Adaptation Process of U.S Healthcare Workers During COVID-19: Policies, Practices, and Programs

by

Sandeela Coonjbeharry

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Advisor: Wei-Wen Chang, Ph.D.

National Taiwan Normal University

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ABSTRACT

Healthcare workers have remained a significant part of communities across the world for centuries and have continued to provide care for people in times of need. Once the Coronavirus took over the world and changed the daily lives of millions of individuals, it was healthcare workers who were at the forefront taking care of an overflow of ill patients while exposing themselves to the virus. This study focuses primarily on healthcare workers in the United States during the course of COVID-19 and the interviews were conducted in 2022. To conduct this research the Culture Shock U-Curve was adopted to analyze how participants adapted to the changes and challenges of the virus in their personal and professional wellbeing at the individual and family level. This includes healthcare workers' mental, physical, and socioeconomic wellbeing. The study investigates how policies, practices, and programs were used to support healthcare workers. The researcher used qualitative method, document review, and conducted interviews with healthcare workers to accumulate significant data. To support the credibility of this study the researcher used peer assessment, an in-depth literature review, and thick description. The researcher found that healthcare workers were likely to feel stressed, fearful, burnout, and overwhelmed during the beginning of the pandemic due to several changes they were experiencing rapidly. The researcher also found that there were many different policies, practices, and programs that the government and healthcare facilities implicated to curb the spread of COVID-19, and for the safety of healthcare workers. For instance, support programs were made available and additional steps were taken to keep healthcare workers safe, such as Personal Protective Equipment (PPE) and limiting the visitation of family members.

Keywords: Cultural Adaptation, Interpersonal Conflict, Healthcare Workers, COVID-19

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CHAPTER I INTRODUCTION

In this chapter, the background of the study will be introduced along with the statement of the problem, research purposes, research questions, the research scope, the significance of the study and the definitions of key terms. Overall, this section will explain why it is crucial to investigate more about healthcare workers in the United States throughout the course of COVID-19.

Background of the Study

On March 11, 2020, the virus, COVID-19, was proclaimed a pandemic by the World Health Organization (WHO, 2020a). Over the past year, the COVID-19 pandemic has triggered significant fear and concern around the world. Frontline professionals are faced with frequent news of high death rates and new infection, this takes a toll on their mental health, particularly in individuals operating on the frontline as they are subjected to be at a higher risk of transmission, morbidity, and death (Newman, et al., 2021). Healthcare workers were confronted with a virus that spreads rapidly and there was little to no information about this new virus as they encountered confusion and shock. Existing scientific data recommends that proper personal protective equipment usage, hand hygiene practices, execution of widespread mask policies in health care facilities and sufficient infection prevention and control (IPC) training and schooling relate to the reduced risk of COVID-19 within health workers (WHO, 2020a).

SARS-CoV-2 is the novel coronavirus that causes COVID-19, and it is known to spread between people. According to the Centers for Disease Control and Prevention (CDC, n.d.), COVID-19 spreads as soon as an infected individual breathes out droplets and these extremely small particles are made up of the virus. Then, the droplets and particles are inhaled in by another individual or it settles on their eyes, noses, or mouth. SARS-CoV-2 can be evident in "aerosols for up to three hours, on copper for up to four hours, on cardboard for up to 24 hours, and on plastic and stainless-steel surfaces for up to two to three days" (Fuentes, 2020, p. 444). COVID-19 symptoms include fever or chills, cough, fatigue, shortness of breath, body aches, loss of taste or smell, nausea, diarrhea, and headache; these symptoms may appear between 2 to14 days ranging from moderate symptoms to serious illness (WHO, 2020a). The virus can kill individuals by contaminating their lungs, causing an immune-system response that can intensify

an illness known as Acute Respiratory Distress Syndrome; this is when fluid escapes from the lungs, producing inflammation, and restrains the lungs' ability to transfer oxygen into the bloodstream (Fuentes, 2020). To prevent this, health professionals, need a combined system that involves occupational health and safety (OHS) measures and IPC (WHO, 2020a).

Statement of the Problem

Around the beginning of 2020 the United States confirmed their first case of COVID-19 in Seattle, Washington, gradually the number of cases began to rise. The nation underestimated the harm and devastation COVID-19 could bring to its people, particularly its healthcare workers. There was reporting of a SARS-like virus in China in December 2019 but he United States federal government did not response to reports until weeks later (Singer et al., 2021). The government both at national and state levels put healthcare workers in precarious situations due to the absence of their leadership. Healthcare professionals can be subjected to work-related threats putting them in danger of disease, injury, and death in an environment where COVID-19 is prominent (WHO, 2021b). When the situation appeared to have subsided there would be another spike in COVID-19 cases causing further difficulties for workers.

Due to the pandemic, millions of recently unemployed individuals were receiving pandemic unemployment assistance (PUA) in addition to their unemployment benefits. To qualify for unemployment insurance (UI) applicants' cause of unemployment had to be an act of the employer, like being laid off (Carey et al., 2021). Healthcare workers did not receive any type of compensation for their work during this crisis. The PUA system extended the eligibility of UI benefits to workers who were self-employed, independent contractors, and part-time workers (Carey et al., 2021). Frontline workers were apprehensive about limited and inadequate amount of personal protective equipment (PPE) since interest was focused more on supplies instead of safety (Newman et al., 2021). Nurses encountered more stress because their responsibilities include spending more time providing direct patient care and offering social and emotional aid to patients since their families are prohibited from visiting them during the pandemic (Croghan et al., 2021).

Hospitals and emergency rooms were overflowing with patients as cases increased again in the United States (Matzke, 2021). Countless healthcare workers had to work in an environment that exposed them to a deadly virus while trying to protect their family members at home and avoid spreading the virus to their loved ones similarly to what healthcare managers from the National Civic League Staff (2021) mentioned. Healthcare workers were met with new challenges they were not completely ready to tackle as it is unpredictable what may take place during a global pandemic. Several employees had coworkers who died or were at a high risk of contracting the virus, they sought to overcome this but felt that their lives were not of importance (Newman et al., 2021).

Significance of the Study

It is vital to report concerns at the organizational level, but it is also necessary to recognize individual concerns that have caused fear and adversity in healthcare workers for over a year. We need to learn about the journey healthcare workers had during this difficult and confusing time. There is a lack of research concerning all healthcare workers in the United States who were put into inexcusable situations at the beginning of the pandemic when the number of cases spiraled out of control, and they were not provided with sufficient equipment needed to work. If more research is done on this situation, it will provide substantial help for future healthcare professional who encounter a virus where there is little or no information available for it. Most cultural adaption studies are centered around individuals who go abroad and face a new and diverse cultural in a work or school setting. On the other hand, this study will emphasize the adaptation process and policies that come about when individuals confront cultural shift in the age of COVID-19. The U.S government, researchers and practitioners will gain a greater understanding of what may be done to prevent a shortage of equipment, how to avoid overcrowding at hospitals and how to provide better assistance to healthcare workers in the future.

Research Purpose

The objective of this research is to examine how healthcare professionals adapted to the emergence of the coronavirus disease from the end of 2019 to present. This study aims to give new insight into what the conditions and situations healthcare workers were faced with when the disease began to spread in the United States and their journey to present-day. This study will likewise focus on the interpersonal struggles healthcare professionals encountered throughout their time working with COVID-19 patients. Additionally, this study aims to gain knowledge of how polices, practices and programs were implemented to assist healthcare workers during the pandemic. Most cross-cultural adaptation studies focus on expatriates at an external level over an internal level (Jhong, 2019). Research should go beyond expatriate and as an alternative it should give attention to workers who go through culture shock in their own country in a familiar work environment. Therefore, more research should be conducted about healthcare workers internal conflicts and the journey they went through during COVID-19.

Research Questions

This study intends to uncover the adaptation process of healthcare professional and how they managed interpersonal struggles during the span of COVID- 19 in the United States and how policies, practices, and programs were formed to provide assistance for them. The following questions will be asked in this study:

Question 1: What challenges and interpersonal conflicts did healthcare workers encounter and how did it impact their wellbeing?

Question 2: How were policies, practices, or programs developed to help healthcare professionals in the U.S to provide support, structure, and stability during the pandemic?

Research Scope

For this study, the focus will be on healthcare workers/professionals who have encountered patients who were infected with the COVID-19 virus during the beginning of the pandemic. This research intends to interview practitioners who are actively working in the United States healthcare system and to perform an in-depth document review.

Definition of Key Terms

Cultural Adaptation

As individuals learn the suitable behaviors in a foreign setting, they frequently face situations regarding cultural differences that assess their skills to perform effectively in the new setting and their confidence with new cultural guidelines (Ward & Kennedy, 1999). The way individuals react to the new conditions and navigate their way through the cultural changes affects their individual efficiency (Black & Gregerson, 1999).

Interpersonal Conflict

Interpersonal conflict as a "phenomenon that occurs between interdependent parties as they experience negative emotional reactions to perceived disagreements and interference with the attainment of their goals" -- collectively, this includes "situational (interdependence), cognitive (disagreement), behavioral (interference), and affective (negative emotion) elements of conflict situations" (Barki & Hartwick, 2001, p. 198).

Healthcare Professional/Worker

A *healthcare worker/professional* refers to individuals who are currently working in the health care industry.

CHAPTER II LITERATURE REVIEW

This chapter is going to review literature relating to healthcare professionals/workers, COVID-19 in the United States, and in parts of Asia (China, South Korea, Taiwan). Likewise, this chapter will take a closer look at literature regarding the polices, practices and programs related to COVID-19 and healthcare workers. Lastly, the use of the Cross-Cultural U-Curve Theory will be explained in relation to COVID-19 and practitioners in the United States.

The Beginnings of COVID-19 in the U.S

The world has drastically changed over the past two years, and this is due to a virus called Coronavirus (COVID-19). The outbreak of COVID-19 throughout the world still took us by surprise and showed how truly unprepared we are considering how advanced we are as a world in science and technology (Kerim, 2020). Governments across the globe had delayed reactions causing misunderstandings and the United Nations and the World Health Organization (WHO) contributed to this (Kerim, 2020). There were varying reactions throughout the world, some countries were on high alert while many like the United States toned down the effectiveness of the virus because of this world leaders including former President Donald Trump himself contracted the coronavirus (Kerim, 2020). The U.S was shockingly slow and cultivating misunderstandings about the narrative of the virus, as states and local regions were using their public health authorities disproportionately (Mellish et al., 2020).

It is because the coronavirus started with people underestimating the virus's impact in the United States that researcher opted to use the U-curve of cross-cultural adjustment to analyze the impact of COVID-19 on healthcare workers in the United States. Many people would probably question 'why' use a theory that has a honeymoon stage, however, before the virus arrived in the United States many individuals including our president and government downplayed the seriousness of the virus causing more harm to the countries' people. The absence of inter-jurisdictional management cost many people their lives as government facilities did not enforce science-based social distancing and guided quarantine procedures when the virus started circulating. There was as extensive infringement of recommendations from the CDC to begin social distancing, regardless of many regions announcing stay-at-home orders and some states ordering non-essential businesses to close. Even with these recommendations there was an

insufficient amount of robust enforcement procedures both at a state and federal level (Mellish et al., 2020).

Due to the COVID-19 pandemic over 40 million Americans lost their jobs and 3.3 million businesses had to close within a short period of time in the United States (Kerim, 2020). The country also had the highest rates in the world for morbidity and mortality during the pandemic, this gravely impacted America's status and its' global ranking (Kerim, 2020). The circumstances in the United States showed that the nation was not living up to its world-leader status which it achieved during World War II but instead the nation became unwilling to be a leader during the pandemic. Consequently, turmoil and discord triumphed nationally shattering the country's reputation (Kerim, 2020). The Trump administrations pursued to "play the blame game" together with China over the coronavirus. An example of this is the following, in February 2020, Trump commended China's leaders for effectively controlling the pandemic but then in June the administration switched their statements and condemned China accusing them of circulating COVID-19 to different countries (Kerim, 2020). The way the Trump administration managed the coronavirus outbreak in the United States resulted in many people contracting the virus, losing their jobs, and countless deaths throughout the country. As of January 21, 2022, there has a been nearly 70 million individuals who contracted COVID-19 with roughly 858,909 individuals succumbing to the virus, therefore, approximately 1 in 6 individuals become infected with the virus (Table 1.1). Within the past week there has been over 5 million cases across the United States with the hospitalization 7-day average being 144,636 patients (CDC, 2022).

Table 2.1

United States COVID-19 Cases, Hospitalization & Deaths as of January 21, 2022 (CDC, 2022)

Total Cases	Cases in the Past 7 Days	Total Deaths	Hospitalization Of Patients with Covid-19 (7-Day Average Jan 13, 2022 – Jan 19,2022)
69,437,067	5,088,100	858,909	144,636

Healthcare Employees in the U.S: Their Responsibilities and Challenges

According to WHO, lower risk jobs are those without frequent or close contact with the public and they do not require contact with people who have or are suspected to have COVID-19. For instance, individuals who work in telehealth services, remote interviewing, and those working in private or low-density offices. Medium risk jobs consist of workers who have "frequent contact with patients, visitors, suppliers and co-workers" however, they are not in contact with people who have or are suspected to have COVID-19 (WHO, 2021b, p. 3). High risk jobs have an elevated possibility for close contact with people who have or are suspected to have COVID-19, or they come in contact with objects and surfaces that may be contaminated. When working in healthcare there are different roles and responsibilities for each person, and they are all exposed to COVID-19 to a certain degree. The amount of exposure to the disease depends on the individual's position in the field. Very high-risk jobs are when healthcare workers are exposed to aerosols comprising of SARS-CoV-2 or working indoors with people who are infected and in congested locations without sufficient air circulation (WHO, 2021b).

Nurses were the majority of healthcare employees, and they have a significant role in healthcare organizations. Their roles when treating COVID-19 patients includes conducting a preliminary assessment of patients, recognizing possible infections, bestowing vital treatment in an emergency, and treating suspected patients with necessary safety measures. Nurses correspondingly had to help sanitize and organize accordingly with other healthcare workers, provide universal nursing procedures when dealing with multiple infections at once, being a crucial role in increasing care services and overseeing patients' relatives (Al Thobaity, 2020).

In the United States, healthcare workers were not given the same support as in many other countries therefore, they protested to acquire safer working conditions and for the government to have a stricter response to the epidemic. Healthcare workers have protested in 38 states and the District of Columbia, these protests began as COVID-19 started spreading at the beginning of 2020. Before the national emergency declaration, healthcare workers were the main group of people leading coronavirus-related protests. Healthcare workers are directly affected by the coronavirus and the virus creates an increased risk for frontline workers, like healthcare experts (Kishi, 2021). During the pandemic, healthcare professionals worked extended hours with inadequate quantities of personal protective equipment (PPE) and their demands for

healthier working environments, better pandemic protection, and tougher government response to the crisis nationwide caused demonstrations throughout the pandemic (Kishi, 2021).

Healthcare workers in the United States are consistently subject to high risks of infection and the risks have elevated as the number of patients looking for care overflowed all over the country. Corresponding to the Centers for Disease Control and Prevention (CDC), roughly 9,300 healthcare workers were infected with COVID-19 and 27 died early on in the pandemic from February 12 to April 9 (Kishi, 2021). Healthcare workers are experiencing high-stress levels not simply from "exhaustion and loss of life, but from having to make painful, ethical decisions on patient care in an environment of constant shortages" (Miyamoto, 2021, p. 1). The rapid growth in hospitalizations increased the need for PPE, "including hazmat-style suits, goggles, gloves, face shields, and N95 particle-filtering masks" (Kishi, 2021, p. 8) but with the government's constant failure to keep up with rising demands, health workers continued to hold demonstrations demanding for mass production of PPE and proper government measures to control the spread of the virus. Table 2.2 shows the challenges healthcare workers (essential workers) and non-essential workers faced during the beginning of the pandemic in 2020.

Table 2.2

Healthcare Workers vs. Non-essential Workers Challenges

Healthcare workers	Non-essential workers
• High risk of infection • High stress levels • Lack of hazard pay • Insufficient safety measures • Extensive hours	• Temporarily furloughed • Forced to work reduced hours • Loss of employment

Policies, Practices and Programs

According to WHO (2020b) to prevent COVID-19 infections among healthcare workers a unified method that incorporates occupational health and safety (OHS) procedures and infection prevention and control (IPC). To do this healthcare facilities needs to create or reinforce and execute IPC programs and Occupational Health and Safety programs to guarantee the safety of healthcare workers in work settings. Correspondingly assuring sufficient clinical staffing levels is suggested by WHO (2020b) to avoid the transmission of healthcare related contaminations. The initial discovery of COVID-19 related infection amongst health workers may be attained by "syndromic surveillance and/or laboratory testing" (Table 2.3) (WHO, 2020b, p. 1). WHO (2020b) states this is a crucial policy to avert secondary transmission from healthcare workers to patients, healthcare workers in healthcare sites and subsequently healthcare workers who come in contact with people infected elsewhere.

The WHO (2020b) recommended that health facilities have a system in place to keep track of contacts centered around risk assessment to support and assist healthcare workers. They also proposed a system to manage alleged infections which includes actions for healthcare workers who test positive for COVID-19 and individuals who are symptomatic but test negative. A clear-cut criteria for workers to go back to work must be produced corresponding to the WHO standards for suspending isolation due to COVID-19.

Table 2.3

Examples of Syndromic Observation Methods Adapted from WHO (2020b)

Situation of COVID-19 Spreading	Type of syndromic observed for health workers	Possible Methods
No cases or Infrequent cases	Execute passive syndromic observation	• Employees should self-report to professional health or other authorized officer if they have any symptoms such as a fever.
Clusters of cases	Execute passive syndromic observation, cogitate active inspections if resources are accessible	• Employees should self-report to professional health or other authorized officer if they have any symptoms such as a fever. • If resources are accessible, cogitate a procedure to continuously monitor employees for symptoms such as fever.
Community transmission	Execute continuous syndromic observation	• A procedure should be put into place where employees' temperatures are monitored, and they are screened actively for symptoms at the start of every shift.

Methods Executed in Other Countries

This section will describe the steps countries took in order to contain the spread of COVID-19 in China, South Korea and Taiwan. It will illustrate how each country came together to send help and aid to their citizens during a time of great need. These countries were chosen because they were fast acting and their policies, practices and program were beneficial to the nations people.

China

The Chinese National Center for Disease Control and Prevention (CDC) publicly declared that a novel form of coronavirus triggered pneumonia in Wuhan on 8 January 2020, and twelve days later Dr. Zhong Nanshan confirmed the virus is transmissible from person-to-person Cai et al.,2021). The Chinese government acted relatively quickly, on January 23, 2020, a lockdown policy was executed in Wuhan and surrounding Hebei Province cities. Cai et al. (2021, p. 114) declared that "social donation, service provision, information dissemination, and advocacy" are four reasons social resilience developed in China. There were large donations of both, monetary and medical supplies and there were 8.81 million registered volunteers by the end of May 2020 participating in 460,000 volunteer projects. The amount of people encumbered with psychological stress has increased as number of cases grew consequently counseling services were provided to medical workers, patients, and quarantined locals. Organizations collaborated to spread rightful information to residents and provide them with a place to find names, addresses, contact numbers, available materials, and services in the YunNiXing COVID-19 Support Platform. Additionally, special programs to boost public awareness and offer financial assistance medical workers, sanitation workers, and volunteers were set up by various foundations where frontline workers who were infected by the virus were entitled to file for financial support (Cai et al., 2021).

South Korea

While South Korea's way of tackling COVID-19 showed that the countries strength during the pandemic relied on "technocratic measures that deprived from the political necessity" for leadership and "demand by the public to end the pandemic, while simultaneously relying on the participation of the people and resisting public protests as a democracy" (Park, 2021, p.105).

The people in South Korea came together to fight against the virus with proper leadership and guidance, unlike the Trump administration that instigated division among the countries' people. In 2015, South Korea had previous experience with the Middle East respiratory syndrome (MERS), and they used their prior knowledge to deal with the coronavirus years later (Park, 2021, p. 105). The nation provided walk-in and drive-through testing, testing 15,000–20,000 individuals a day, and the test findings were sent within 24 hours to individuals' cellphones (Lewis & Mayer, 2020). South Korea's social policies financially support the "public, the vulnerable, small business owners and medical facilities" since various parts of the country were hit hard due to the pandemic (Park, 2021, p. 106). The government sent out stimulus packages to its citizens, these were supplied by the Ministry of Economy and Finance (MOEF) and it was given in the form of "prepaid cards, cash, or regional currency cards" (Park, 2021, p. 107). The first patient (Patient Zero) diagnosed with COVID-19 was in Incheon, South Korea, this is the same day (January 20, 2020) Patient Zero was also diagnosed in Seattle Washington in the United States. Unlike the United States, South Korea acted swiftly and formed a public health plan to counter COVID -19. The country's plan included testing, tracing, and treatment, the three Ts. Social distancing, disinfecting, and public mask requirements were also included as part of the public health plan (Park, 2021). When the first COVID-19 case was detected the South Korean government started to mass-produce test kits and when cases surged testing and quarantine practices based on progressive information and communication technologies (ICT), text alerts, smartphone apps, and contract tracing were initiated (Lewis & Mayer, 2020). Although the United States and South Korea encountered their very first case of COVID-19 on the same day, the actions they took, and the consequences of their actions varied.

Taiwan

Taiwan is another country, which had a quick-thinking response to COVID-19 because, as of February 15, 2021, Taiwan had only 937 cases with more than 90% of them being imported cases and nine deaths (Huang, 2021). According to Huang (2021), there are two explanations for Taiwan's impeccable COVID-19 response, first, the orientalist explanation recognizes the presence of social dilemma, and the other is the technocratic explanation which abstracts from the social dilemma and highlights a list of strategies needed for victory. The technocratic methods are comparable to what Park (2021) mentioned in his research about South Korea's

ways of dealing with COVID-19. Taiwan also had experience with diseases, in 2003 they came face to face with severe acute respiratory syndrome (SARS). Another reason Taiwan triumphed in its reaction to COVID-19 is due to an early acknowledgment of the threat possibly caused by political tension from China and the nation's ongoing detachment from a majority of international organizations (Huang, 2021). Three weeks before Taiwan's Patient Zero (January 21, 2020) was reported the Taiwanese government initiated several policies and measures on December 31, 2019. Taiwan's strategy includes three vital parts: "Border quarantine, target-based measures (such as testing and contact tracing), and population-based measures (such as physical distancing and wearing masks)" (Huang, 2021, p. 35). Border quarantine means that all travelers must quarantine for 14 days after their arrival, report their health status, and travel history (Huang, 2021). While contact tracing, social distancing, and wearing masks in public places were crucial to Taiwan's success, having control over the country's borders may have been more significant.

Cross Cultural U-Curve Theory

The U-Curve Theory was first identified by Sverre Lysgaard in 1955, with his study of Norwegian Fulbright scholars in the United States (Chien, 2016). Lsygaard found that students who had resided in the United States six to eighteen months described lower adjustment periods than those who were there less than six months or more than eighteen months, however; he did not provide a theoretical explanation of his conclusions (Black, 1991).

Lysgaard declared,

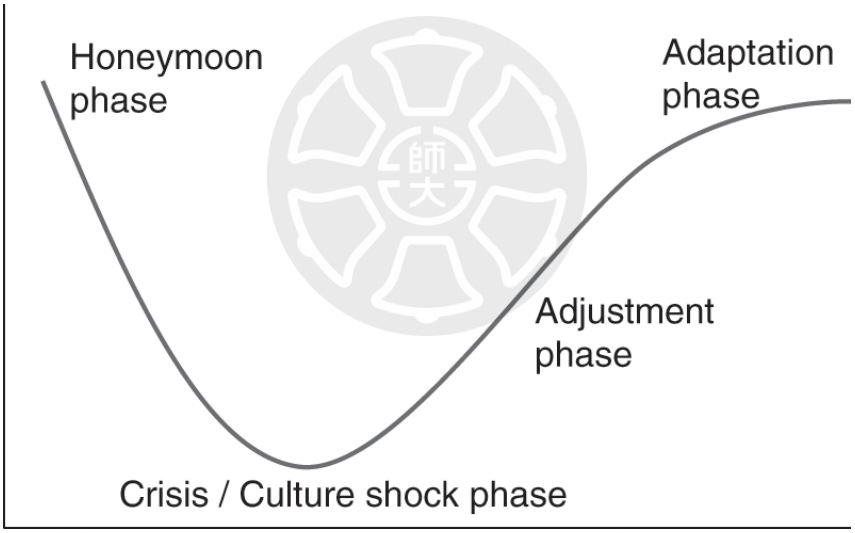
> Adjustment as a process over time seem[ed] to follow a U-shaped curve: adjustment [was] felt to be easy and successful to begin with; then follow[ed] a 'crisis' in which one [felt] less well-adjusted, somewhat lonely and unhappy; finally, one [began] to feel better adjusted again, becoming more integrated into the foreign community. (Lysgaard, 1955, p. 50)

Researchers determined that a U-curve pattern of adjustment did in fact exist, but they did not provide a statistical data to support their findings (Black, 1991). Initially the terms *honeymoon, crisis, recovery, and adjustment* were used to describe the four stages of the U-curve hypothesis by Kalervo Oberg in 1960 (Chien, 2016). Most researchers describe the U-Curve theory as

comprising of four stages, shown below, in Figure1.1. In the first stage, the honeymoon stage, individuals are intrigued by the new culture and are enthusiastic about all the fresh and exciting things. This initial stage of cultural fascination is then followed by a period of disenchantment and dissatisfaction this is the culture shock stage, in this stage one has to truly manage living in a new culture. The third stage the adjustment stage is described as ongoing adaptation to the new culture and understanding how to conduct oneself properly in accordance with the cultural norms of a different country. During the fourth stage, the mastery stage there are improvements in the individual's skills to perform successfully in the new culture they are living in (Black,1991).

Figure 1.1

Culture Shock U-Curve



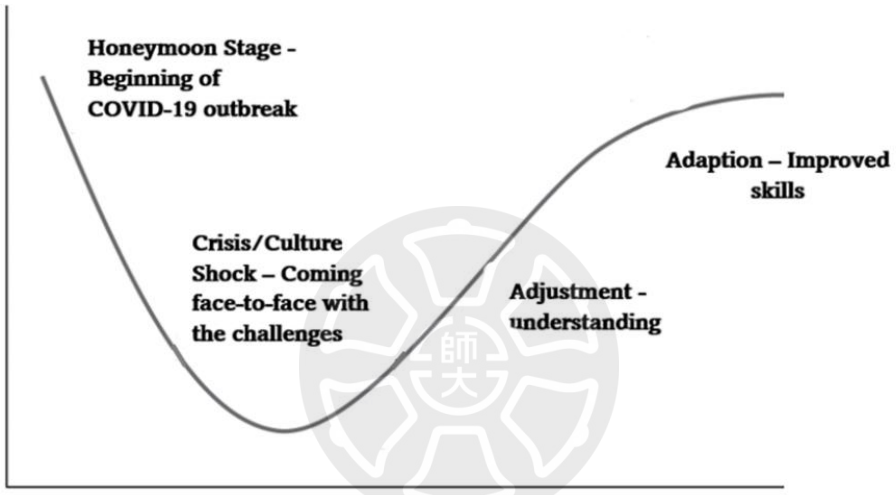
U-Curve Theory and US Healthcare Workers in the Context of COVID-19

The U-Curve in accordance with nealthcare workers in the United States during the COVID-19 pandemic is shown below (Figure 2.1). During the honeymoon stage healthcare workers in the United States are unaware of what will happen and the extent of the seriousness of the virus. In the next stage, a shock takes place when the virus finally makes its way to the country and spreads rapidly. Third, healthcare workers are slowly getting adjusted to working with the new challenges and understanding what the necessary measures are that should be taken

in this new environment. In the last stage, adaption, healthcare workers are more familiar with the situation and can act in accordance with the changes. While some healthcare workers may experience an ideal u-curve others may not accordingly the adaptation process will be left up to the interpterion of each individual.

Figure 2.1

Culture Shock U-Curve: Adapted to COVID-19



Grounds for Using the Culture Shock U-Curve

The cultural adjustment model (culture shock u-curve) will be used to analyze the various adjustments healthcare employees encountered throughout this period. From the honeymoon phase to the crisis/cultural shock phase, the adjustment phase, and the adaption phase. Raill W. Nolan (1990) defines culture as "a pattern of meaning, a way of defining the world and living in it, the rules are deeply internalized in individuals" (p. 2). Cultural exchanges arise when an individual leaves one "world" (pre-COVID) and moves into another "world" (COVID-19) (Nolan, 1990, p. 2). In the case of healthcare worker, it would be going from a world of zero COVID-19 patients to a world where COVID-19 exists in their everyday life. A new culture may seem turbulent to new eyes but be assured that it is being conducted according to its own rules and structure and they are to be learned by the novices (Nolan, 1990).

The honeymoon phase will represent the beginning of the outbreak in the United States. During the honeymoon phase, people have a tendency to focus on everything but not on the most beneficial information coming from the new situation, this eventually ends, and the crisis phase begins (Nolan, 1990). Followed by the crisis/culture shock phase where the healthcare workers do not have necessary equipment and struggle to adapt to this unknown virus. During this phase, individuals will utilize their previous cultural rules and they will instantly produce unsuitable results for the new environment they are coming face to face with (Nolan, 1990). This will cause confusion, frustration, and doubt, thus, leading to stress, one of the main characteristics of culture shock (Nolan, 1990). Next, is the adjustment phase, this is where gradually workers become accustomed to their new environment and lastly, the adaption phase is present day.

CHAPTER III Research Methods

The following chapter will outline the study's research approach, framework, procedure, and methods of a phenomenological study. The sampling strategies and criteria, data collection, data analysis and the research quality will also be included in this chapter.

Research Approach

The research intends to investigate and understand how healthcare workers interpret their experience, what meaning they give to it, and how they adapted to working during a global pandemic. This study implements a qualitative approach given that it is exploring the experiences people have encountered and the significance of these life experiences (Mertens, 2005). Qualitative researchers, according to Mertens (2005), are interested in the way people interpret their experiences, what importance people bring to their experiences, and aiming to make sense of it all. Qualitative method seeks primarily for "clarification, interpretation and, to a certain degree, explanation" (Heyink, 1993, p. 293). Essentially, the objective of qualitative research is to examine and understand the meaning individuals or groups attribute to societal drawbacks. The process of the research consists of questions and methods, data collected about the participant's experience, and the researcher forming interpretations of the data (Creswell, 2012). Creswell (2012) also mentions that qualitative methods comprise of open-ended questions, interview data, document data, observation data, and audio-visual data. In qualitative research data collection and analysis is a *simultaneous* process and it is set in a naturalistic setting (Merriam, 2015). In naturalistic assessments, the researcher does not regulate or manipulate the sample being studied. Qualitative studies are discovery focused meaning the results of the research cannot be determined prior to the study taking place (Jhong, 2019). This study concentrates on the individual adjustment, interpersonal conflict, and what policies were created as a result of COVID-19. These polices will focus on how they were developed to provide support, structure, and stability for healthcare professionals. Accordingly, literature regarding these topics will be incorporated for theoretical proposes and data assessment.

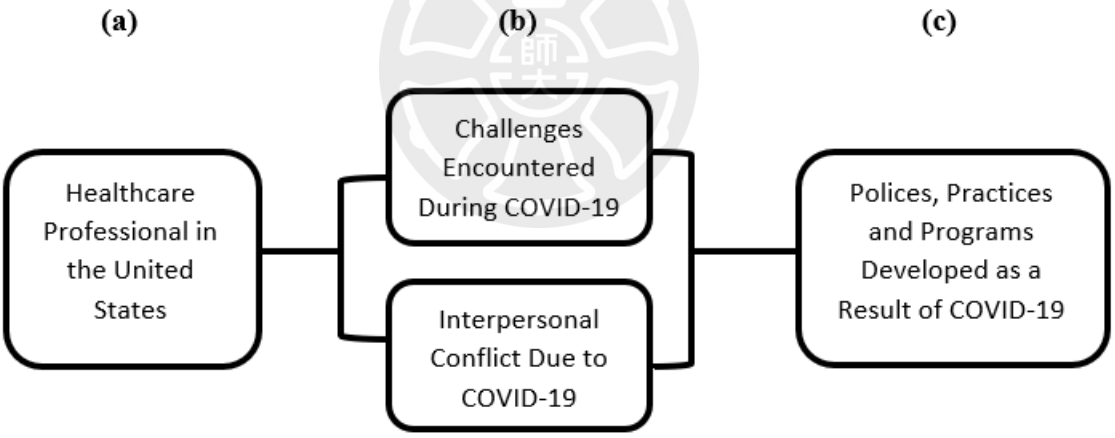
Research Framework

The purpose of this study is to discover how healthcare employees adjusted to new working conditions during COVID-19 and what changes occurred as a result of this. The research framework for this study was established according to the research purpose and questions listed in Chapter One.

In Figure 3.1, the research framework is described using alphabetic points; (a) represents the participants of this study; (b) is divided into two sections, the challenges healthcare workers confronted working during COVID-19 and the interpersonal conflicts they met with; (c) is the polices, practices and programs which were developed as a result of the pervious section.

Figure 3.1

Research Framework



Research Procedure

This section provides a description of the research procedure for this study. (Figure 3.2)

Identify the Research Topic

The researcher was living in the United States at the beginning of the COVID-19 pandemic and based on the researcher's personal experience, she saw how chaotic and confusing

it was for healthcare workers to adapt to the new situation. Therefore, the researcher wants to dig deeper into the challenges healthcare workers faced during this time and how did they adapt to the circumstances.

Review Literature

After the researcher was certain about the research topic, she started to examine literature related to crisis management, adaptation, culture shock and COVID- 19 in different countries around the world.

Establish a Research Method

To analyze the process of healthcare workers' adjustment and polices during the beginning of COVID-19, the researcher decided to implement a qualitative research approach.

Research Question and Purpose

During the process of reviewing various literature and studies, the researcher was able to determine research questions and the purpose of the study.

Form Research Framework

After completing literature review and finalizing the research topic, purpose and questions, the researcher developed the research framework for this study.

Construct Interview Questions

When the research questions were completed, the researcher constructed interview questions based on the research questions.

Peer Review

The interview questions were be sent out to be reviewed by the researcher's colleague and a pilot interview was conducted following the peer review.

Modify Interview Questions

The interview questions were be modified accordingly after the pilot interview and the peer review took place.

Conduct Interview and Document Review

After the interview questions were finalized, the researcher interviewed participants according to the criteria set in this study and performed an in-depth document review. A review of various documents was conducted based on newspapers, websites, blogs, and videos.

Analyze Date

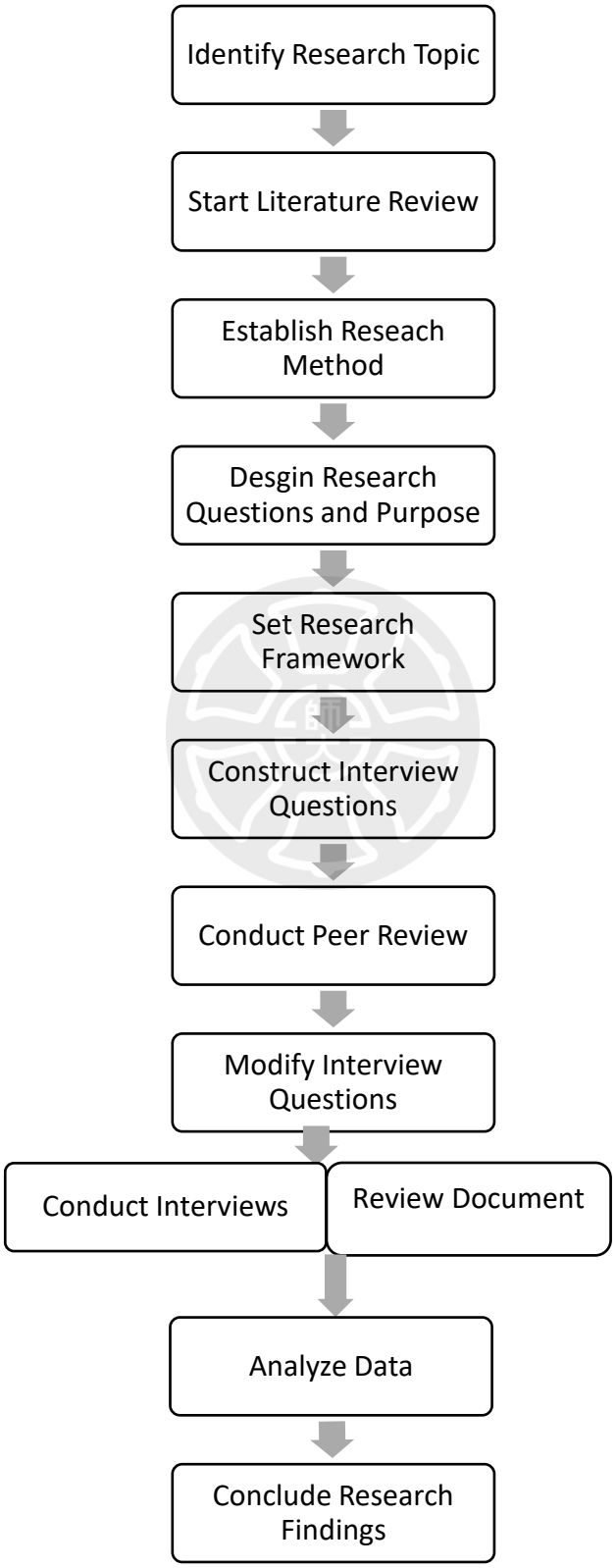
Notes and voice and video recordings were be used to analyze the data of this study. The researcher transcribed and analyzed each interview, records, and applicable documents. Subsequently, the researchers used open coding and axial coding to categorize the data into themes and distinct categories.

Conclude Research Findings

After the data was completely analyzed, the researcher formed a conclusion based on the literature previously reviewed and the findings after the data was examined. Then the outcomes and implications were presented for practical contexts and future studies.

Figure 3.2

Research Procedure



Sampling Strategies and Criteria

Networking and snowballing were used to conduct this research with 21 healthcare workers taking part in the study. Each participant signed a non-disclosure agreement to ensure their identity and affiliation remained confidential. Participants were asked to take part in a semi-structured interview. Each participant was chosen based on characteristics more suited for this study, therefore, gaining a high-quality perspective. The criterion for this study includes the following requirements, the participants must be working in the United States healthcare system and worked directly with COVID-19 patients for at least three months. Each participant was chosen to gain a clearer perspective of their challenges, experiences and how health care establishments developed ways to support healthcare workers. Black and Mendenhall's (1991) interpreted Lysgaard's U-curve adjustment theory as individuals producing adjustments to living or working in an unfamiliar culture. Prior to the interviews participants were be asked a series of background questions such as their age, gender, job title, and years working as a healthcare professional.

Table 3.1

Participants Profiles

Participants	Pseudonym	Gender	Age	Number of Years Working in Healthcare	Job Title
Participant 1	Kyla	Female	24	4	Medical Student
Participant 2	Emma	Female	36	15	Certified Physician Assistant
Participant 3	Mia	Female	34	6	Registered Nurse
Participant 4	Sophia	Female	26	5	Registered Nurse
Participant 5	Johnny	Male	52	21	Registered Nurse Manager
Participant 6	Luna	Female	61	25	Registered Nurse
Participant 7	Josh	Male	37	13	Advanced Practice Nurse
Participant 8	Ella	Female	61	25	Registered Nurse/Staff Educator
Participant 9	Lilly	Female	53	13	Certified Nursing Assistant
Participant 10	Aria	Female	24	3	Registered Nurse
Participant 11	Ivy	Female	29	3	Registered Nurse
Participant 12	Kate	Female	24	7	Registered Nurse
Participant 13	Violet	Female	31	10	Registered Nurse
Participant 14	Daisy	Female	58	20	Registered Nurse
Participant 15	Henry	Male	43	12	Physician
Participant 16	Rose	Female	48	13	Registered Nurse
Participant 17	Louis	Male	38	25	Chief Nurse
Participant 18	Casey	Female	31	5	Registered Nurse
Participant 19	Kelly	Female	24	2-3	Emergency Medical Technician/ MA
Participant 20	Riley	Female	53	19	Registered Nurse
Participant 21	Ana	Female	21	2	ER Technician

Data Collection

The interviews for this study were conducted in English using an online video meeting instrument (Microsoft Teams, Zoom), due to the severity of the pandemic was it difficult to conduct face-to-face interviews. The type of interview that was performed is a semi-structured interview, to allow flexibility of the questions and the researcher can easily use the interview questions to obtain additional information. To ensure the effectiveness of the interview questions they went through peer and expert review and a pilot run. During the peer review the questions were sent to another researcher for review and they will give feedback to the researcher. Expert review was performed by an individual who has knowledge in field related to the study. A pilot interview was conduct with individuals who have similar backgrounds to the participants in the study. To ensure that the participants information will be kept confidential, they were asked to sign a consent form prior to the interview taking place. The length of the interview was between 20 to 45 minutes and each interview was recorded for the researcher to review. Background questions were asked about their work experience in healthcare, their job title, age, and gender. Along with the interviews a detailed document review was conducted to incorporated more supporting information for this study. According to Merriam (2009), the term document is regularly referring to widespread written, visual, digital, and physical material correlated to the study. These documents can be presented on website, official records, newspaper accounts, diaries, blogs and beyond. Accordingly, the researcher browser, websites, blogs, newspaper articles and videos to gather more substantial information. The interview question was based on the four stages of the adaptation curve, honeymoon, crisis, adjustment, and the adaption phase.

Online Interviews

This study uses one on one interviews to collect data from qualified participants. In terms of qualitative research, the data is collected through interviews, face-to-face interviews are the most popular type of interviews used (Merriam & Tisdell, 2015). The research was unable to conduct face-to-face interviews in person however, the interviews in this study were performed using an online meeting software. The interview questions were based on the research framework and the interview questions can be found in Appendix A. A semi-structured interview with open ended questions was used for this study in order to allow the participants to freely answer the questions to the best of their knowledge. Prior to each interview the participants were sent the

questions and a consent form (Appendix B). After each participant consented to taking part in the study and having the interviews recorded then the interviews would take place. The consent stated that all participants information will remain confidential and anonymous, using a pseudonym to protect each participants identity. Every interview was conducted in English, recorded, and transcribed. Each interview lasted between 20 to 45 minutes.

Document Review

Marriam and Tisdell (2015) described that documents are regularly "used as an umbrella term" to describe a variety of "written, visual, digital, and physical" records appropriate to a specific study (p. 162). They also mention that documents can include official records, letters, newspaper accounts, corporate records, government documents, historical accounts, diaries, autobiographies, blogs, and these documents can be from the physical world, websites, or both (Marriam & Tisdell, 2015, p. 163). The researcher watched the news and browsed online news articles, blogs, and social media videos about healthcare workers working during the COVID-19 pandemic to attain more information for the study. The research knows some of the interviews personally and was able to view their social media posts while the pandemic was a its peak.

Table 3.2

Collected Data

Squadron	Personal Questionnaire		Interviews		Document review
	Type (number)	Date	Type (number)	Date, duration	
Healthcare Workers			Pilots (2)		*Healthcare workers reports and publications (20a), over 200(b) pages; news articles, blogs, social media pages*
	Participant 1	March 2022	*Interview 1*	March 2022, 20’	
	Participant 2	March 2022	*Interview 2*	March 2022, 30’	
	Participant 3	March 2022	*Interview 3*	March 2022, 26’	
	Participant 4	March 2022	*Interview 4*	March 2022, 40’	
	Participant 5	March 2022	*Interview 5*	March 2022, 26’	
	Participant 6	April 2022	*Interview 6*	April 2022, 20’	
	Participant 7	April 2022	*Interview 7*	April 2022, 35’	
	Participant 8	April 2022	*Interview 8*	April 2022, 30’	
	Participant 9	April 2022	*Interview 9*	April 2022, 27’	
	Participant 10	April 2022	*Interview 10*	April 2022, 45’	
	Participant 11	April 2022	*Interview 11*	April 2022, 34’	
	Participant 12	May 2022	*Interview 12*	May 2022, 30’	
	Participant 13	May 2022	*Interview 13*	May 2022, 21’	
	Participant 14	May 2022	*Interview 14*	May 2022, 26’	
	Participant 15	May 2022	*Interview 15*	May 2022, 44’	
	Participant 16	May 2022	*Interview 16*	May 2022, 21’	
	Participant 17	May 2022	*Interview 17*	May 2022, 20’	
	Participant 18	June 2022	*Interview 18*	June 2022, 20’	
	Participant 19	June 2022	*Interview 19*	June 2022, 20’	
	Participant 20	June 2022	*Interview 20*	June 2022, 21’	
	Participant 21	June 2022	*Interview 21*	Jun2 2022, 20’	

a. The researcher examined 20 healthcare worker’s reports and publications

b. The researcher examined 200 pages of new articles, blogs, and social media pages

Data Analysis

In order to obtain knowledge and insight into the experience of United States healthcare professionals during the COVID-19 pandemic, the researcher the qualitative research approach. 21 healthcare professionals working in the United States were interviewed about their experience working during the beginning of the COVID-19 pandemic using a semi-structured format. All the interviews were recorded and analyzed to form a conclusion.

The data analysis for this study was conducted with three steps: open coding, axial coding, and constant comparison. Open coding was used as an identifier for the original data and to divide the data into distinct categories, creating the first level categories. Axial coding was used to group each category obtained from the first level categories and then the second level was developed. Constant comparison between the theoretical framework and the new categories will be utilized together with the open coding and axial coding process to ensure that the new categories and the theoretical framework is related to one another.

First the researcher used a coding system (Atlas.ti 8.0) to summarize the interviewee's thoughts and opinion and divided the data into distinct categories. The researcher thoroughly analyzed the meaning of the original data from the interviewee's transcripts and then put together a few ideas or theories based on the data, to form codes. The results of open-coding were the first-level categories and there were no assumptions made by the researcher prior or during the coding process. Next, axial coding was utilized to evaluate, study, and categorize the coded data, and to band the categories into parallel subtexts. The second level of categories was use at the same time along with open coding and axial coding process. This is to make sure the budding categories and the theoretical foundation can connect to one another (Strauss & Corbin, 1990; Strauss & Corbin, 1998). Lastly, constant comparison among the theoretical framework and the new categories are used simultaneously with open coding and axial coding to guarantee that the new categories and the theoretical framework are associated to each other.

Figure 3.3

Analysis Procedure

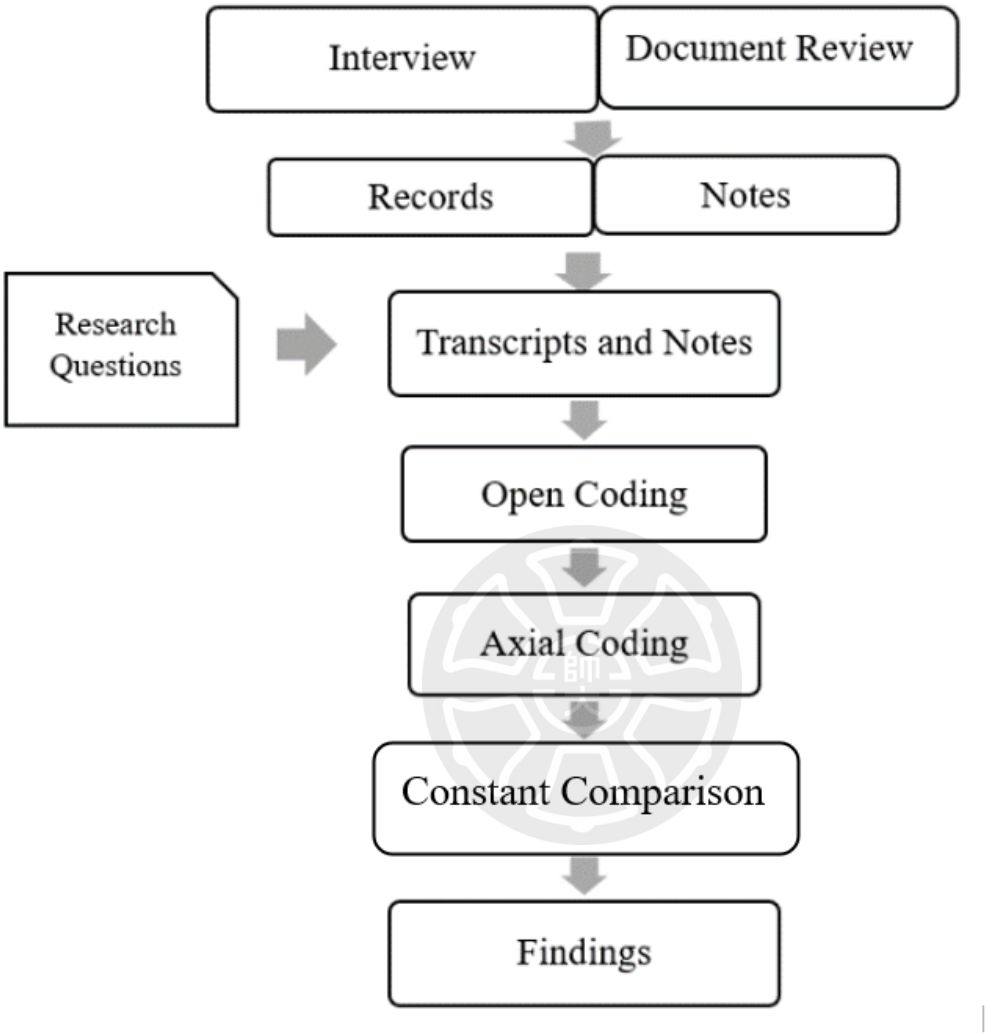


Table 3.3

Data Table

Themes	Representative Quotations
Well-being of Healthcare Workers *The effect of death on healthcare workers*	"I saw a lot of patients die. You try to do everything you can to save them, but there isn't much you can do. And I guess that was kind of what was getting to me." (Participant 3) "There was so much death around you, and you know you see on the television and other hospitals, but it trucks, we had the freezer trucks to outside, which I've never seen before." (Participant 6)
Living in fear	"So, my friends and I did like a quarantine pod. If that makes sense with five of us. And we were the only people who we would see unmasked. And mostly that was again 'cause if, like fear of testing positive and not being able to go in and complete like clinical tasks." (Participant 1) "The biggest way I would say was living in fear, especially knowing that you know you're exposed 12 hours at a time to COVID patients and you're coming home to a family who has underlying conditions." (Participant 4)
Feeling Isolated	"COVID-19 definitely shows you that you can kind of be like shunned from society like I was afraid to go to the supermarket afterward, 'cause people thought I had COVID on me. And then a lot of isolation because I couldn't see my friends and family 'cause everyone knew I worked in the hospital." (Participant 2) "I don't want him coming into my house because, you know, he could have been exposed. So, it kind of like I feel like shunned." (Participant 7)

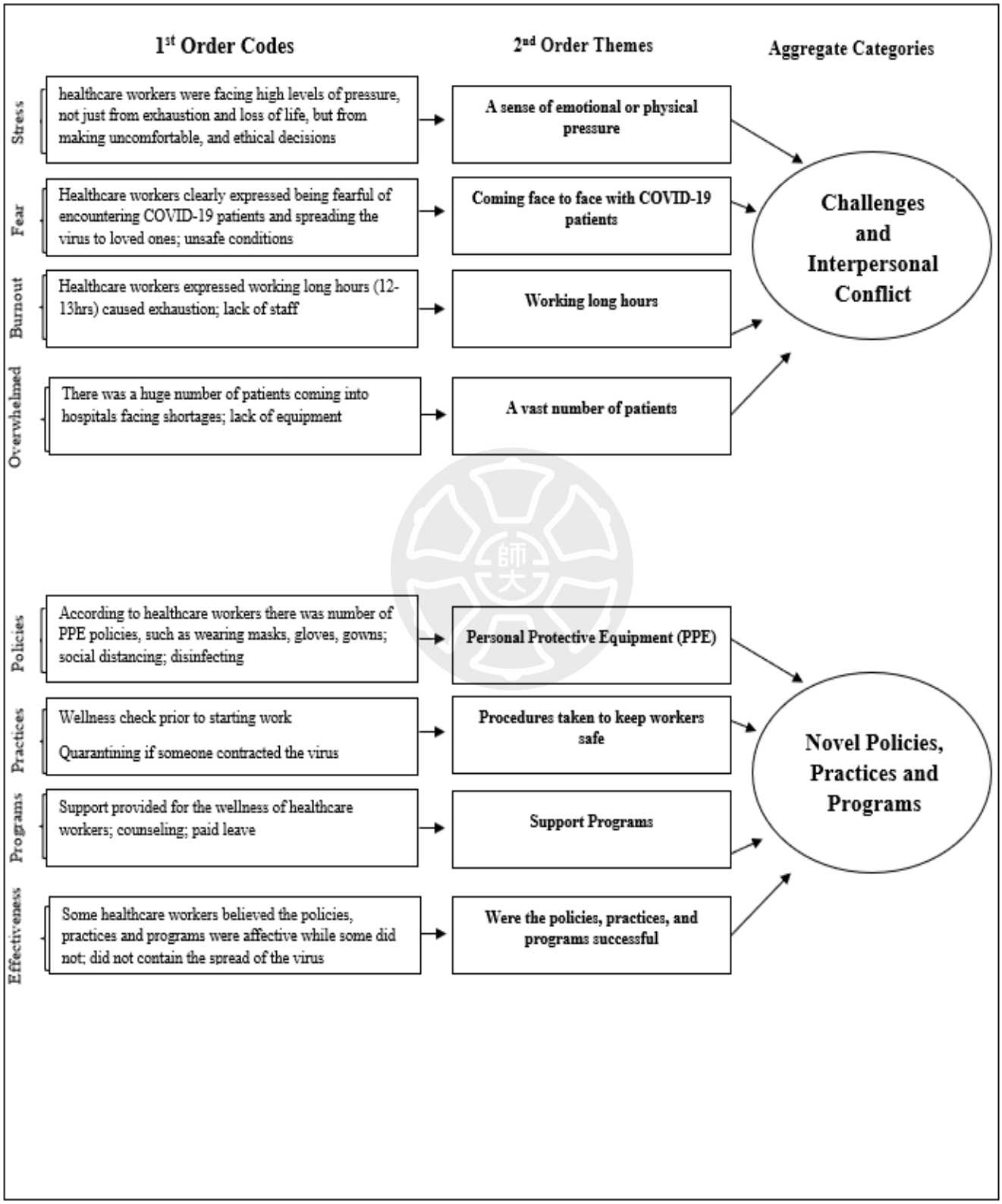
Table 3.3

Data Table (Continued)

Policies, practices, or programs	
Lack of Personal Protective Equipment (PPE)	"We didn't have enough gowns, so we used garbage bags. Over here we didn't have shoe covers. We didn't have face cover. We didn't even have proper PPE." (Participant 5) "There was a shortage of staff and equipment. We had to reuse masks that were primarily from one time use." (Participant 9)
Slow response from state and federal government	"Well, I definitely think they were very slow to respond 'cause it was definitely over the news and you know that our leaders and government officials are in contact with other countries. There's so many international relations. So, I definitely think they were very slow." (Participant 2) "Upper government roles knew about it. They knew it was serious, but they didn't communicate it down to people who really needed to know about it. I think healthcare workers took it seriously." (Participant 8)
Effectiveness of the policies	"I feel like the policies they have now are way better, but I also know that's because they know how to handle the situation now. In the beginning, they didn't know what to expect. So, it was like a guessing game." (Participant 12) "I don't think they were effective because I don't think they really knew the extent of what they were dealing with. I think that probably they did the best they could with what they had. I feel like our country was not prepared in any way for a pandemic, even though I feel like they were warned by the higher ups." (Participant 16)

Figure 3.4

Data Structure



Research Quality

This section will discuss the quality of qualitative research and the approaches the researcher executed to improve the quality of the research. Guba and Lincoln (1989) identified the criteria for determining the quality of qualitative research that corresponds with the criteria for determining the quality of quantitative research. They associated the quality of qualitative research to credibility (internal validity), transferability (eternal validity), dependability (reliability), and confirmability (objectivity). Qualitative researchers are intrigued with the idea of understanding how individuals explain their experiences, how they structure their environment, and what significance they attach to their experiences (Merriam & Tisdell, 2016).

Credibility (Internal Validity)

The researcher used several strategies to increase the of credibility from a range of sources. Peer debriefing was be used when the interview questions are evaluated by associates of the researcher to ensure the meaning of the questions are understood and after all data is collected. Moreover, document review was be used since the information collected is going to be checked for consistency using various sources. Member check, where the researcher must authenticate with the interviewee the concepts that are being established as an outcome of the data collected and evaluated. An example of this would be is for the researcher to summarize the interview and ask if the report correctly depicts the individual's outlook. Furthermore, progressive subjectivity was be used to avoid bias from the researcher. To do this the researcher kept track of their evolving beliefs and document process for changes from the start of the study to the end and a peer debriefer will be used to challenge the researchers' ideas (Mertens, 2005).

Transferability (External Validity)

Mertens (2005) explains that researcher obligation in transferability is to provide adequate details (i.e., time, place, context, culture) to allow the reader to define the relationship with the study setting and the receiving framework. This is a thick description, and it is needed so other researchers can express the context of the research and make comparisons of the similarity in their own research. The techniques to support transferability in this study was peer review, think descriptions and researcher's position or flexibility. Peer review was conducted by consulting with colleagues about the development of the study, the consistency of the findings, and the analysis of the data. Transferability was likewise be reinforced with thick descriptions, described above and researcher's position or flexibility which is self-reflection by the researcher

concerning their “assumptions, worldview, biases, theoretical orientation, and relationship to the study that may affect the investigation” (Merriam & Tisdell, 2015, p. 259).

Dependability (Reliability)

Reliability is how consistent a study is of over time in a postpositivist paradigm but in a constructivist paradigm change is inevitable and it should be monitored and be widely inspectable (Guba & Lincoln, 1989). One method of guaranteeing reliability is audit trail which is a thorough description of the methods, procedures, and conclusion stages in the study (Merriam & Tisdell, 2015). To ensure dependability peer review, the researcher's position or flexibility, and an audit trail was conducted to support the study.

CHAPTER IV Research Findings and Discussion

The main findings are reported in the sections below. The sections are based on the research questions mention in Chapter One. This section consists of healthcare workers: challenges and interpersonal conflict; novel policies, practices, and program and suggestions from healthcare workers. At the end of this section there will be the discussion section, stating the conclusions of the findings.

Healthcare Workers Challenges and Interpersonal Conflict

In this section, Healthcare Workers Challenges and Experiences it is divided into four parts based on the words they used to describe the psychological feelings they were experiencing at the start of the pandemic. This study found that it was not an easy adjustment for healthcare workers as they were confronted with many unfamiliar and unexpected situations during a time of turmoil. For this section the researcher divided healthcare workers psychological and interpersonal adjustment into four segments, stress-a sense of emotional or physical pressure, fear-a sense of emotional or physical pressure, burnout-working long hours, and overwhelmed-a vast number of patients. This is highlighted in Table 4.1.

Table 4.1.

Challenges and Experiences

Dimension	Healthcare Workers Challenges and Experiences
a) Stress	A sense of emotional or physical pressure
b) Fear	Coming face to face with COVID-19 patients
c) Burnout	Working long hours
d) Overwhelmed	A vast number of patients

Stress: A sense of emotional or physical pressure

Miyamoto (2020) stated that healthcare workers are experiencing high levels of stress and it is not simply from fatigue and loss of life, but from needing to make uncomfortable, ethical decisions based on patient care in an environment where there are frequent shortages. Stress can be described as a feeling of emotional or physical pressure and various situations can cause stress

to an individual. For example, stress can be caused from certain event or thoughts that makes one feel unhappy, irritated, or anxious. Participant 7 stated feeling stressed due to an acquaintance saying the following:

> I don't want him coming into my house because, you know, he could have been exposed. So, it kind of like I feel like shunned. You know you feel like you're like a pariah you know like you're shunned away. So, it gave me a lot of stress because we didn't know anything, you know, and we didn't want to bring it back home.

Several healthcare workers might inconsiderately experience avoidance from their family members or their community due to stigma or anxiety (WHO, 2020a). Another participant talks about feeling this way as well similar to Participant 2 who had the following to say regarding being shunned from the community around them and not being able to see their friends and family.

> COVID-19 definitely shows you that you can kind of be like shunned from society like I was afraid to go to the supermarket afterward, 'cause people thought I had COVID on me. And then a lot of isolation because I couldn't see my friends and family 'cause everyone knew I worked in the hospital.

Participant 4 speaks of how their day at work became even more stressful do to the increasing COVID-19 causes at the beginning of the pandemic.

> It was definitely stressful. It was very, very different compared to when I became a nurse in 2017. It was just. It was hard seeing people die every day. We had a lot of situations where typically you would go to work; you greet your patience. I explained our plan of care for the day, give them medications. You know, build a personal connection with them. However, at this point when COVID began, you

> couldn't really make a connection with your patients because a lot of them couldn't speak to you. They were short of breath with oxygen mask on their face.

Participant 16 disclosed how her life at home had become more stressful because she is a single, working parent and during the pandemic classes were being taught online. This cause her to be more stressed out. She spoke about the difficulty she faced when trying to balance being a healthcare worker and a parent.

> You know, I'm more stressed at home because I'm a single parent and trying to keep my kids safe and especially with the online school during the pandemic was pretty disastrous for my family. You know, working through healthcare and at the same time being expected to home school for children. It just was way too much and consequently my children, you know, are behind in school, particularly my sons. So that's been hard with the pandemic.

This is reinforcing what Miyamoto (2020) mentioned, healthcare workers were stressed not only due to the amount of work they had to do but also because they were being stigmatized by their community and people, they usually spend time with. Furthermore, healthcare workers branded with COVID-19 if they were in their scrubs as the public thought, they would contract the virus from them. Participant 4 spoke about how their work environment became more stressful as they were several changes take place rapidly. It was not the workplace they were accustomed to.

Fear: Coming face to face with COVID-19 patients

Fear can be characterized as an unpleasant feeling generated by concern, worry, or in this case COVID-19. It was evident that healthcare workers were living in fear, not only for themselves but for their friends and family members. Participant 4 mentioned in response to how their life has changed the following:

> The biggest way I would say was living in fear, especially knowing that you know you're exposed 12 hours at a time to COVID patients and you're coming home to a family who has underlying conditions.

Participant 3 similarly shared their fear about going home to their kids and how it might affect their lives.

> Coming home to my kids and stuff. I don't know how, like if I caught it and bring it home to my kids, how it would affect them. That was the scary part.

Healthcare workers were in continuous fear of circulating the virus to their friends, families, and acquaintances. They were faced with fear and unease in their daily lives, and they took compulsory precautions to avoid the spread of COVID-19. Participant 5 did the following to keep their family safe from the virus.

> I remember when I used to go home, I used to walk straight into my basement, take my clothes off, put it in Clorox, soak it. I'll come home and run straight into the shower and take a shower and just run to bed and then try to get back to work.

Participant 6 had the following to share about their experience working during the height of the COVID-19 pandemic and being fearful of visiting their family members because they did not want to spread the virus to any of them.

> It really was a dramatic change actually because of the fear. I work in a hospital. I worked at the time the pandemic started. My mother was 80. She's now 82. I was afraid to visit her. My other family members, my brothers, and sisters, didn't wanna visit her because they were afraid. You know, if they have the virus, but were asymptomatic that they may transfer it to her. So, she was pretty much in isolation. My brothers and sisters we didn't see each other. We talked, I talked to my mom, but we didn't visit each other, and I didn't go out. None of us went out.

Burnout: Working long hours

Healthcare workers expressed that working long hours and having more patients than they normally would be responsible for caused them to feel exhausted and burnout. Participant 11 spoke about hazard pay at their health facility and how she did not believe it was worth the overtime due to burnout, she had the following to say:

> They only did hazard pay if you did overtime. So, if you're working, you're 3 shifts for that week. They were regular pay. But the hazard pay was like, ridiculous. But at that point, you're so burnt out from those three days like it's not even worth the overtime you can't even justify coming in for a fourth day because you're so spent, and you're so burnt out that it's almost not worth it. But the hazard pay, I think depending on the need it was like. I think the lowest was like $100 an hour or like $90 an hour and the highest I think was like $175. From what I can remember per hour which is crazy like a crazy gargantuan amount of money but to me, it was never worth it. I was just too tired all the time.

When asked about when her typical day at work was like during the pandemic Participant 10 shared that her average day at work had changed drastically as many things would take up much more time than it would normally take prior to COVID-19. Here is what Participant 10 has to say about her hectic day at work, ending with “Burnout is real”.

> Once you go into a COVID patient room, gown up and provide all care, take their vital signs, change them, clean them, feed them, give them medications. Basically, if you had a patient, a room with two patients, you would be there for a whole hour before coming out, making sure that the rest of the patients are OK. So, you would be there for a whole hour.

Participant 10 continued to speak about having to check on COVID-19 patients and non-COVID-19 patients.

> Just make sure that everything's OK with the non-COVID patients or someone watching out for them before you could go into a COVID patient room. And then it's worse if they have, like, medications every two hours because once you go in there, you're not out for a whole hour cause you know you want to make sure they're OK before you leave. You want to make sure they're cleaned up and they're OK before you leave. And then you come out. So that would be like the whole day, like, making sure everyone's OK.

Then Participant 10 spoke about how working long hours affected the psychological state.

> So, it was a hard 12 hours and then, after that you give your report. Of course, you have to go in. You have to go out with the other nurse and then you have to clean everything, so you have to take off your, your net, your hair net. You have to clean, wipe your whole phone, your goggles, your shoes. Cause if you're going to go in your car, you have to make sure that you're, you know, you're not taking any COVID bacteria.

This Participant also mentioned that nursing had changed drastically for when they initially started working as a nurse.

> So that was like, it was very hard. It did change a lot, it was different from what it was like, when I went into nursing and then how I came out. It's much harder. Burnout is real.

Another participant voiced their opinion about the healthcare system. Participant 16 stated that she that she felt the healthcare system is “broken” and healthcare workers had to work

around what they had in order to work during COVID-19. She also spoke about how this caused healthcare workers to be “emotionally, mentally and physically” drained.

> Well, I feel like the healthcare system has been broken for a long time, but during COVID, I think that it reached a breaking point where, you know, like I said, you're expected to keep doing more with less and then that becomes the standard that you're working for. And then the expectation of what you can do even grows more. And it's just there's not enough. There's just not enough. It's everybody is empty. And I think too, you know, the way that most institutions have handled it, where they're all of their, you know, the superiors and the higher ups are getting all these bonuses, but yet nurses pay has not increased. I think we're all just really tired emotionally and mentally and physically.

Overwhelmed: A vast number of patients

Healthcare workers recognized that their mental health was significantly affected when they were working during COVID-19. Participants cited feelings of being overwhelmed for instance they were overcome with emotions of exhaustion due to the quantity of work and patients they were encountering. Healthcare workers were also overwhelmed with the countless changes they were rapidly experiencing. Participant 6 explained how overwhelming it felt seeing freezer trucks waiting for patients who had passed away.

> There was so much death around you, and you know you see on the television and other hospitals, but it trucks, we had the freezer trucks to outside, which I've never seen before. So just when you see those trucks, you kinda, you think like you are in a horror movie. It's hard to explain because you know what's going in there. That these patients aren't going in the morgue because the morgue is overflowed. They're going into these trucks, these freezer trucks.

Participant 6 mentioned that many people had seen or heard of freezer trucks from the news, but they said to physically drive by it almost every day and to know what was happening there caused them to be inundated with emotion due to the situation. Participant 3 declared that seeing so many patients succumb to the virus was difficult for them to go through every day. They revealed:

> I saw a lot of patients die. You try to do everything you can to save them, but there isn't much you can do. And I guess that was kind of what was getting to me.

Healthcare professionals were seeing an enormous amount of death every day and in many circumstances the control was out of their hands causing them to be more devastated and overwhelmed with countless emotions. In addition to feeling burnt out Participant 10 felt as a nurse working during COVID-19 that it was very overwhelming to work with a shortage of nurses and taking care of 10 patients for 12 hours a day and do it all over again the next day. She also mentioned that she did not know how to handle the large amount of death she was seeing daily.

> Nurses are, like, really overwhelmed. There are times that there's no staffing. My floor had 32 beds, sometimes it would be I think at max capacity like at 32 and they would only give us three nurses. Since they would call out or you know they would get COVID and call out they're just tired. Like it's really hard for the nurses. So, we each have 10 patients to take care of COVID with a mix with COVID and non-COVID. 10 patients are a lot for one nurse, you know. So, you are just beat up and then you have to come back the next day. For 12 hours. So, I understand how a lot of people right after once COVID hit and then I guess the first wave of COVID they retired or they just quit because it was just so hard for them to see people dying every single day, and that's just another toll to your emotions. You know, it's like. You just don't know how to live with yourself for a whole day. You just have to lay in bed and just, I guess, try to recuperate all the

energy for the next day and you don't know what's going to happen the next day. You might have a good day. You may have a bad day. You don't know.

Overall, working during the COVID-19 pandemic made it incredibly psychologically, emotionally and physically draining for healthcare workers as they were faced with unknow and uncertain situations daily. It was difficult for them to overcome the stress, fear, and burnout leading them to feel overwhelmed because of the situation and the various difficulties healthcare workers faced during the beginning of the pandemic.

Novel Policies, Practices, and Programs

This section will focus on the policies, practices and programs that were introduced during the pandemic to benefit and support healthcare during a time of ambiguity. Moreover, the researcher will present whether the participants of this study found policies, practices and programs to be effective and suggestions from healthcare workers.

Table 4.2.

Novel Policies, Practices, and Programs

Dimension	Policies, Practices and Programs
a) Policies	Personal Protective Equipment (PPE)
b) Practices	Procedures taken to keep workers safe
c) Programs	Support Programs
d) Effectiveness and Suggestions from Healthcare Workers	Were the policies, practices, and programs successful

Policies: Personal Protective Equipment (PPE)

Participant 2 was working In New York City at the beginning of the pandemic during this time New York City was the epicenter for COVID-19. With an immense number of individuals coming into the hospital testing positive for COVID-19 she speaks about the PPE situation and the lack of medical equipment at her place of employment. This is what she shared about her experience:

> March 12th is when New York City went on lockdown, and I was seeing patients. I didn't have goggles. They were like you could wear like a, it's like PPE, like the body, the disposable bomb body cover and the mask, like there weren't too many strict protocols. And then when patient started picking up, when it started picking up a lot more and we started seeing all the respiratory symptoms and we needed multiple patients to be intubated. We had patients sharing ventilators most of the time. So yeah, we were definitely, we definitely did not have enough equipment.

Participant 3 likewise shared their story about there being a lack of medical equipment at their hospital. She reported that a patient needed an oxygen machine but unfortunately the patient passed away because the hospital only had one machine left and it went to another patient in the hospital.

> I remember one time I had a code and the patients oxygen levels in the 70s. So, we called a rapid response team like whole bunch of people came like doctors, some nurses and then like a couple minutes later, another code was called on another floor. Basically, they had something called a HEPA filter which filters the air in the room, my patient needed that. I called to get that machine and they were going to give it to us but then by the time somebody went down to get it, the second call that was called, they already took that machine for that second code. That was the last one in the hospital. So, my patient actually ended up passing away, probably within the hour after the cold was called.

Participant 13 spoke up about the shortage of PPE, they had the following to say about the issue at hand:

> We didn't have proper protection or PPE; We were reusing masks and gowns for about a week at a time. Which wasn't safe at all. We actually ran out of test during

> the height of the pandemic between, like I want to say, March to May. We were reserving our test for patients who are actually needed attention. And it's sad to say that we actually had to turn many people away and advise them to go home and quarantine. We ran out of ventilator equipment which was really unfortunate. So again, we were kind of reserving all of our equipment for patients who were a little bit younger and probably had a better prognosis.

This participant also spoke about turning patients away because there was not enough equipment for everyone who tested positive for the virus. Participant 13 mentioned that it was an "unfortunate", but they had to use the equipment on those who had a better prognosis.

While there were participants who stated that their place of employment did have shortages, some participants like Participant 19 stated that they did not have any shortages stating:

> No. In fact, we are required to wear PPE at all time, even in our vaccine clinic like we don't really have to. I didn't really have to have direct contact with COVID patients, but we actually treat everyone as potential patient. Yeah, so we all have to wear PPE.

Instead, Participant 19 said in Hawaii they faced shortages of medical staff therefore travel nurses from different states had to come in to help.

> In Hawaii, when they were facing staff shortage, they just keep hiring travel nurses from different states, like a lot of them. And then as soon as they don't need them, they had to, like, go back to their states.

Although there was a shortage of PPE national some hospitals or health facilities did not have shortages in PPE. Another example of this is Participant 4 who stated the following:

> Nationally, there was a shortage with PPE. However, I've also worked in the COVID ICU, the COVID PCU and I could say there wasn't a time that I ever; I was short of a, you know, PPE which includes the gown, a mask, and a face shield. I was always provided with those materials.

Depending on where the healthcare facilities are located in the United States depended on if there was a lack of PPE or staff. Participant 19 was working in Hawaii and Participant 4 was working in Florida while the other participants mentioned in this section were based in New York, which was the epicenter of the pandemic at the beginning.

Practices: Procedures taken to keep workers safe

Participants report the necessary measures that were taken to keep healthcare workers safe. Participant 1 communicated the following:

> We had to do a pass every morning where you like check off any symptoms that you might have experienced, whether or not you've had any exposures, etc. And based on that you either get like a green pass or red pass for the day. And then also, of course, like the masks. And then like eye protection for seeing any patients, even if they don't, we don't think they have COVID. And then of course like gowns and stuff too, if there's any concern that people have COVID.

To keep healthcare workers safe, practitioner had to be wearing PPE to keep themselves safe from and pateiint that may have the virus. Simailaly Participant 17 mentions a sreening proces employees had to go though in order to work on a particular day.

> They had a screening process. So they asked if you had any, cough, cold or flu like symptoms. If you responded yes to any of those, you weren't allowed to proceed to work, you had to go to a fort and get tested for COVID and long term care. They had implemented a directive that everybody had to be now tested twice

> a week. So that was actually something that I had started and spearheaded, making sure that we had the appropriate testers, making sure that we have the staff.

Participant 19 confirmed what the previous participant said by stating that PPE and screening was a major way to keep healthcare workers safe throughout the pandemic. She had the following to share:

> The masks, wash your hands as soon as you get in. Wash your hands almost like 10 times throughout the shift, because every patient we go to we wash hands before and wash our hands after and wear N95 masks. We will constantly clean the structure over and over again the entire bus after every patient.

Since she worked as an EMT they had to clean the ambulaces everytime their was a patient in there becsue they did not know if the paetient had COVID or not.

Programs: Support Programs

Many participants reported that their place of employment did provide support programs for workers. Participant 4 shared that her place of employment did provide support programs form their employees, for example:

> Our employee health, who was available, if you needed assistance, we have a hope fund for, people who had to quarantine and they didn't have to pay for quarantine. They were helped with assistance. —There was our employee health made it pretty aware that we were able to call their hotline and speak about anything we saw. There was support groups that took place at the hospital also in our Chapel. We had our chaplain who would do a daily prayer. If you just wanted to go and you know, just to clear your mind. So they were, they were definitely supportive.

This hospital provided various types of support for their employees if they were having a difficult time. Paticicpant 12's place of employment also implemented various support programs for their employees. Heres what she had to say:

> They set up like a stress room, like a room where you could go for like 10 minutes or so. It has a massage chair. And it was allowed, like one or two nurses at a time could go as long as somebody was covering your patients. They have somebody that you could talk to. They had you know those stress dogs, therapy dogs. They had brought them up on the units. So they did stuff they gave us thank you notes. They were feeding us a lot of pizza. But yeah, they tried. And it helped.

Similaly, Participant 20's place of employment provide counseling to employees who needed it. "They do have counseling. They do have the distress program counseling. It was provided to the staff. " However, there was also health facilities that did not provide support progams for employees. Those particicpants simply answered "No." or they were not aware of any support prgrams that were being offered.

Effectiveness and Suggestions from Healthcare Workers: Were the policies, practices, and programs successful

There were varying answer form participants about whether the policies, practices or programs were effective and successful. Participant 2 spoke out and said she did not believe they were effective.

> I'd say no. It wasn't effective in the beginning because I think they didn't; they should have like when we knew it was happening in China, they should have looked there for help and find out what they were doing and have a plan instead of rolling out everything last minute and kind of like throwing us to the fire to figure it out with them. They needed better guidance and not just sending out emails.

> They need to physically be there and see what was happening, in terms of management.

She felt that healthcare facilities took to long to provide a plan for heathcare workers and they had to figure out many things on their own as they did not have proper guidance. Likewise Participant 12 stated it was like a “gussing game” when the virus started to spread in the United States but they do feel that the policies currently in places are improved.

> I feel like the policies they have now are way better, but I also know that's because they know how to handle the situation now. In the beginning, they did not know what to expect so it was like a guessing game.

Particicpant 17 shared that they did not agree with some of the policies that where in place due to COVID-19, for instanse the policy about not visitation.

> To a certain degree, I think one of the policies that came out was about visitation that I didn't agree with, especially at end of life. Like if somebody's dying, you know, I'm all about them being at the bedside. But we had people dying alone. There was also a policy. That, you know, we had to limit the number of visitors if they did have a visitor.

Others did find the policies, practices and programs to be effiective like Participant 15 who thought they were effective in places like New York City.

> Yes. I think they were effective. Well, I mean, I think in certain hard hit areas, the idea of having essentially a lockdown, so you know, New York City comes to mind, have a lot of used to live in New York City. So I have a lot of friends there. You know the they essentially did a relatively effective job of curbing the, you know, number of cases despite all the sensationalistic like news reports and all that stuff about, you know, meat lockers outside of hospitals and bodies piling up

> in that sort of thing. It could have been significantly worse if people just went about their business.

Similarly. Partticipant 6 felt the there was not major effectiveness and the very beginning of the pandemic but as time went by he could see that the policies, practices and programs were indeed effective.

> In the beginning? No, not nothing was effective because nobody knew what the hell they were doing. Nobody knows what to do. But yes, as you went on and we were getting more information about this, this virus and the the research and they're doing more research in it. Yes, the policy at start was effective. The mask mandate, the social distancing and the biggest the biggest and the most greatest thing that happened that save us from the virus is the vaccine, the vaccination was one of the biggest finding.

As we can see for this study different healthcare facilities and hospitals had varying policies, practices and programs to help keep their employees safe and protected during the pandemic. Additionally, healthcare workers have their own thought on how effective these policies, practices, and programs are.

Appendix D provides all the suggestions healthcare worker who participated in this study. Participants suggests there be a faster reaction from higher ups, follow the guidelines provided by the government and wear proper PPE. Other participants suggested that we need to communicate better on a globe level to prevent the spread of such viruses. Furthermore, participants suggested that there should be a plan set in place by the government before a virus starts to spread around the globe. If their suggestions are followed there is a possibility of avoiding the same devastation COVID-19 cause in the future.

Discussion

This section completes the findings in this chapter, including Healthcare Workers Challenges and Interpersonal Conflict, and Novel Policies, Practices, and Programs. This study brings out discussions on the mental health of healthcare professionals, how policies, practices and programs were implemented to assist healthcare workers and how the public can be more prepared in the future for other health scare like the COVID-19 pandemic.

Healthcare Workers Challenges and Interpersonal Conflict

Healthcare workers faced various mental challenges when working during the pandemic. They described feeling stressful, fearful, burnt out and overwhelmed due to the unpredicted situation they were put in. Block and Vindrola-Padros (2021) found in their study that healthcare workers were fearful they would become infected with the virus and bring it home to their three adolescent kids. Participant 3 who was going home to young kids after their shift revealed what going home was like after they finished their shift at the hospital. Participants explained that they encountered challenges they never had before, such as not having enough PPE or medical equipment, seeing freezer trucks where bodies of deceased patients were stored because the hospital morgues were overflowing with bodies of COVID-19 patients. Some participant revealed that their workers quit or retired because of the amount of psychological, physical, and emotional turmoil work during the pandemic took on their mental health. After working the height of the pandemic four out of twenty-one of participants stated they quit their job and began seeking employment elsewhere or they went back to school to further their education. They cited this was due to the amount of death they were seeing and the vast number of patients that were enter the healthcare facilities. Correspondingly, the WHO (2021a) confirmed that healthcare workers had a substantial amount of burden enlisted on them during the COVID-19 pandemic and it has required healthcare workers to adjust to a drastically greater number of patients and lengthier shifts for a prolonged period. The WHO (2021a, p. 2) suggested that this will cause “exhaustion, burnout, physical and mental stress” similar to what participants in this study spoke up about.

Novel Policies, Practices, and Programs

There were many changes taking place very quickly at the beginning of the COVID-19 pandemic therefore, healthcare workers had to adapt very quickly to the changes happening around them. They had to adapt to the new policies where they had to wear proper PPE consisting of masks, gloves, gowns, and face shields. Miyamoto (2020) stated that the world needs healthcare workers to take action during the pandemic, although they are fighting to remain strong in an environment where there is a shortage of PPE and of access to rapid testing for COVID-19. This was rather difficult to do as many places were facing a shortage in PPE thus healthcare workers had to adapt and reuse PPE that they would usually throw out after every patient they see, not after a day or a week. Some healthcare workers used garbage bags instead of the proper gown, clothe masks instead of N-95 masks and worked without the appropriate gloves and face shield. Not all healthcare workers were provided with support groups or counseling by their place of employment. They had to take necessary precaution when going into work such as taking a survey which ask if they have had any COVID-19 related symptoms. Healthcare workers also had to get tested for the virus frequently throughout the month. Likewise, staff screening and testing, staff illness procedures and safe return-to-work polices were implemented as suggested by WHO (2020a).

The researcher asked each participant what should be the first step we as a global community take so that we are better prepared for the next pandemic? They provide varying answers to the question, but some similar answers include communicating with other countries and have a plan put in place before and other virus arrives. Some said the country needed better leadership and a substantial amount of PPE. Other healthcare workers said the United States needed to lockdown immediately and stop all air travel as soon as they knew the virus was spreading. Healthcare professionals also felt that the public needed to be better educated on the situation and follow the prohibitions the WHO and the CDC was recommending. Additionally, some participant believes the public needs to be more empathetic to their community and have more trust in their healthcare workers.

In the sections above, Healthcare Workers Challenges and Interpersonal Conflict and Novel Policies, Practices, and Programs the U-Curve adaptation process was used to analyze the findings in each section. The questions that were asked by the researcher were based on each

stage of the adaptation U-curve. There were questions based on the Honeymoon stage, the crisis stage, the adjustment stage, the adaptation stage. At the beginning of pandemic some healthcare workers were faced with uncertainty, and they then went into a crisis phase where there was not an adequate amount of PPE and leadership. Then healthcare workers had to tackle the crisis in the adjustment phase where they had to adjust to new rules and regulations the government and healthcare facilities implemented. In the adaptation phase healthcare workers reached some sort of mastery where they were well adapted to the new situation, they had come face to face with at the beginning of the pandemic.

CHAPTER V CONCLUSION & SUGESTIONS

This chapter is comprised of four segments, which includes the conclusion, implications, limitations, and suggestions. The researcher will conclude with a brief synopsis, main findings, and then theoretical contribution. Next, implications are described at both an individual and organization level. Lastly, suggestions for future studies will bring this chapter to a close.

Conclusion

This study aims to understand and for readers to become aware of the conflicts and challenges healthcare workers encounters working during the height of the COVID-19 pandemic in the United States. Literature concerning COVID-19, cultural adjustment model (culture shock U-curve) and healthcare professionals was used as the foundation of this research. The interviews were coded, categorized, and finalized in to three segments in order to answer the research questions stated Chapter 1. The three segments include psychological adjustment, strategy adjustment and suggestions from healthcare workers. The cultural adjustment model (culture shock U-curve) is the foundation of this study, and it was adapted to analyze the adaptation process of healthcare workers who worked in the United States during the beginning of the pandemic.

Main Findings

Challenges and interpersonal conflict. During the COVID-19 pandemic, healthcare workers faced significant challenges such as feelings of being overwhelmed, stressed, fearful and burnout. In fact, past research has revealed that epidemics, like COVID-19 can trigger severe and unpredictable psychological effects on individuals. For example, individuals can develop a fear of becoming ill or dying, intense worrying, anxiety, or feelings of vulnerability (Spoorthy, Pratapa, & Mahant, 2020). Another study found that a variety of factors were linked with mental stresses healthcare workers experienced. The research suggested those who worked in regions with a high prevalence of the virus were linked to greater stress and psychological effects (Vizheh et al.,2020).

Based on the healthcare workers interviewed in this study and pervious research, we can assume that while working during the pandemic they were faced with uncertainty, stress, and

fear. Healthcare professionals were fearful of spreading the virus to their loved ones, they were stressed out about the overflow of patients, and they were met with uncertainty as both hospitals and the government were unfamiliar with the virus. Due to hesitation and the vagueness of the virus numerous facilities were slow to react causing delays, confusion, lack of PPE and medical equipment.

Novel policies, practices, and programs. This study found that there was a slight divide between healthcare workers as some found the policies, practices to be helpful there were also some did not think they were effective. Many participants felt the government was too slow when responding to the outbreak of the virus in the United States causing the virus to spread more and infect millions of people in the country. Healthcare facilities and the government were not prepared for the huge number of patients who will be going into hospitals to seek help. They were not prepared for the amount of healthcare work who would contract the virus and have to quarantine. They were not prepared for how this pandemic would affect the lives of healthcare workers.

Practical Implications

If there was reliable leadership by the United States government during the beginning of the COVID-19 pandemic maybe healthcare professionals would have been more prepared to take on the virus. Additionally, if there was profound leadership from the start, healthcare workers would not have to deal with so many challenges and their well-being would not be so deeply impacted. Healthcare workers were met with a variety of challenges during the course of the pandemic; therefore, this paper provides references to future healthcare professionals, healthcare facilities, and the United States government. Moreover, this research helps provide a credible view into the challenges healthcare professionals come across. This research gives firsthand suggestions for healthcare workers across the United States therefore, the United States government and health care facilities can take into account what healthcare workers have suggested for future pandemics.

If the United States government took into account, the suggestion from the healthcare workers they could be better prepared for another outbreak. Moreover, the government and healthcare facilities could work together to implement the best possible solution for the safety of

workers and patients. Additional training could be given to healthcare workers and better support programs could be made extensively available to those who need it. If healthcare workers are treated better and supported well by the government in the United States then they could avoid situations like a shortage of staff, lack of PPE and overall improved working conditions.

Theoretical Implications

The researcher chose to use the U-curve theory for this study because the United States was in a state of crisis when the virus began to spread rapidly throughout the country. Moreover, before the nation was in a state of crisis they were in a state of denial and repudiation as the country did not want to admit how serious the virus could become, thus the researcher referred to this as the honeymoon phase. During the adjustment phase the healthcare workers had to grow accustomed to new policies, practices, and programs. Furthermore, healthcare workers had to adjust to longer working hours with less staff, a lack of PPE and the interpersonal conflicts that comes with the job. During the adaptation phase this is where healthcare workers have become accustomed to their new working environment. The researcher believes using the U-curve model in this study is justified for the above reasons.

Limitations

This study was conducted on American healthcare professionals; therefore, external factors such as a country's policies, laws, customs, and employee practices could affect results of this study. Additionally, it is uncertain what other healthcare workers experienced. There was only 21 was participants who contributed in this thus it is an insufficient and small sample size. Ones well-being can affect how they respond to the situation they are confronted with. Moreover, an individual's personality and character can affect the way they respond to each question. The way each participant was recruited (convenience sampling and snowball sampling) into the study may have a defining factor as to how sincere and passionate they are when speaking about their experience. For example, some participants may be reluctant to share very personal details while other may be more forward. Lastly, this study has participants from several different states in the United States thus each participant may have vastly different experiences.

Suggestions for Future Studies

Future work could concentrate on a more international level, gaining a wide variety of perspectives and assessments from healthcare professionals around the world. Studies can focus more on the countries that had proper protocol and reacted quickly to the virus such as China South Korea, and Taiwan. Researchers could take a closer look into how affective their strategies were and if they still are effective in present day. This paper focuses on the challenges healthcare workers encountered at the beginning of the pandemic, so future studies could examine how healthcare professionals have progressed since the start of the pandemic. Future study can focus on a specific field in the healthcare industry, for example, EMTs, cleaning staff, emergency staff or primary care physicians. Future researchers can consider doing a study with the W-curve of adaptation as there will be more pandemics and the curve will continue.

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APPENDIX A: INTERVIEW QUESTIONS

Honeymoon Phase:

1. When you first started hearing about COVID-19, what were your initial feelings (worried, unconcerned, etc.)? Did that initial impression change as time passed – if so, what triggered the change?
2. How do you think the government (state or federal) handled the situation at the beginning of the pandemic?

Crisis Phase:

1. What policies or programs has your place of employment made for the safety of employees? Did you find them helpful?
2. If one of your co-workers is infected with COVID-19, what steps will be taken to keep the rest of the employees safe?
3. What is the biggest way your home and work life has changed during this pandemic?

Adjustment Phase:

1. What did your typical day at work look like and did you think the virus would impact your life so much?
2. Were there support programs made available to you and your co-workers?
3. What benefits were you provided with to help you get through COVID-19?

Adaption Phase:

1. What have been some of the most difficult part of this experience and what is the biggest way your life has changed during the pandemic?
2. Do think the polices that were established were effective, why, or why not?
3. In your opinion, after this pandemic come to an end, however long that may be, what should be the first step we as a global community take so that we are better prepared for the next pandemic?

APPENDIX B: CONSENT FORM

Participant Consent Form

Dear Sir/Madam:

You are being asked to participate in a research study titled "Adaptation Process of U.S Healthcare Workers During COVID19: Polices, Practices, and Programs". This study is being conducted by a student from the Graduate Institute of International Human Resource Development at National Taiwan Normal University. The researcher will describe this study to you and answer any of your questions. This form provides you with information about the research.

The purpose of this research is to (a) assess how healthcare professionals adapted to the rise of COVID-19, (b) the interpersonal struggles healthcare professionals confronted during their time working with COVID-19 patients and (c) to increase awareness of how polices, practices and programs were implemented to assist healthcare workers during the pandemic. Carefully read the following information and confirm that you understand the information regarding this research study.

- The interview will be approximately 45 minutes and conducted through an online platform.
- The interview will be recorded, and the researcher will be activity taking notes.
- The data will be accessible only to the researcher and related personnel (committee members and advisor).
- Any data collected will be used for research analysis.
- Participants personal information will be kept confidential, and they will be assigned a pseudonym to protect their identity.

I have read and fully understand the above information. I hereby consent to take part in this study.

Participant's Signature	Printed Name	Date

I hereby confirm that I have explained this document to the participant prior to requesting him/her to sign.

Researcher's Signature	Printed Name	Date

APPENDIX C: PERSONAL INFORMATION

PERSONAL INFORMATION	
NAME:	
AGE:	**GENDER:**
JOB TITLE:	
NUMBER OF YEARS WORKING AS A HEALTHCARE PROFESSIONAL:	
AFFILIATED INSTITUTION	

APPENDIX D: SUGGESTIONS FROM HEALTHCARE WORKERS

Participants	Suggestion
Participant 1	I think a lot of it will again just be like in the US trying to build up trust in the medical system and make sure we're having discussions ongoing about the COVID vaccine, flu vaccines, etc. So that we're better prepared.
Participant 2	I think countries should all team together rather. I think that all the countries need to work together as a team in order to share health care information.
Participant 3	I think like having a lock down like immediately that would be effective.
Participant 4	We still need to raise awareness and education because, of course there are some people out there who still believe COVID is not real.
Participant 5	The powers that be like The WHO and CDC, should have a special unit of scientists.
Participant 6	Just take all the precautions that's out there, hand washing, keep your distance. If there is vaccination, take your vaccine.
Participant 7	That's working more collaboratively, countries working collaboratively because, there's so much diversity. And I think countries working collaboratively will be one of the best things for us to tackle a pandemic as a whole global community working collaboratively and I think we should follow closely, the science.
Participant 8	Education first and foremost to pretty much everybody.
Participant 9	People should, be more cautious of their hygiene, for example, hand washing that's one of the most important.
Participant 10	I feel like we should not go against the government sometimes.They try their best.
Participant 11	I think closing borders and stopping nonessential travel was first. It should have been done sooner. Because that's why New York was a hot spot It has two major international airports. We stood no chance. Implementing mask mandates sooner. and supplying communities and people, with the support that they needed to survive.
Participant 12	If they saw something becoming an issue somewhere else, I would. Say we should start enforcing certain things like policies or whatever. From now, just to prevent it from becoming an issue. Quick to react to the COVID pandemic in the

	beginning, it wouldn't have been a problem. Well, it would have been a problem, but it would have been a big of an issue.
Participant 13	I think the research that they've been doing and you know the ongoing research should definitely be put into place. We should follow the basic foundation of science. I mean for influenza and other viral illnesses. You know, there's a quarantine period.
Participant 14	I think equipment that is needed for the people who would be taking care in case of a pandemic. They should be well prepared. The higher power should have supplied the hospital if they don't have enough equipment. We had a pandemic here that was killing thousands and thousands of people and you couldn't supply the people or the healthcare worker with enough PPE or the proper PPE, I should say. You know when you see nurses wearing garbage bag, that's a disgrace to the country. It's a disgrace to the hospital facility, you know, to get to that point.
Participant 15	So I feel like anybody who's lived through the pandemic will realize that you can live through a pandemic and come out on the other side. And so it'll be easier the second time around if it happens. And so I think that is because countries and communities have now established they're sort of pandemic protocols or procedures.
Participant 16	There seems to be a general lack of consideration for each other as as a humanity, and that's probably not something that's gonna change overnight, but it would be nice if that would be the first thing you know if you know you're sick, you're staying home, you're not lying about it and going out and exposing other people, because I'm sure we will have another pandemic at some point. But also just, being a little more proactive from the beginning and making sure that, people who are at high risk have the proper protection.
Participant 17	I think having the the important stakeholders at the table representing nursing or other people because you know some of these policies coming down.
Participant 18	I just feel like. As long as we are prepared, for example like prepare for like enough rooms. Enough units before the cases got high. Then they would be well, well prepared.
Participant 19	I think we should work on expanding hospitals. When we saw those videos of all the bodies piling up and nowhere to put it, and they were like mass graves, it literally made me think of the Holocaust. But I feel like we should be better prepared for that specifically. And when it comes to like protection. We need a lot more PPE, we need a lot more masks, a lot more supplies. I feel like we need a lot more supply on hand. We need to find a better way just in case if this would happen again. And also support systems, you talked about a lot of places don't really provide that support for you and your family.

Participant 20	The best way is to just identify the source, where it come from. And just, if, if it's a country, just keep all flights, all traveling away, like just one country could get the lockdown instead of like spread it by traveling. It's like an isolation, no traveling, no, in and out, you know, try to get the source isolated. I think that would help stop the spreading.
Participant 21	I think that people should be open to medical advice and leaders should be more informed before they decide to say something. And kind of treat it as like worst case scenario in the beginning rather than maybe, that it's nothing. So, then it kind of prevents it from, hopefully prevents it from getting to a worse case.