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The uneven consequences of rapid organizational change: COVID-19 and healthcare workers

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ABSTRACT

We examine the consequences of rapid organizational change on high and low-status healthcare workers (HCWs) during the COVID-19 pandemic. Drawing on 25 interviews, we found that rapid change can create a sense of social disorder by exacerbating the uncertainty brought on by the pandemic, crystallizing the lack of training to deal with crisis, and upending taken-for-granted roles and responsibilities in health infrastructures. Our work contributes to scholarship at the intersection of organizations, professions, and social studies of medicine. First, we show how organizations that must respond with rapidity, such as during a crisis, sets up workers for failure. Second, hastily made decisions can have monumental consequences in the work lives of HCWs, but with differences based on status. All HCWs had trouble with the rearrangement of tasks and roles. Low status HCWs were more likely to feel the strain of the lack of resources and direct contact with COVID-19 patients. High status HCWs were more likely to experience their autonomy undermined – in the organization and content of their work. In these contexts of rapid change, all HCWs experienced social disorder and a sense of inevitable failure, which obscured how organizations have perpetuated inequalities between high and low status workers.

Since 2020, healthcare workers (HCWs) have labored in stressful workplace environments because of the COVID-19 pandemic. At the beginning of the pandemic, news reports documented the cascading crises in health delivery because of inadequate equipment for patients, HCWs facing longer work hours, rampant misinformation about the pandemic, and murky knowledge about the symptomology and treatment trajectory for working with COVID-19 patients (Brooks et al., 2020; Masiiero et al., 2020; Tutić et al., 2022). Health organizations were compelled to respond quickly to the pandemic, rearranging the workflow of the hospital, shifting hospital floors from elective to intensive care units (ICUs), and tasking HCWs with new roles and responsibilities. The context of the COVID-19 pandemic thus offers a unique vantage point to examine the consequences of rapid organizational change in the daily work lives of HCWs.

In recent decades, health infrastructures have undergone major restructuring in healthcare and care delivery, occupational classification schemas, and increased specialization in response to broader political, economic, and cultural forces (Adams, 2010; Pescosolido and Boyer, 2001; Trotter, 2015; Underman, 2020). But these kinds of massive structural changes have rolled out over a lengthy amount of time, such as the transition between the 1950s and 1990s from the doctor knows best model of paternalistic medicine to patient-centered care (McKinlay and Marceau, 2008) or the rise of a new class of “hybrid professionals” who operate in a liminal space of not quite practitioner and not quite upper administrator (Waring, 2014) but with some tasks and expectations drawn from both occupational roles in healthcare. The growing body of work at the intersection of organizations, professions, and medicine documenting slow but monumental change over time consistently demonstrates how change in organizational structures complicates taken-for-granted assumptions that shape the workplace experiences of HCWs as they take on new job responsibilities and are called upon to demonstrate new knowledge competencies (Cain et al., 2021; Timmermans and Angell, 2001; Trotter, 2020) that might conflict with their socialization into their profession. HCWs confronting change must also navigate new hierarchies in health organizations (Wingfield, 2019) which often translates to the need for HCWs to renegotiate autonomy over knowledge and the division of labor (Coburn et al., 1997; Waring, 2014). Moreover, change can create uncertainty in one’s work

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role, or the expectations of what one should do in their job, and lead to jurisdictional disputes (Abbott, 1988; Seim, 2020; Shuster, 2016; Whooley, 2012) between different specialists as well as between high (e.g., surgeons, physicians) and low (e.g., medical technicians and nurses) status HCWs (Adams, 2010).

Drawing on 25 in-depth interviews with HCWs between 2020 and 2021, we leverage the context of the COVID-19 pandemic and ask: What are the consequences of rapid organizational change in the work lives of HCWs? And how does one’s job status shape their experiences with rapid change? We found that in the first year of the pandemic, HCWs experienced their workplace environments upended. Rapid organizational change created a sense of social disorder among HCWs as they were confronted with massive shifts in the organization of day-to-day care, lack of training, and being called upon to engage in work tasks and roles they felt ill-prepared to do.

Our findings align with previous findings from scholars of professions and socialization who have demonstrated how actors may experience a sense of disorder amidst change, especially if they are not adequately socialized into the new roles, values and norms (Parsons, 1951; Gubin et al., 2021) of an organization. We extend previous scholarship by using the case of rapid organizational change to offer two contributions to existing scholarship at the intersection of organizations, professions, and social studies of medicine. First, we show how organizations that must respond with rapidity, such as during a crisis, sets up workers for failure, especially in acclimating into their newly assigned roles. Second, hastily made decisions can have monumental consequences in the work lives of HCWs. All HCWs had trouble with the rearrangement of tasks and roles but there were notable differences between HCWs in high and low status positions. Low status HCWs were more often called upon to engage in patient care they felt under-trained and ill-equipped to do. They also had more direct patient contact and longer work hours, leading to workplace strain. High status HCWs more often experienced their professional autonomy undermined – in both the organization of their work such as scheduling, and the content of their work such as making decisions about patient care. In these contexts of rapid change, all HCWs experienced social disorder and a sense of inevitable failure because they had few tools to draw upon to help them sort through their new work responsibilities, which obscured how their organizations have perpetuated workplace inequalities between high and low status workers.

1. Background

While there have been epidemics in recent years, such as the H1N1 influenza outbreak in 2009 and the Ebola outbreak in 2014, the far-reaching nature of COVID-19 has translated to few schemas to help people make sense of the implications of the pandemic to individual and collective social life (Masiero et al., 2020). Many taken-for-granted infrastructures such as global supply chains (Sharma et al., 2020) and public transportation (Tirachini and Caits, 2020) faced difficulty adapting to the pandemic. Healthcare organizations were not immune to this upheaval, and subsequent change, falls on them as they have less power to influence the experience of work. Meanwhile, lower status actors within health organizations, HCWs must still work together within health decision-making during organizational and professional role restructuring (Vanheuvelen and Grace, 2020; Cain et al., 2021). For example, Cain et al. (2021) studied the creation of a new occupational designation, “care guides,” and found that higher status actors responded with antagonism because they thought their professional legitimacy was undermined by lower status workers in these newly created roles. Meanwhile, lower status actors within health organizations may find that the responsibility to resolve organizational upheaval, and subsequent change, falls on them as they have less power to refuse to engage in this kind of labor (see also Trotter, 2020). Despite the overwhelming resistance to new roles across the occupational ladder within health organizations, HCWs must still work together within health decision-making during organizational and professional role restructuring (Vanhoeuvelen and Grace, 2020; Cain et al., 2021).

In light of previous scholarship that has documented the complex challenges that arise during and in the wake of organizational change, the COVID-19 pandemic offers a unique opportunity to examine the consequences of rapid organizational change. In what follows, we document the uneven consequences of organizational change in the work lives of HCWs, based on status hierarchies. We found that lower status HCWs took on a significant burden of role restructuring mandated from upper-level administrators in response to the pandemic. Meanwhile, higher status HCWs experienced threats to their autonomy. Yet, all HCWs experienced social disorder at the taken-for-granted assumptions about
who should do what work, when they should do it, and how to accomplish such tasks with limited resources and little socialization into the newly assigned roles and responsibilities during the pandemic became upended.

2. Data and methods

[Author name] conducted 25 interviews with HCWs from across an upper Midwestern US state between 2020 and 2021. HCWs came from a variety of specialties such as pulmonology, sports medicine, or pediatrics in primary care (44%) and ICU/Emergency (56%) medicine. The types of jobs that interviewees held also varied, including nurses (44%), medical technicians (8%), physicians (28%), and surgeons (20%). Most interviewees worked in hospitals (80%) or primary care clinics (15%). Some had split time allocation between hospital units and outpatient clinic rotations in sports medicine, obstetrics, cancer care, or worked in elder care facilities (20%). While we have variation in specialization, our sample was limited in gender diversity. 75% of interviewees were cisgender women, many of whom were in low status positions within healthcare (e.g., nurses compared to surgeons). This is unsurprising, given the persistence of gendered stratification in health organizations (Acker, 1999; Reskin and Roos, 1999) and across specialties (Adams, 2010; Bell et al., 2014).

To identify interviewees, [Author name] used a purposive snowball sampling method that began in his networks that originated from volunteering in various healthcare clinics and as a pre-med student. After completing an interview, [Author name] asked if interviewees would send the call for interviews to their personal and professional contacts who also worked in the upper Midwest. As others have suggested, the snowball sampling method has limitations reaching people beyond the networks of origin (Gerson and Damaske, 2020). To buffer the limitations of this sampling method, [Author name] made additional contacts by contacting professors, community members, lab mentors, and anyone else who might be connected to HCWs working in healthcare in the upper Midwestern state during the pandemic.

Once a HCW said they were interested in participating in the study, we sent an informed consent memo to the interviewee two weeks ahead of the interview. At the beginning of the scheduled interview time, [Author name] reviewed a consent memo with participants and obtained verbal consent to proceed. No respondents opted out of the study following the consent protocol. All names and identifying information, except the area of specialization and job position, have been changed to protect respondent’s confidentiality. The Institutional Review Board at [University name] approved this research under protocol [number].

Interviews were conducted primarily on the phone because of in-person research restrictions. All interviews were recorded and transcribed verbatim for data analysis purposes.

The interviews were semi-structured around three broad categories of questions related to: 1) the workplace contexts of HCWs; 2) new practices and procedures instituted since the onset of COVID-19; and 3) HCWs’ personal and professional experiences with the pandemic. When describing their experiences, interviewees were asked to share specific stories or examples but not information about patients or other confidential and protected health information.

We analyzed the interview transcripts using a team-based inductive approach. First, we began by coding the transcripts separately to see how closely aligned our codes were in the first round of open coding (Charmaz, 2008). The words we used to name a particular code were slightly different (i.e., one person’s “challenge” was the other’s “hardship” code) but we had a relatively high rate of inter-coding reliability (80%). We discussed and resolved the remaining discrepancies, re-coded the data to compile the major themes related to organizational change and personal and professional challenges associated with the pandemic, and cross-verified our coding schema. This resulted in a high rate of inter-coder reliability (94%).

Before doing a final stage of data coding and analysis, we paused to review the existing scholarship on health organizations, the effects of public health crises on healthcare workers, and the social consequences of job role restructuring. It was during this phase that we recognized the importance of rapid organizational change as contextualizing what was happening on the ground for HCWs and how it led to a sense of social disorder. Thus, in the last stage of data coding and analysis, we assessed the “challenges” code and refined it to code for moments in the interviews when HCWs described feeling unequipped to carry out their work tasks, and why. We also re-analyzed the interviews in the final stage for differences between high and low status HCWs.

3. Results

Confronting a global pandemic, HCWs have found their work lives upended. While emergent scholarship (e.g., McGarry et al., 2020; Nyanarutu et al., 2020; Yarrow and Pagan, 2021) has begun to examine the mental and physical effects of the pandemic on HCWs and patients, here we first analyze how the context of COVID-19 necessitated rapid organizational change in practices and protocols about resources such as PPE, work load distributions, and job responsibilities. Then, we turn to how HCWs experienced social disorder because of the challenges they encountered in their new work roles and responsibilities including who should be primarily responsible for working with COVID-19 patients, lack of training, and being called upon to engage in tasks they felt ill-prepared to do. Throughout, we document the similarities and differences that high and low status HCWs experienced in their work lives during the first year of the COVID-19 pandemic.

3.1. Rapid organizational change during crisis

HCWs interviewed for this study described how many of the practices and protocols that were instituted in responses to the pandemic came from upper-level administrators with little input from HCWs. They were hesitant to critique hospital administrators for initiating such changes, even when the changes were misaligned with the workflow of the hospital or typical job responsibilities. However, the challenges HCWs experienced during the early months of the pandemic were monumental, especially when it came to the lack of personal protection equipment (PPE) which created concerns among HCWs about their personal safety, and that of their friends and family. Low status HCWs more readily expressed frustration with what they perceived as a lack of responsiveness to the needs of patients, their colleagues, and themselves, by hospital administrators. As Shirley, an RN who worked on an intensive care unit (ICU) floor shared, “I had co-workers contact administrators to be like ‘you know this is unsafe for us to not have proper PPE.’ And the response has been either ‘good luck’ or just did not respond at all. It’s very frustrating.” Shirley and other nurses found such attitudes from administrators exasperating.

For many HCWs, the scarcity of PPE was symbolic of a larger problem in the protocols rolled out by upper-level administrators; they felt like they were required to go into dangerous work situations without proper resources which also created unease among HCWs such as Anna, an RN, who rhetorically asked, “What are we supposed to do? I mean, literally, how do I do my job?” Combined with what some HCWs felt was a lack of empathy by administrators, the frustration in their voices was palpable when asked about how administrators attempted to ameliorate their concerns. Carla an RN who worked on a progressive care unit (patients assigned to a progressive care unit are those whose condition should be primarily responsible for working with COVID-19 patients) but then conflicted with HCWs who perceived the conditions of working with
infectious patients, especially in the early months of the pandemic, combined with a lack of PPE for workers to use to protect themselves while on the job, as unequivocally an extenuating circumstance. Richard, an emergency medicine surgeon was quick to point out how, “It’s not even that you have to work in these situations that is the concern. But when you’re not given the equipment to work in the situation [of a pandemic] that was causing a lot of stress.”

As ICUs became inundated with COVID-19 patients, hospital administrators rolled out new protocols that, “loosened regulations because the PPE was still on shortage or back order,” as Brent, an RN, noted. Mike, an ICU physician echoed Brent’s observation by sharing that, “We’re doing sparing techniques where we are wearing a mask until they’re basically soiled. Or we’re keeping it for more than a shift when usually it’s supposed to be just a one-time use.” Strained by the lack of resources, protocols that increasingly put HCWs at risk, and perceived attitudes of administrators to just “buck up and get the work done” as one nurse put it, HCWs began to wonder, “Do they [administrators] even care about us? It just seems like this all moved so quickly and the bottom line was more important than the staff and patients,” as Evan, an RN, reflected.

Rapid change in the hospital infrastructure also translated to many HCWs not feeling on top of their work. HCWs noted how their patient load, combined with newly mandated tasks, felt like a burden to accomplish. Only four (16%) HCWs interviewed for this study said that in the early months of the pandemic, their hospitals had access to proper PPE. But even among this small portion of HCWs, they found that the mandate to change PPE with every patient was itself, difficult. Mary, a medical technician stated, “We have had to up our PPE. That was a unique challenge and stressfull time for me. I was constantly on the go. Having to gown up and gown down for 20 or so rooms. It puts you behind and you start to scramble to pick up your work.”

Scheduling changes belaguered the work lives of many HCWs, which contributed to workers feeling a sense of “dread every time I got in the car to go to work,” as Olivia, an RN, said. Much of the scheduling on hospital units shifted based on patient census, which is typically defined as the number of patients a unit admits and provides care for. Ana, an RN, reflected, “So obviously right now with the whole Coronavirus thing we’re on call more often because our census is completely out of whack [pause] it’s just a weird situation with our census.” Ana had worked on the psychiatric care unit before the pandemic but was reassigned to the progressive care floor. With fewer patients seeking certain types of care, such as psychiatric services, and administrators dialing down the patient census on units deemed medically unnecessary, HCWs noted they had little say in their work assignments, which included what tasks they were assigned, when they were supposed to report to work, and how long they were asked to stay. This was notable especially among lower status HCWs. Maggie, an RN, used militarized language to describe her workload, “I am like deployable two out of the five days of the week right now.”

In contrast to many low status HCWs who felt like they had little control over their patient load or time, some HCWs in higher status positions found that the demands on their schedules decreased during the pandemic. Sara, a nurse practitioner in a cardio unit said, “We are more or less discharging everyone. Our patient census has been quite low, at least in our cardiology group. Um, so we’ve been down staffing, and we’ve been at home and on call. So it’s actually been quite nice.” Sara explained that part of the rationale for some HCWs to be on call instead of at the clinic was to limit their exposure to COVID-19 patients. Nonetheless, high status HCWs were not asked to manage quite the same burdens that low status HCWs did when it came to how many patients they were assigned on any given shift.

Despite some high status HCWs experiencing lighter workloads or hours compared to those in lower status positions, many high status HCWs interviewed for this study directly expressed their concerns about upper-level administrators changing practices or protocols that resulted in a loss of autonomy. For example, changes to workloads were perceived by high status HCWs as directives from “on top” as Peter, a surgeon, stated and then elaborated how, “this is not the way it is typically done. We [surgeons] usually have more say.” Similarly, Cary, an ER surgeon said:

Everybody’s kind of getting pulled into different areas than we are used to and it’s also that some of my colleagues don’t want to work in the ER or haven’t worked in the ER since residency. For them, they chose different areas like oncology or sports medicine. So being told to go to the ER [for work assignments] is really difficult and is angering a lot of people.

As Cary, Peter, and others suggested, high status workers are not used to being told what to do, especially when it conflicted with one’s professional status. Even as many of the high status HCWS recognized the urgency of needing more surgeons and physicians to rotate through the ICU or ER to help with the COVID-19 patient load, they expressed resentment about not having a say in their work assignments.

HCWs spoke at length about how implementing new practices was difficult to negotiate. Often, it was nurses who were tasked with these newly assigned responsibilities for direct patient care. Jill, a nurse typically assigned to an obstetric unit but had recently been reassigned to the ICU reflected, “We receive dozens of emails a day detailing new requirements and it is impossible to keep up.” With such expeditious change, Jill and other HCWs noted that some units may not be following the latest protocols from hospital administrators or recommendations from the CDC. This was, as many reflected, an unfortunate outcome of organizational restructuring and new responsibilities. As HCWs described, the rate at which the information was distributed was faster than they could accommodate into their workflow.

The work hours HCWs were asked to take on also became less routinized during the pandemic; further contributing to the difficulty many HCWs experienced amidst massive change to established practices and anticipating how their work lives were arranged. Emily, a surgeon who worked in emergency and sports medicine, shared that the changes to her work schedule made it difficult to know when she would be at work and when she had time at home. Before the COVID-19 pandemic unfolded Emily had reduced her hours in the ER and increased them in the sports medicine clinic to spend time with her young children. With the pandemic, she noted how, “not only did my work schedule revert back to a high caseload in the ER, but I was working even more hours at the hospital than previously.”

Other HCWs said that administrators would send notice that they should anticipate longer hours once a surge hit their local areas, which created ambiguity in how to plan for time off or the future. Shirley noted, “It has been challenging to know what to expect. We haven’t had any changes yet, but they said as soon as we hit our surge, we’re gonna have to pick up an additional 12 h every two weeks.” Anticipating a surge also meant that nurses found that administrators were, “changing our staffing these next few weeks with COVID and anticipating a possible surge. I’m on call a few more times during the day these next few weeks,” Ben, a nurse practitioner, said with some irritation before noting that, “It’s the [pause] waiting. Waiting and knowing it’s coming but not when or what to do about it.” As HCWs suggested, they appreciated the notices from administrators who were receiving real-time data on potential COVID surges, but still, how that information translated in their daily work lives created a sense of losing control over their schedules and ability to plan for the future.

The rapid organizational change necessitated by the early months of the COVID-19 pandemic presented difficult situations for healthcare workers. While many HCWs appreciated the need to be nimble during a crisis, they also offered insight into how quickly rolled out change created unease. Not being able to anticipate work life and the sense that administrators turned away from requests to be better supported in managing patients during the pandemic, HCWs described untenable workplace environments. Moreover, such rapid change translated to losing autonomy over one’s schedule, work assignments, and
responsibilities for patient care. We turn now to how the context of rapid organizational change amplified the social disorder that HCWs experienced.

3.2. Experiencing social disorder

HCWs interviewed for this study unanimously agreed that they felt unprepared for working in healthcare during a pandemic. As previously suggested, socialization into a profession creates order by instituting norms, values, and routines within the workplace (Parsons, 1951; Guhin et al., 2021). Yet COVID-19 brought about such rapid change and newly assigned roles, that taken-for-granted assumptions about work life were upended which translated to HCWs experiencing social disorder. Uncertainty magnified the social disorder; HCWs were unsure if or when they would receive basic support and guidance from upper-level administrators. They also worried about their own safety. And, because of the accumulation of changes to the organization of healthcare instituted during the pandemic, what roles and responsibilities they had to their patients and themselves became murky.

Central to the social disorder experienced by HCWs was feeling like they had inadequate training to work with acute COVID patients, especially those (re)assigned to the intensive care units created in the early months of the pandemic. Nurses readily described how they felt unprepared, and sometimes afraid, to work with COVID patients. As others (Trotter, 2015, 2020; Wingfield, 2019) have noted, nurses have more direct contact with patients compared to physicians and—until recently—were not trained to only specialize in one area of the body. Therefore, nurses were perceived by hospital administrators to have portable knowledge and skills and more easily moved to different units as patient census changed during the pandemic. As Melissa, a nurse reflected, “We got notified that we have to become ICU nurses. They gave us two days of training that included 6 h in class, a couple hours of a shadow, and one full 12-h shift on the floor. And now we’re supposed to take ICU patients.” Melissa also found that her floor was quickly re-classified as an ICU floor and that all HCWs were expected to be ready for these new tasks. These changes added pressure on HCWs working with COVID-19 patients. Chelsea, also a nurse, echoed Melissa by saying:

Part of our training—and I know a lot of the country’s going through this—is we have to learn how to intubate, insert arterial lines, prescribe vasopressors and take care of patients in two days of training. That’s typically an ICU process that takes three to six months of training.

Later in the interview, Chelsea poignantly remarked, “You don’t go from flying a helicopter to a commercial jet with thousands of people on it in two days. You know, you’ve got to take baby steps. It’s a huge ask of responsibility that, frankly, no one signed up for.” In response, many HCWs insinuated that they felt like they were being set up for failure because they did not have adequate training and were unable to offer quality care.

One of the more immediate problems with a paucity of training was that HCWs were unsure if they would be able to properly take care of patients. Part of this concern was pragmatic, as Brenda, an ICU nurse shared that, “ICU patients are very critically unstable, and no one can be in six rooms at once. So, they, it’s just been a lot of being thrown into things because you have to. I know every floor is dealing with this.” As Brenda suggested, the demands on HCWs in their newly assigned responsibilities challenged their sense of professional expertise in being able to offer COVID-19 patients the proper care. Sabrina shared these concerns:

I’m not equipped to be an ICU nurse, and this isn’t where my training is, and one twelve-hour shift is not gonna be enough for me to adequately handle these people. And when we are seeing people who are coming in and declining as fast as they are, like when this gets really bad, you know people are gonna die. [pause] I’m not equipped or cut out for this. And I’m terrified that someone’s gonna die because you’re not used to this level of acuity of patients.

Sabrina’s fear about being inadequately prepared to work with patients in an ICU was unambiguous. As she suggested, the prospect of being culpable in the death of a patient because of a lack of training was terrifying for her. There was a delicate balance that Sabrina and other nurses we interviewed were trying to find. They understood that the pandemic called for unique responsibilities. But, at the same time, the rapidity of change combined with a lack of training created distress among HCWs.

While the lack of training was a concern more commonly cited among nurses and other low-status workers when discussing how disorder dominated their workplace environments because of new job responsibilities, physicians also felt the strain of working with patients that they felt ill-equipped to care for. As Madelaine, a primary care physician noted, “We had to do all of these things just by jumping into it. It’s like this sense of fear, like am I really going to have to take care of this sick of a patient with this little training? I’m in a constant state of fear and anxiety.” And, while Madelaine said that she didn’t want to sound insensitive, she also worried about:

... making a mistake and losing my license. I’m being asked to take care of these patients and I don’t have the proper training. Like if we do get a surge and I’m asked to take care of these patients and I don’t have proper training [pause]. You know, I don’t want to make a mistake and have this hurt my license.

Several of the high status HCWs interviewed for this study cited concerns about making a fatal mistake because of inadequate training and losing their licenses to practice medicine.

HCWs felt the strain of the pandemic as their responsibilities to patient care and professional norms began to conflict with each other. They were particularly concerned about the impact that inadequate training would have on patient care. As one Emergency Medicine physician noted, “It’s kind of impossible to figure out right now what to do and what is the best way to work with patients in this situation.” Many of the high status HCWs shared that they were not used to being asked to practice medicine outside of their specialization and it made them uncomfortable because of making medical errors. In contrast, and as previously mentioned, nurses were perceived by upper administrators as having more portable knowledge because of their generalist training. And, while nurses expressed concerns about making medical mistakes, they more frequently focused on the need for better training for these new assignments, and not such a reluctance to take on new responsibilities and patient care tasks as higher status workers.

Elsewhere in the hospital infrastructure, the workflow of health delivery was adjusted to prioritize COVID patients. An unintended consequence of this restructuring was that healthcare interventions deemed non-essential were cancelled or rescheduled to occur months out from the original appointment. Because of these cancellations, HCWs who previously worked on units deemed as non-essential found their units reassigned. Most of the HCWs we interviewed empathized with these changes. But many, especially high status HCWs, shared that they wanted more agency in the decisions being made. Emily, a sports medicine and ER doctor offered, “I was completely pulled out of the sports medicine clinic and was told, ‘All of your time’s going to be in the ER now.’ So now I’m on much more of that up and down schedule. Every week is a little bit different.”

Being pulled out of one’s usual work assignment or having significant schedule changes was common among the healthcare workers we interviewed. In the previous section we noted how scheduling changes were made in response to prepare for COVID-19 surges. Such massive fluctuations in one’s schedule and being reassigned responsibilities without much notice exacerbated the sense of social disorder experienced by HCWs. Samantha, a nurse on a progressive care unit, reflected:
So, our floor has been hit hard with Corona because we were a progressive unit and then all of a sudden, out of the blue, we’re told in a little email, “Hey you’re a Corona floor.” We were like, “What?!” And then two weeks later, we get another little email saying, “Hey you’re actually going to be learning how to take care of ICU patients in two days.”

Disconcerting for many HCWs was that they had little say in the structural rearrangements mandated from upper-level administrators. In the interview, Samantha’s tone was biting; sarcastically referring to the “little emails.” But Samantha and many of the HCWs were quick to assure [Author name] that for them, their resentment stemmed not from the fact that their floor was reassigned to operate as a COVID-19 floor, but not having much of a say in these matters at all.

We briefly note that not all HCWs felt resentment towards hospital administrators. Those most likely to have an empathetic stance were those in high status job roles. Justin, the lead occupational therapist in his department, reflected:

I guess when you become more of like a leader in healthcare and more the supervisor management type role definitely has its challenges. You know people are – especially in like a pandemic – that we’re in right now is that you’re trying to do what’s best for the patient and trying to adapt to our constant evolving world of health care.

Pandemic-related strain in the workplace has become, as Adam, a physician stated, “just part of the routine.”

As we demonstrated, the social disorder that HCWs experienced during the first year of the COVID-19 pandemic created new job demands and roles on all healthcare workers that they were unprepared and ill-equipped to accomplish. We anticipate that HCWs have become acclimated to the organizational change in practices and protocols implemented by administrators as COVID-19 has unfolded over the last several years. But in the first year of the pandemic, there was an unevenness to who was disaffected by rapid organizational change and the coinciding social disorder experienced because of such rapid change. In trying to mitigate social disorder in the hospital, lower status workers shouldered more of the burden of implementing protocols and practices and taking on direct patient care. While taking on more responsibility for direct patient care could be a status boost, from their perspective, it created more disorder as they felt disempowered to change their work life situations which fed into a sense of inevitable failure in offering quality patient care. In contrast, higher status workers—many of whom were also reassigned in their workloads and tasks—experienced social disorder around their autonomy, which they perceived as being undermined by administrators. In shuffling the burden (Seim, 2020) of direct patient contact to lower status workers, they could protect themselves, and their medical licenses, a little bit. Yet they too felt a sense of inevitable failure which was amplified by the uncertainty of when their work tasks and scheduling would return to how it was before the pandemic and feeling ill-equipped to work with COVID-19 patients in work units outside of their areas of specialization.

4. Conclusion

We examined how rapid organizational change has uneven consequences in the workplace for those affected by restructuring. We documented how HCWs feel their work lives are upended because of hastily made decisions. From inadequate training and tools to do their jobs, to new practices that render HCWs vulnerable to the risk of becoming infected with COVID-19 or unable to anticipate their futures, the rapid restructuring of healthcare organizations amplified social disorder experienced among HCWS working under extreme stress. As HCWs reflected throughout the interviews, new practices enacted during COVID-19 were a double-edged sword. On one hand, some of the practices afforded HCWs more flexibility in eschewing protocols such as not changing masks with each new patient encounter to preserve the PPE, given the shortages. But on the other hand, these same work-arounds to newly instituted practices put HCWs, and patients, in unsafe working conditions.

The rapidity of organizational change and who was expected to take on the burden of scheduling changes, longer hours, and patient loads often fell to lower status workers who already experienced less compensation, fewer resources, and heightened expectations to engage in labor that high status HCWs are not expected to do. As a result, the pandemic reflected and amplified existing inequities in health infrastructures. As other scholars (e.g., Trotter, 2020) have noted, nurses frequently experience the brunt of interpreting and implementing new policies, even in routinized care situations. Nurses interviewed for this study noted more frequently how they were asked to take on the medical care of patients and serve as organizational actors interpreting new protocols while rearranging the workflow of the hospital. As we suggest, health institutions have also created stressors for HCWs who had few resources available to them to carry out their new roles and responsibilities.

The COVID-19 pandemic affords numerous opportunities to examine not only the structural changes that impede healthcare delivery, but the downstream consequences in the everyday lives of social actors. Pandemics, by definition, disrupt social order (Strong, 1990) as they undermine routines in everyday life; creating unfamiliar situations that people have few tools to draw upon to help them rebalance a sense of order (Goffman, 1967). We extended the existing scholarship by showing the downstream consequences of rapid organizational change in exacerbating social disorder during a time of crisis. HCWs are professionalized to be competent, knowledgeable, and experts (Shuster, 2021) in the provision of healthcare. Yet, while professional socialization trains HCWs to turn to clinical experience or scientific evidence (Timmermans and Angell, 2001) to help parse novel situations, we demonstrated how their training has not helped them navigate a global pandemic. Moreover, for HCWs—who are a part of a professional identity that expects expertise in the delivery of care and knowledge of disease and illness—the pandemic exacerbated the cognitive dissonance between desiring to offer quality patient care and lacking the knowledge or training to do the job.

Previous scholarship has documented how administrators may not offer tangible support to low status HCWs negotiating the challenges associated with new roles and jurisdictional boundaries (Cain et al., 2021). Upper-level administrators were a frequent source of frustration for HCWs interviewed for this study. As administrators rolled out new protocols and practices, even surgeons and physicians noted how they were asked to take on tasks they were not equipped to deal with. We found that while all HCWs experienced social disorder, high status workers were concerned were about losing their medical licenses and not feeling knowledgeable about COVID patients. Lower status workers expressed similar concerns. We suggest that even though higher status workers experienced social disorder because of their decreasing autonomy, they were able to uphold the medical hierarchy by shuffling the burden (Seim, 2020) of direct patient care to lower status workers. In contrast, lower status workers could not shuffle the burden to someone else, which reinforced their lower status even while taking on a significant amount of risk with direct patient contact and having more responsibility over patient care.

Pandemics also afford opportunities for scholars to revisit classic puzzles in the scholarship on the social aspects of health and medicine. For example, as we have already noted, scholars working at the intersection of professions, organizations, and healthcare have depicted the rise of new professional classifications in health organizations which creates new status hierarchies and intragroup conflict (Cain et al., 2021; Waring, 2014) as HCWs renegotiate work assignments and autonomy. Here we were able to document how rapid organizational change created a situation where high and low status HCWs needed to negotiate their changing roles and responsibilities and felt a loss of autonomy.
Future research should examine the long-term effects on the medical status hierarchy, autonomy, and if HCWs eventually settle into their new roles and status positions or find long-term strategic workarounds to rapidly instituted change.

In addition, undergirding our findings was a growing awareness of, and concern for, the mental health consequences on HCWs for working under the stress of COVID-19 (see also Lai et al., 2020). Whether or not stress is evenly distributed during crisis is an empirical question. We found indications in our data that lower status workers were uniquely disadvantaged. All HCWs expressed experiences with mental distress in their workplaces and this is a critical area for future scholarship to explore in greater detail and across a broader range of HCWs than our study could accommodate focusing mostly on HCWs whose primary work site is the hospital.

Taken together, studying how HCWs respond to rapid organizational change during a pandemic demonstrates how social disorder is amplified in crisis because their socialization into the profession and the norms and values of the organization become upended (Parsons, 1951; Gubin et al., 2012). As we have shown, HCWs had few tools to draw upon to help them sort through their new work responsibilities. HCWs are trained to be heroic, have formidable confidence even when experiencing social disorder, and carry out actions with decisiveness (Abbott, 1983). During a pandemic, however, as HCWs continue to hold themselves accountable to these implausible expectations, they may be setting themselves up for failure which deflects attention from how their organizations are failing them. The findings presented here point to new opportunities to consider structural gaps and organizational failures in health infrastructures. While the responsibility of failure is often claimed by HCWs as their own, the findings presented here point to the vital need for more empirical data to understand how rapid organizational change, and efforts to alleviate a sense of social disorder, amplifies pre-existing inequities in healthcare between high and low status healthcare workers.

Credit author statement

The first author took lead on the data analysis, theoretical framing of the paper, framing of the contributions to scholarship, and revisions. The second author conducted all interviews. All other work for this manuscript including data coding and drafting of major paper sections was conducted by both first and second author.

Data availability

The data that has been used is confidential.

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