%)
Black or African American	6 (10.7%)
Latinx or Hispanic	4 (7.1%)
Asian	4 (7.1%)
Middle Eastern or North African	2 (3.6%)
American Indian or Alaskan Native	0 (0%)
Preferred not to say	1 (1.8%)
<b>Age range</b>	
18-30	19 (34.5%)
31-40	11 (20%)
41-50	12 (21.8%)
51 or over	13 (23.6%)
<b>Job role</b>	
Registered nurses or nurse assistants	22 (38.6%)
Physicians	23 (40.4%)
Attendings	12 (21.1%)
Fellows	5 (8.8%)
Residents	6 (10.5%)
Respiratory therapists	6 (10.5%)
Pharmacy, supply-chain, and environmental-service staff members	6 (10.5%)
	<i>Mean (standard deviation)</i>
<b>Years in job role</b>	10.88 (10.19)
<b>Years in role at this institution</b>	8.08 (9.13)

<sup>1</sup>Participants could select more than one.

really tough things and we're working overtime and we're picking up shifts and we're picking up these crazy patients while getting the same [pay]... No incentive pay, no hazard pay, and people are actually at home getting paid differential night shift, weekends. It's just like we're all sweating

and literally with marks on our face and people are kind of just chilling.”

The respondent described how, in spite of the signs of constant work that the public deemed to be heroic—such as the face marked from hours of wearing an N95 mask—the workers were not valued in terms of compensation. Uncertainty, fear, and

a sense of heightened personal risk strongly contributed to the workers' opinions that nurses should be fairly compensated for the risks they undertook every shift, as they constantly recommitted to staying the course at work. These feelings reflected a continuous and inescapable existential crisis, one that also came into play as workers navigated spatial divisions in the ICU.

Respondents frequently pointed to the space and spatial boundaries of the hospital room as they discussed this as a site of ongoing ethical work struggles, especially in the time before vaccine availability. Covid-positive patients were isolated in negative-pressure rooms with clear sliding doors that must remain closed to prevent escape of aerosolized virus. In the early months of the pandemic, the hallway outside the rooms was monitored by nursing assistants or redeployed nurses tasked to serve as “PPE observers.” Their job was to ensure that workers appropriately donned and doffed personal protective equipment, such as gowns, masks, and gloves, and followed frequently changing infection-prevention policies.

Covid-19 isolation policies created a clear boundary: one marked by the door separating workers who could perform their job duties only inside the room from those who could work outside it. In other words, Covid concretized a divided and spatialized structure in which certain workers had to enter a patient's room to do their job, while others could choose to stay outside of the room and find workarounds or, in some cases, have others perform tasks on their behalf. This division quickly settled into the “normal” rhythms of labor in the unit and made spatial differences a key feature of distressed work.

A nurse described taking care of a pregnant teenager who was being ruled out for Covid: “OB [obstetrics] did not want to go in the room and see her. They'd rather talk to her outside with the walkie-talkie.” The nurse also discussed a similar expe-

rience with a pregnant patient who was on extracorporeal membrane oxygenation. The patient was having significant nose bleeds, and otolaryngologists [ear-nose-and-throat specialists] were consulted. “ENT wouldn’t come and assess,” the nurse explained. “Finally, they came and assessed, but wouldn’t follow up and reassess. And in their note, they would always type, ‘didn’t assess because limiting Covid exposure.’ I feel like if we’re consulting a specialty team, it’s kind of their job to look and assess that patient ... . We [nurses] were the guinea pigs, and I remember feeling, ‘Why should I have to go in a room if the providers won’t go in a room? ... Why is it only my responsibility? It burns [the nursing staff] out.’”

These examples suggest how different groups conceived of their ethical responsibilities around care for patients and how these understandings connected to fear of Covid exposure. While ICU workers had to commit to confronting their fears head-on, others were able to direct orders from outside the room using walkie-talkies, create their own specialized protocols for PPE, or even cease providing direct patient care altogether. ICU workers had an unavoidable and constant exposure risk, while other workers faced more episodic and abbreviated exposure risks.

Even in situations in which the moral imperative to care for a patient was clear and shared among health care workers, the now-chronic spatial boundaries provoked complex care struggles. A resident described caring for an incarcerated male who contracted Covid in prison. The resident was in the room when the patient developed a life-threatening, abnormal heart rhythm. “The guy is going to die if we don’t shock him, but we didn’t have a defibrillator in the room ... ,” the resident recalled. “But you know how it is; you have to, like, close one door, open another door.” The resident described getting the defibrillator into the room and getting ready to shock the patient, but then realizing that the patient was

handcuffed to the bed with metallic handcuffs, which would have made shocking him unsafe. Prison guards stationed outside the room (who before the pandemic would have been in the room) had the keys and were reluctant to give them to a nurse entering the room to assist. This delay mattered, the resident explained. “We were just like, ‘We need the keys right now ... . [T]he guy is going to die if we don’t shock him. You need to give us the keys to the handcuffs,’ ... and this was a person who was intubated, paralyzed, like, was not going anywhere. ... We shocked him, went back to a normal rhythm, but then a day later ... he had an intracranial hemorrhage.” The patient ultimately died, and the resident reflected, “That was an experience that I’ll never forget. ... [T]hat’s going to stick with me.” For this resident, the spatially inflected distress of the work had lingering effects, a trauma they anticipated bearing throughout their career.

Scholars have detailed how hospitals operate as powerful social spaces, how the spatial divisions of health care labor can affect care, and how space can influence the ways in which workers’ roles shift in emergencies.<sup>19</sup> Adding to these insights, our data suggest that spatial divisions within the hospital created scenarios in which respondents questioned their labor. In this process of distressed work, such scenarios occurred over and over, constantly destabilizing the possibility of knowing the “right” thing to do and fostering a sense of pervasive distress.

### Chronic Distressed Work

Unlike during the initial wave of the pandemic, when expressions of a moral imperative to provide care prevailed in interviews, our respondents expressed feelings of alienation, exhaustion, and frustration with increasing frequency during the second wave in summer 2020, the Delta surge of summer 2021, and the Omicron resurgence of winter 2021. They connected these emotions to a particular

sense of loss of cohesion in their hospital units. Collectively, these feelings and the sense of loss were associated with significant emotional distress. To some of our respondents, the ICU as a space of collective and personal intimacy, history, and memory was unraveling.<sup>20</sup> A sense of isolation and loss of community cohesion, along with struggles with visitation policies and end-of-life procedures, rendered critical care labor into something different entirely. Distressed work alienated people from their jobs, and their jobs alienated them from themselves.

Respondents described various spheres of isolation—individual, domestic, professional, and public—as well as multiple sufferers of isolation—themselves and their families, patients, patient families, and colleagues. An ICU fellow explained personal isolation in very basic human terms: “Covid has been so isolating, even in the hospital. You can’t see people’s faces.” Spatial divisions due to isolation protocols heightened the lived experience of isolation. A nurse stated, “A lot that has broken down during Covid is the isolation and the feeling you get in a room alone with a patient and sometimes for hours on end.” Others described the embodied effects of isolation. A pharmacist reflected on how she saw colleagues’ experience caring for patients: “The isolation is making [everyone] crazy ... . They’re sweating, you got the mask on, you’re hot, you get in there, you get your business done, and you get out.”

ICU workers’ isolation persisted at home. In the first few months of the pandemic, some health care workers felt that they had to isolate to protect their loved ones. A nurse explained, “Initially, when Covid started, all of us took it home with us just because there was so much unknown. You know, protecting our family or loved ones. Just relatively isolating ourselves from everyone that we know except virtual communication just to make sure that we weren’t putting them in harm’s way.” Some of these measures were ritualistic, such as re-

moving shoes and clothes in garages and carports, heading directly into the shower upon entering the home, or delaying greeting and hugging their children until they felt decontaminated.

Other measures were more extraordinary. Some workers stayed in hotels, and others stayed in separate trailers in their driveways while working a series of shifts. A nurse with a sick family member at home described physically isolating from their loved one: “I have separated myself, and I live upstairs ... . I wear a mask inside my home anytime I’m downstairs.” Workers did not merely feel isolation. They actively practiced it, and they did so for substantial stretches of time, turning what seemed initially exceptional into new rhythms of ordinary life.

Prior to vaccine availability, several workers also described being ostracized at sites of everyday public life. A nurse told a story of going to the grocery store after work, still in their scrubs: “The [cashier] said, ‘Don’t put your groceries on my counter.’ The person before me had all of their things on the [grocery belt]. How do you respond to that? You kind of get beat up at work, and then you go home and go to the store, just to take care of your kids, and someone’s beating you up there.” This was particularly challenging for the nurse, whom it struck as a biting reality check in the face of the health care worker-heroism discourse circulating at the time.<sup>21</sup>

Through work, the presumed collective community of the ICU was threatened in unexpected ways as isolation intensified. While the early months of Covid brought wartime metaphors and a “we’re all in this together” theme, over time, there was significant erosion of the unit’s social cohesion. An ICU nurse described, “We had a breakroom ... . [N]ow, as Covid has come up, one of the big differences is you can’t sit next to anybody and eat because you can’t be without your mask, so everybody

is spread out all over the place. So, any of that resilience building that occurred on the unit, in the break-room, forming relationships, forming teams, or getting to know people outside of just work, is gone.”

Staff turnover requiring the hiring of new nurses or travel nurses underpinned some respondents’ sense of community erosion. Feelings of trust, comfort, and camaraderie, which take time to develop, felt newly diminished, compounding feelings of isolation and loss of community. An ICU fellow related how they had developed connections to other unit staff members before the pandemic. In the fellow’s first year in the ICU, trust from nurses and respiratory therapists had to be earned across

nal relationship building resulted not only in strong interprofessional relationships but also friendships among workers.

However, the turnover during Covid strained the fellow’s feeling of community and further exacerbated feelings of isolation. The fellow noted,

A lot of the nurses who are the backbone of the unit have quit and taken travel jobs or something, and it’s just really eaten away at the character of the unit and the level of camaraderie ... . Some of the nurses that made nights more enjoyable and that you could really rely upon have moved on ... . [T]hat’s hitting everybody

## Covid concretized a divided structure in which certain workers had to enter a patient’s room to do their job, while others could choose to stay outside of the room.

differences of authority and experience, particularly at night, when the fellow was considered the most senior authority on the unit. Comfort and cohesion built over time.

Prior to the pandemic, the fellow explained, “[F]ellow-nurse cohesion was at an all-time high because we had just spent twelve months getting to know each other ... . I was able to say to the nurses, ‘I haven’t done this before, but I don’t have another choice,’ and they were like, ‘We know.’” The fellow felt “you have that level [of comfort] ... without fear that people are going to lose faith in me.” The fellow depended on the respiratory therapists’ input and recognized that many of the respiratory therapists have “been doing this for longer than I’ve been alive.” This longitudi-

pretty hard ... . [Trust] is very, very hard to develop in isolation and physical isolation and very hard to develop quickly with new people ... . You gotta have that resuscitation moment overnight where you and the charge nurse and three other nurses are in a room for four straight hours, nobody’s peed, you all got a kidney injury because you can’t leave the room ’cause the patient is so unstable, and that builds trust and camaraderie, community ... . [N]ow it’s just becoming an ever-rotating door of new people. It’s isolating, you know; there’s the physical isolation, and I don’t know what the right word is—“social isolation,” “emotional isolation”... . There’s numerous dynamics of isolation

... . We're isolated intellectually; then like our basic needs are taken away with toilet paper and then our friends."

Together, isolation and loss of community caused distress for ICU workers at the interface between self-care and doing their jobs. For example, another ICU fellow noted how feelings of isolation extended into their social life. They described being exhausted from navigating the demands to be a good and publicly visible physician-citizen and the moral imperative not to set a bad example when one is a physician-citizen:

[W]e [health care workers'] are constantly on the frontlines, which means we are by proxy advocates of following the rules. ... I constantly have to protect those rules with family members, with things outside of the hospital. I have to be an example. ... So, that means that I can't go out, [whether ...] I want to or not ... because I have to stand for what I believe, and what I believe is protection.... [F]or example, I haven't seen my mom for over a year. ... I saw her in January [2020], and then I didn't see her again because I couldn't. ... I waited until I was vaccinated. ... I am exhausted about protecting and defending our [health care workers'] behavior, and that means not only being perfect because all the people don't want to follow Covid precautions. I go somewhere, and we're [my spouse and I are] like, 'You know what, let's just not go because we're gonna have to fight with this person and this person about them not following the rules.' So, we might as well not go, which is a very different feeling, honestly, than it was even the first four months. It wasn't even the isolation. It was an exhaustion about work. My exhaustion now is we have to seal off almost. ... [I]t has a feel of having to also be at work when I'm not at work.

The above examples illustrate how work-derived isolation did not appear overnight and was not limited just to the workplace or peoples' roles as health care workers. Rather, it emerged slowly, encompassed their multiple other roles—such as being a son or daughter, in the case above—and became reinforced as workers felt distress across various spheres of their life.

Our respondents also described how the very role of health care worker was itself becoming isolating. They had to "seal off" from certain commitments for safety and to uphold pandemic precautions as part of their professional identity, but simultaneously, this chronic cordoning off was distressing. This was felt especially strongly during the summer before the Delta wave in the United States. Health care workers observed their relatives and friends moving on from the pandemic, taking vacations, taking off masks, and starting to socialize in prepandemic ways, no longer upholding a chronic sense of threat. Yet health care workers still felt a sense of responsibility to be cautious and to set an example by performing that caution when not at work. It was alienating to experience the dissonance between wanting to lead by example through a commitment to public health and watching others abandon those cautions.

A sense of a convergence between work and not-work—"a feeling of having to also be at work when I'm not at work," as the ICU fellow put it—became a profound source of chronic distress for many respondents. There were individualized elements of distress here—having to protect family from the potential danger one posed as a vector of disease or fulfilling a professional obligation to science and society that required one to be a model health care worker who obeyed prescribed public health measures. Beyond this were collective and structural elements that show an unmooring that occurred at both work and home, especially for those work-

ers who had felt as though the ICU was a second home.

Many workers felt that the hospital failed to recognize the specificity, chronicity, and pervasiveness of their distress. It was hard enough to cope with family and friends who did not understand the suffering experienced as an ICU worker, but even more distressing was when hospital policies amplified and then misrecognized this distress. Banal tokens of appreciation such as packaged vending machine-style lunches or inspirational messages from hospital leadership struck many workers as a profound misrecognition of their distress. Workers vocalized their distressed work, but they felt that the institution either would not listen or talked past their concerns.

### Visitation and End of Life

Changes to visitation policies at the end of life further exemplified this misrecognition of work's chronic instabilities. End of life care is among the most important and commonly shared experiences of ICU workers. In a unit where up to one-fifth of patients admitted ultimately die there, providing compassionate care to patients and their families at the end of life is more than a task workers share; it is a shared experience for them.<sup>22</sup> As Covid erupted across the United States and isolation protocols were put into place, visitation policies dramatically changed. Before the pandemic, there was generally no limitation on the number of visitors a patient could have at a given time or the amount of time they could spend with the patient. The staff was accustomed to having family members sleeping in the room and to extended visits from close family and friends. Patients, their families, and ICU workers often established a strong bond, especially with "long termers" (patients who spend multiple weeks or months in the ICU).

Families also became key parts of care provision, helping with bathing, turning, and lip-reading inter-



pretation. They taped pictures to the walls, joined rounds when clinicians arrived at their family member's hospital room, and offered insights into the patient's prior medical history or hospital course. Granted, the involvement of families was not a universal or always-rosy experience; there were often points of strain and tension. Yet the broad consensus among ICU workers was that families and friends should be a part of the care team and could see the ICU as a temporary home.

At the beginning of the pandemic, the hospital eliminated family visitation to curb exposure risks. ICU workers recognized the public health need to limit exposures, but as months passed, the risk of exposure was weighed against the notable strain that the absence of family created. After complete lockdown ended, non-Covid patients were allowed to have one visitor during the day. The only exceptions to this policy were for goals-of-care conversations and for the actual end of life. Two family members (later increased to four) were permitted to discuss goals of care with the medical staff in person or to be present at the end of life (though, for Covid patients, only one family member was permitted in the room). They could see their loved ones only from outside the room, through the glass divider. Visitation policies were relaxed in stages, with more visitors allowed after vaccine availability increased. Ultimately, one family member was allowed to don PPE and enter the room of a Covid patient.

Our respondents pointed to end-of-life situations and family visitation around the end of life to articulate the impossible balance between care imperatives, public health concerns, and the safety of hospital staff and to describe the distress that emerged in turn. They explained how in the face of imminent death, when it is crucial for the field of medicine to provide care and compassion, health care workers found themselves unable to. "The visitation policy was draconian

and bordered on immoral," one ICU attending asserted. "For all of human history, patients have died with their families, and we decided that this moment in history is different, that people need not die with their families, which is appalling to me."

At first, disallowing visitors was not thought to be universally negative. An ICU nurse noted, "Initially, we weren't having visitors coming to the ICU, or in the hospital in general,

**"The visitation policy was draconian and bordered on immoral," one ICU attending asserted.**

which was kind of nice, because you didn't have to deal with [families]. We get a lot of different family members that are frustrated or needy. It can be difficult sometimes when you have family members interrupting your care." Yet, over time, it became increasingly clear that the restricted visitation policy made care difficult, even at the point when visitors were allowed in Covid rooms. The nurse continued,

We've realized how much we need them or the patients need them. It's been really sad to see ... [W]e're not allowing any visitors into the Covid rooms until the patient is imminently dying, which is terrible. I had one patient that really hit me because she was so sweet and then entered comfort care, and she was intubated, and her two sons finally were able to come. She couldn't talk to them at all. They just stood up and held a phone to her ear for hours for all the people to say goodbye. But at that point, I just wished that they were able to see her when she could still talk to them.

This distress was palpable for health care workers who had their own experiences of loved ones dying.

Another ICU attending expressed how there were things about working during Covid that kept them up at night:

One, that [patients] are dying alone and we can't have family with them and, two, that they're dying and we can't do anything for them. Having been through that recently with my family member, I know how important it is for families to

be at the bedside. I have to disconnect myself, because I just can't even imagine, and then I have to make these decisions when someone calls and says, "Hey, we have family members here, should we let them in?" And I have to be the person who says no. That's what keeps me up at night. That's what I lose sleep over. I wouldn't want to be kept away from my family, and yet here I am doing that [to others]. So, I have to really disengage from my emotions to be able to do this job sometimes.

These problems of disconnection and disengagement were shared by many patients' family members and compounded the distress that workers felt around goals-of-care conversations and end-of-life care and discussions. Visitor restrictions meant that families were often not witness to what workers saw as patient suffering. An ICU pharmacist explained,

How can [families] make a decision to withdraw support on someone [when] they don't realize how sick the person is? They don't see them every day. They don't see them struggling on the ventilator; they don't see them wasting away. They come in for one hot

second. ... You are up to your ears in it for six and eight weeks, and you just know this person's suffering, and so you're just [thinking], "Of course, the family's going to realize this person's suffering." But they don't see it every day. They don't see the sores. They don't see the pain. They don't see the agony. They don't see the isolation. All they see is the person they love they've been separated from for weeks. So, the isolation from the family, I think, is just horrible. I just don't think it's right.

Patterns of distress that came from physically disconnecting family and patients became a point of struggle, conflict, and disagreement with hospital administration. Since special exceptions could be made in extenuating circumstances, ICU workers found themselves often "fighting to get families in." A nurse described such an experience:

One of the worst things that I've seen is just the fight to get families in when their loved ones are passing. Last week, when I was there, we had this one woman, and she had four kids. We just wanted her four kids to come in while we withdrew care so they could say goodbye. It was an absolute fight to get that to happen, and then [administration] wanted us to pick just two of her children to come in to see her. How do you tell two of her kids, 'You can come in and see your mom as she dies, but your other two siblings can't?' I know that this has not been an isolated incident ... . Nobody should die alone, and that has been happening. It's just really sad."

In a time when things felt out of control, physicians found meaning in engaging with families and getting them in the room, whether in person or virtually. An attending reported, "I get [families] on their iPad, or I get pastoral services, and they were very helpful. Or I get palliative care to get

me into a Zoom with the family. I don't care if they're in Mexico. I don't care if they're down the street. I just negotiate the system to say, 'This patient is dying, they've got four kids, and all four kids want to be there.' And I will do what it takes to make sure all four kids can be there. And eventually the system gives a little bit, so I try to control; I try to influence whatever sphere I can influence."

Another attending summed up the effect of the absence of family and of in-person end-of-life conversations between patients and their loved ones: "A part of why a lot of us go into critical care is that there is a lot of humanism in talking to people about the end of life," they explained. "When families are here, they share who their loved one is. They give us a glimpse of who they are as a person. So, then, that also helps in the healing process. We just don't get that [anymore], and I get a sense with a phone-call conversation that families just don't know what to ask or what to say ... . It's just this very sterile conversation, and I think not having the in-person visit and that human connection, it just feels very void. I think that's something that's been the hardest for me, over time." The attending called this a "depersonalization of what we do."

The fights, struggles, and detachment that resulted from visitation policies at the end of life distressed workers deeply. It cemented in many of them a feeling that the work they were doing no longer resembled the work that they had felt such a strong personal and professional commitment to do when they first embarked on their careers. The structures and patterns of work had shifted. They fell back on "just doing their job"—a continuous balancing act between fulfilling their public health responsibilities as workers and meeting the individual needs of their patients and their families. Workers had to fight with administration and disengage their own emotions. Doing their job and providing care had previously been inseparable, but the pandemic

forced them to separate the two in ways that were unsettling. New and disturbing patterns of labor resulted from this separation, became normalized and constant, and alienated them. The effect was the evacuation of the heart of medicine. Care work in the ICU, in the words of the physician above, had become a void.

### The Next Normal of Health Care

Our data collection concluded around the time that case numbers and hospitalizations from the Alpha and Delta waves of the pandemic waned. It seemed from conversations with our colleagues in health care as if the world desperately wanted to move on to "the next normal" in which the pandemic lies in the rearview mirror. However, the health care workers' moral relations to work structures and practices continue to unravel and rethread. Labor shifts in the health care field predate the pandemic, were exacerbated by it, and continue today in terms of aftershocks and new fault lines.

The deep-seated roots of these processes remain profoundly concerning. At our own institution, twenty-seven nurses in our unit resigned in a five-week period during the height of the pandemic, and well over a third of our nursing and respiratory therapy staff members left our ICU during the period of our study. This may be specific to our unit, but it reflects the concrete realities of the processes we describe as distressed work. Nothing like the pandemic's disruption or physical and emotional burdens of care has ever occurred in the three decades of critical care that the most experienced intensivist among us has witnessed. For us, the pandemic was in every way a disaster of shifting patterns of health care labor, and this disaster remains lodged in how health care workers relate to work. The shift in patterns of health care labor is a process that, left unchecked, threatens to continue beyond any one pandemic. Distressed work, we believe, is

already built into the “next normal” of health care, and its labor instabilities must be addressed directly.

Our analysis highlights the key features of distressed work, the disrupted connections between care and work, and how these disrupted patterns contribute to the current health care workforce crisis. Experiences of isolation, detachment, and alienation pushed workers to a point at which they could no longer tolerate balancing these things with the moral imperative to do the work. These experiences caused instabilities in labor related to spatial rearrangements of care, the extension of work life outside the bounds of the hospital, the efforts to maintain a sense of community amid structural and institutional changes, and the shifting landscape of end-of-life care.

To address these instabilities, public and expert discourses often use terms such as “resilience,” “adaptation,” and “burnout” to describe the cumulative impact of distress on workers and purported strategies to change this impact. However, along with our respondents, we find these terms to be insufficient. They too often locate both the problem and the driver of the problem in the individual and not in structuring systems. While distress continued to be an individualized experience, it became more and more frequently a collective and systemic experience, rendering it no longer manageable or mitigated through individually focused interventions, such as a debriefing around a patient death, or forms of self-care, such as exercise or time with family and friends. Even less helpful for our respondents were the institutional and formulaic societal calls for resilience. These calls did not prevent the departure of a significant number of nurses and the resulting disequilibrium in the unit. Attention to resilience and burnout are certainly necessary, but their repeated invocation by health care institutions may not attend to the most urgent structural processes in play.

By contrast, our analysis of distressed work begins from the premise that work’s structure and strain cause unsustainable levels of distress on both workers and the system. Work is a process, and processes shift. Workers may no longer be driven in the same ways by the moral imperative to do health care work, not because they have been hardened beyond caring, but because their working conditions are no longer tolerable. The systems in place to support the distress that health care workers experience at work may no longer be supporting them. The workers’ ethical relations

## Distressed work is already built into the “next normal” of health care, and its labor instabilities must be addressed directly.

to their own professional roles are undergoing a profound shift. For some health care workers, that shift is reshaping connections to patients and families, to colleagues, and to fundamental career commitments. This is a systemic crisis whose solutions must begin with the matter of work. We emphasize that, because work can shift, it is also amenable to change for the better.

Our study has site- and participant-related limitations. Most of our interlocutors self-identified as White, and thus questions about the connections between distress and the racialization of the health care workforce could not be thoroughly assessed. Our focus on health care workers, and not patients and families, means that we approached and describe care labor selectively. The experience of distress as systemic was not necessarily universal among our interlocutors. Some—albeit a marked minority—expressed confidence in their ability to separate their work life from their home life, or disavowed any distress at all. While our study occurred at a

single site, our results are nonetheless potentially transferrable. A number of the initially strange experiences and stressful issues that became quotidian (such as rituals of cleansing at home, isolation in rooms, and the complexities of visitor restrictions) at our hospital were common in institutions across the United States and the world during different waves and degrees of pandemic severity.<sup>23</sup>

Some of the shifts in work practices we describe may be particular to ICUs where workers treat for the most severely ill Covid-19 patients while continuing to care for critically

ill non-Covid-19 patients. The constancy of the distress felt in our unit may also be explained by the addition of beds to our ICU during the pandemic. While workers in other units did not experience the extremes of distressed work we have described, it nonetheless may be germane. The difference may simply be in degree, rather than in kind. In this light, our account serves as a cautionary tale: there are limits to the changes that institutions can make to labor structures and to ways workers enact care as part of that work. Pushing workers past these limits may further damage already strained health care systems.<sup>24</sup>

Looking back, the transformation of the health care workforce should have been predicted. That it was not is partly because of the failure to predict the emergence of a disease on a pandemic scale. It is also due to erroneous assumptions made about the stability of relationships between health care workers and their work. Instead of handling that relationship as a dynamic process, leaders affirmed an evergreen institutional contract

that conflated heroism, service, and work, even when workers vocally problematized and distinguished these matters. Moral imperatives to care always matter to health care workers. But how they matter may be changing, and that change derives from strain on the deep structure of work more than any single cause or symptom of moral distress.

Looking forward, health care leaders cannot expect workers' relation to their work to stay constant. Health care work is work under transformation, and the changes wrought by the pandemic might serve as a blueprint for the future of the health care workforce and bioethics scholarship. In June 2020, Nancy Berlinger posed the critical question, "What will we remember, as scholars, practitioners, policy-makers, educators, and citizens, about this acute phase of the catastrophe in the United States?"<sup>25</sup> We suggest that many health care workers will remember the events of the past two and a half years as pivotal markers of the conditions under which they will want and be able to work and to provide care. As they consider and continue their careers, individual workers will test the balance between their imperatives to do the work, the fulfillment that results from that work, and the distress that work engenders. In other words, health care workers will be testing systems for distressed work and making calculations about their labor in turn.

We struggled to capture all the accounts of care work we heard and experienced with a single term; indeed, no one analytic can capture the distress in and beyond the hospital that workers faced. Nonetheless, the idea of distressed work underscores how a pandemic can systematically strain a health care system and re-script how health care labor gains its bioethical values. Our interlocutors shared strong imperatives to just do their jobs. They also provided ample evidence of the continuous physical, emotional, and moral tolls of their work. Many still wished to do their

jobs, but not under the working conditions they were facing.

If health care workers' distress is continuous and systemic but unequally distributed, then future research must address precisely where, when, and for whom it becomes accentuated. Researchers must begin from the premise that distress is a structural process and that work is often the backbone of that structure. Scholars must also consider how workers value their work based on the changing relationship between work and care. Finally, scholars, practitioners, and leaders must recognize that changes in individual care labor are inextricable from the ongoing transformations of health care institutions.

The pervasiveness of distressed work will require that the health care field, and the organizations, institutions, and leaders that are parts of it, examine distress structurally and relationally to rethink how care labor is valued and remunerated. A high-level understanding of the relevant factors, which include but extend beyond financial incentives, is imperative. Deeper attention to this awareness is especially necessary amidst calls for policy-makers to articulate what the "next normal" of Covid-19 might look like. Will distressed work be an integral component of the next normal of health care? If distressed work is normalized, what can be reasonably expected of health care workers? What kinds of institutional and social contracts are possible when these workers no longer view their jobs in the same ways? The complex and varied answers to these questions must come from workers themselves.

#### Acknowledgments

We would like to thank the individuals who participated in this study, dialing in from home and Zooming with us between shifts, to share their experiences and perspectives; Andrea Hill for her prompt and thorough transcriptions; and Jamie Mills for grant management and support. We also benefited greatly from research assis-

tance carried out by Rhea Jain, Preetha Ramachandran, Megan Zheng, and Christopher Webb. This study was supported by the National Science Foundation's Cultural Anthropology Program through award #2032735 for RAPID: Healthcare Workforce Resilience in the Time of Covid-19.

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