The Glass Hospital

by

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A thesis submitted to the Graduate Faculty of
Auburn University
in partial fulfillment of the
requirements for the degree of
Master of Science

Auburn, Alabama
May 7, 2022

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Abstract

This paper considers how the COVID-19 pandemic altered health care workers (HCWs) and their experiences with workplace discrimination. This research combines theories using glass as a metaphor (such as the glass escalator, the glass ceiling, glass cliffs, and glass cages) with intersectionality and microaggressions to describe the notion of a glass hospital (Cotter et al. 2001; Frye 1983; Gabriel 2016; Hill 2019; Kalev 2009; Pierce 1970; Ryan and Haslam 2005). The glass hospital represents HCWs' concerns with workplace discrimination issues.
The stories of the glass hospital represent locations where various HCWs are found, from the glass basement reserved for marginalized HCWs, up to the glass penthouse, limited to predominantly white, cis-normative HCWs. Discrimination and microaggressions ensure around-the-clock staffing by determining who works in the glass basement versus other stories of the glass hospital. For this qualitative study, I conducted interviews with 21 HCWs from across the United States. Their responses revealed the impacts of COVID-19 on discrimination in healthcare. Research subjects describe the growth of traveling HCWs, defined as Traveling Independent Contractors (TICs) in this paper, and acts of discrimination.

Acknowledgments

Thanks to my committee chair, Ryan Thomson, PhD, for indispensable mentorship throughout my master's program. Thank you to Natalia Ruiz-Junco, PhD, for your invaluable contributions to my sociological theory knowledge. Also, thanks to Anthony Campbell, PhD, for key contributions to my medical sociology knowledge. Thank you to my husband and my rock, Frank, for supporting me in all my endeavors despite my absence. My wonderful daughter, Ana, you are my heart. Since the day you were born, you have inspired me, and your dedication and hard work continue to inspire me. Thank you to my parents for a fascinating life. The unique opportunities I had as a child continue to inspire me, and I still look back on my childhood for sociological inspiration. My family, I love you all.

To the healthcare workers who participated in this study and the healthcare workers who I have known, your contributions to my work are invaluable. Thank you for devoting your body and soul to helping people.

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List of Abbreviations

24/7	Around the clock
ANA	American Nursing Association
CNA	Certified Nurse Assistant
CMS	Center for Medicare and Medicaid Services
COVID-19	SARS-CoV-2 or coronavirus disease 2019
CQI	Continuous Quality Improvement
ER	Emergency Room
HCW	Health care worker
ICU	Intensive Care Unit
LD	Labor and Delivery
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and the spectrum
LPN	Licensed Practical Nurse
LVN	Licensed Vocational Nurse
NICU	neonatal intensive care unit
OB	Obstetric
PPE	Personal Protective Equipment
PRN	From the Latin 'pro re nata', or as needed
RN	Registered Nurse
TIC	Traveling Independent Contractor
TQM	Total Quality Management

Introduction

How has the COVID-19 pandemic altered HCWs and their experiences with workplace discrimination? The notion of the glass hospital examines interviews with HCWs that occurred during the peak of the Omicron COVID-19 variant in the United States. This study was conducted to expand knowledge of HCW's experiences with aspects of intersectionality, such as gender and race, in the COVID-19 healthcare landscape. While numerous studies have examined race or gender in healthcare, this study intended to examine a diverse sample of HCWs during the COVID-19 crisis. The results show that those who exist at the intersections were further marginalized through pressure to work more and the unexpected result when an exit door appeared. Many HCWs left traditional employed healthcare to become Traveling Independent Contractors, or TICs, changing the dynamics of the existing HCW relationship with hospitals.

HCWs describe their jobs in the healthcare field during interviews by detailing traditionally racial and gendered discrimination and expressing concerns about other issues impacting them. Staffing shortages both before and during COVID-19 were a concern. HCWs described the impacts of Traveling Independent Contractors, or TICs, brought in to solve staffing shortages. The two groups experienced friction among themselves. The interviews were collected and examined using sociological theories focused on structural discrimination. These theories were integrated with HCWs' interviews to create a structure in which some HCWs ride the glass elevator and receive promotions while other HCWs are restricted to lower stories. Gendered and racial shortcuts form the foundations of the lower stories; these shortcuts are methods of rapid decision-making for staffing a hospital open around the clock. TICs have found a way around hospitals' staffing shortcuts, building their schedules similar to gig workers. While employed HCWs are restricted to the glass hospital and unable to exit, TICs have found an exit

strategy.

TICs lurk in the hospital background, unaffiliated with a specific healthcare facility, moving as a renegade among understaffed healthcare facilities in quest of financial reward. Before COVID-19, travel nurses made up only around 3-4% of nurses in the United States (Kinner 2021). As the number of COVID-19 hotspots grew, so did the appeal of travel nursing; presently, travel nurses account for 8-10% of all nurses. Travel nurses comprise a significant part of today's healthcare workforce, with an anticipated 35-40% growth(Bernstein 2021). While TICs resolved staff shortages, they brought a significant financial burden to healthcare facilities. TICs' arrival complicates the already complex landscape of the glass hospital.

The Glass Hospital

The design of modern bureaucratic structures intends to confine people, like the iron cage described by Max Weber (Gabriel 2016). According to Weber, "The bureaucratic organization, with its specialization of trained skills, its delineation of competencies, its rules and hierarchical relations of obedience...[is] in the process of erecting a cage of bondage which persons—lacking all powers of resistance —will perhaps one day be forced to inhabit" (Kalberg 2001; Weber 1978). The hierarchical organization within the glass hospital enforces obedience and requires HCW to specialize in specific skill sets, strengthening structure and bureaucracy. The glass hospital's door allows entry for specialists, such as licensed professionals. Specialization allows entry to individuals who have put in the time and effort to obtain education and licenses to gain access and limits access to others. The door also limits exiting because once a person has invested time and money in specialized, they feel obligated to continue in their specialized line of work. They may feel additional obligations to their co-workers and patients. Obligations felt to co-workers and patients may be leveraged into feelings of guilt to encourage staff to work.

Employed HCWs may feel the doors of specialization entrap them; they can see the glass doors but cannot exit. TICs leverage their licensure to work at multiple hospitals, using the doors to exit the restrictions of employed healthcare work.

Employed HCWs feel stuck as the doors appear only to open inward and may use small acts of resistance against restrictive work policies intended to extract optimal labor. The bureaucratic focus on regulation seems to lack compassion, and HCW acts of resistance may include calling out sick when they feel they cannot continue to work. Interviewed HCWs describe calling out more for mental health sick days than physical illness. The feelings of entrapment and the acts of defiance describe elements of the glass cage, "entrapment and opposition" (Gabriel 2016).

The glass hospital is a place of contradictions; it appears as a glittering glass place of hope from a distance. The gleaming front is also visible from deep within the glass hospital, but the image is distorted by the glass (Gabriel 2016). Both patients and staff inside may be victims of the illusion. The distorted glass exposes staff shortages and the discriminatory tools used to decide how patients receive care. The staff finds the distorted glass exposes the elaborate devices of containment that guarantee labor continues at all hours of the day and night.

Glass has been used as a metaphor to represent something that appears transparent at first glance but is quite solid upon closer study. In glass metaphors, the glass acts as a barrier limiting racial, ethnic, and gendered groups (Kalev 2009; Ryan and Haslam 2005). The term "glass ceiling" refers to a barrier that prevents women from rising to leadership positions (Cotter et al. 2001). Marilyn Frye describes a birdcage as a glass barrier (1983). When very close to the cage, it appears a bird may pass through the wires of the cage because one is too close to see the interlocking wires of the cage that keep the bird from flying away. Glass barriers, like a birdcage,

may appear to allow flight but are also difficult to escape.

Once inside the glass hospital, it may seem easy to find escape routes when looking out the glass; however, economic limitations prevent a viable escape. Equivalent financial prospects outside the glass hospital are difficult to find, especially for women and people of color. Once inside the hospital, like the caged bird, it becomes difficult to leave due to wage limitations. Although flight appears to be simple, they feel stuck like caged birds. The glass doors operate like the wires of the cage, they appear to allow an easy exit to the outside, visible through the glass, but it is illusory.

Women may ascend a few floors in the glass hospital, but those in power within the hospital restrict upper floor access to most women, especially those of color (Hill 2019; Ryan and Haslam 2005). The glass top floor is for executives, while the glass basement is where frontline personnel work the patient units. Low-level managers, predominantly women, work on the middle floors and may be assigned to the top floor or dispatched to the basement. Despite women representing 76% of healthcare roles in 2019, white men have escalator access, advancing them to senior positions, bypassing women (Cheeseman Day and Christnacht 2019; Williams 1992, 2013). Christine Williams use of the glass escalator considers a people-moving device that appears to allow access to anyone who takes the first step onto the escalator. Elevators are the preferred people mover in hospitals, accommodating wheelchairs and stretchers. However, in contrast with escalators, glass elevators may require key access for upward mobility in the glass hospital. Key access elevators prevent some HCWs from taking that first step upward.

White males have access to the glass hospital's keyed executive elevator and vertical access to the top-floor executive penthouse (Ryan and Haslam 2005; Williams 1992, 2013;

Wingfield 2009). They receive keys to the glass elevator rather quickly upon entering through the hospital doors as staff and have the autonomy to perform their work with limited scrutiny. White women may also receive elevator keys with limited access to the penthouse executive suite. White women are more likely to find their elevator keys restricts them to middle-management floors, where they can be transferred back into patient care during a crisis and kept under scrutiny. These roles are likely direct-care nurse management, working the middle stories of the glass hospital still in scrubs, ready to work the basement at any time. Middle-management roles for women are a combination of HCW and service roles, where the expectations of women's work meet, still performing subservient service duties for the leadership on the top floor (Wingfield and Alston 2013). These service duties keep women in gendered roles as note-takers or ordering food for meetings. For women and people of color, any missteps on an upper floor result in dropping off that floor, like a glass cliff, either back to the basement working the units or terminated (Ryan and Haslam 2005).

Organizations are established from the ground up, with rules, pay, and positions defining the organization's commitment to gendered and racially structured hierarchies. An organization's human resource department follows a process that specifies responsibilities and associated wages in gendered ways as early as the recruitment phase of hiring for a position. Gendered notions of the value of women's work presume females as a good fit for certain roles, usually nurturing or administrative, with an attached pay structure (Wingfield 2020; Wingfield and Alston 2013). Underlying assumptions about gender and race place some workers in roles requiring physical strength, such as placing men and African American workers in security or working psychiatric wards. Hospitals rely on these limiting factors to make decisions about placement in shifts or units at the point of hiring. When hiring for positions identified as basement work, such as

working weekends only shifts in a psychiatric ward, racial and gendered notions are shortcuts. Hospitals may also use gendered notions when hiring aides that require less education than other HCWs (Wingfield 2020; Wingfield and Chavez 2020). Immigrant women of color, for example, are generally considered nurturing and subordinate, appropriate for cleaning staff or nurturing roles such as nursing.

Immigrants in healthcare often work shifts and units considered less desirable. Due to nursing shortages, the United States actively recruits for nursing in certain countries, such as the Philippines (Nazareno et al. 2021). The unique intersections of international HCWs include multiple disadvantages, such as race, gender, cultural differences, and tenuous immigration status issues. International HCWs, like many other racial and gendered HCWs, stay in the basement of the glass hospital, unlikely to access any methods of upward mobility.

Staff who exist at the crossroads of gender, color, and ethnicity start work in the glass basement, where they will most likely only be able to move horizontally (Nazareno et al. 2021; Wingfield 2009). If all HCWs had access to the elevator, no one would be left to work undesirable shifts such as overnights or holidays. Staff in the glass basement will be placed on units or shifts regardless of their individual preferences or needs. HCWs in the basement find the rigidity of glass structures as a barrier to management roles on the upper floors, which, if accessible, would provide a reduction to the physically and emotionally demanding work found in the basement. HCWs on the middle floors find their job includes demanding HCWs in the basement cover shifts around the clock. The basement HCWs and the middle managers are all under scrutiny from the top floor executives, looking down through the glass floors and ceilings.

The glass that makes up the hospital is a fragile structure TICs find a means of entering and escaping the glass hospital at will. They enter through a crack in the glass structure, not

intending to seek upward mobility through traditional means such as an elevator. Their short contracts allow them to step in, check out the structure, and exit quickly when they choose. Hospital executives and governmental leaders are concerned about this crack in the bureaucratic structure which allows entry and exit without adherence to the traditional obedience to the hierarchical structures described by Weber (Kalberg 2001; Weber 1978). Sealing up the crack that allows travel healthcare workers to pass in and out ensures that access points to the glass hospital are under control. This crack is currently wide, and TICs are coming and going and making good money in the process.

Intersectionality

Microaggressions and guilt are methods of power used to ensure hospitals operate around the clock. They are disciplinary tools, methods of division that occur to exclude some people from opportunity or advancement because of their race, sexuality, and gender (Hill Collins and Bilge 2020). Intersectional power recreates and continues social divisions based on race, gender, sex, and ethnicity, among other factors, leading to increased inequality (Hill 2019). Kimberlé Crenshaw first proposed the notion of intersectionality to address different social forces and identities and the ideological tools that legitimize power and disadvantage (2017). Where race, ethnicity, and gender meet, oppressive authority emerges. Each relationship influences or reinforces the others synergistically, impacting the social world (Hill Collins and Bilge 2020).

While white women may find the glass door a one-way access into the hospital, Black women may experience the glass door as a revolving door. Those who work in the basement are more likely to have their hours reduced when the hospital has fewer patients or low census. Middle story HCWs have alternative work options, such as administrative work, and are less likely to be furloughed during low census. Basement workers may be furloughed or laid off due

to low census. Women at the intersections, such as Black women, may be compelled to work more than one job for paycheck security and job continuity. Multiple jobs ensure a fallback when furloughed, laid off, or terminated from other work. Data shows that African American workers are more likely to work more than one job than white workers and Hispanic/Latinx and Asian workers (Anon 2022; Merling 2016). Women of color are performing emotional labor in navigating the complexities of relationships within traditionally white healthcare with patients, co-workers, and leaders (Cottingham, Johnson, and Erickson 2018). Emotional labors include the performative work of managing both their own emotions and the emotions of those around them by exuding professionalism, confidence, and appearing at ease in any situation.

The stress and strain of COVID-19 increase power dynamics within healthcare multi-directionally. The demands of COVID-19 rapidly increased hospital censuses and the corresponding need to increase staff. The forces of power use various tools of oppression to increase staffing in crisis times; these oppressive methods include microaggressions and guilt tactics as coercive tools to ensure 24/7 staffing in the glass basement. Guilt is a manipulative tool to incentivize HCWs to continue to do their job during adversity. Leadership takes advantage of HCWs' empathetic nature, using guilt as a tool of manipulation when needed (Brennan 2020; Cheeseman Day and Christnacht 2019; Su et al. 2020). Sick patients and overworked co-workers are tools used to invoke guilt when pressuring staff to work more.

Microaggressions

HCWs who refuse coercion into working longer hours face microaggressions as a form of retaliation. HCWs are aware that stepping up and increasing their work hours during COVID-19 may not positively impact promotions or wage increases in the future. Examples of microaggressions include suggesting a HCW is unfit for their job, does not have a suitable

appearance, their personal life affects their work, and ignores their expertise. Intersectional locations of race, gender, and sexual orientation will likely be invoked during these microaggressions, exponentially increasing the power of the tools of discrimination and microaggressions. Dr. Chester Pierce, a psychiatrist, coined the word microaggression in the 1970s to characterize negative interactions that, when compounded, have a significant impact (Pierce 1970; Wells 2017). Hospital leaders use microaggressions against persons on the margins, such as LGBTQIA+, women, and people of color to keep glass basement staffing in order.

People respond to microaggressions with feelings of unworthiness, doubt, and exhaustion, contributing to imposter syndrome and racial battle fatigue (Acholonu and Oyeku 2020). Imposter syndrome prevents people from progressing in their professions or making valuable contributions at work. In healthcare, self-doubt may prevent people from sharing knowledge crucial to the medical team. Medicine is fast-paced, and the information that HCWs have is critical for a patient's life. Imposter syndrome may limit critical patient care communications in a crisis when HCWs doubt their knowledge. Racial battle fatigue describes the negative impact of repeated microaggressions on a person's emotional and physical health.

Color-blindness brought to the workplace by traditionally white, middle-class providers impact both staff and patients, as it minimizes the experience of race for both groups (Bonilla-Silva 2016). Statements by whites of "I do not see color" is a form of microaggression as it implies there are no distinctions between groups, so discrimination is not a valid issue. Marginalized groups bring their own unique cultural experiences, creating conflict in healthcare with gendered, white, middle-class notions of nurturing. Expectations of acceptable appearances or behaviors of HCWs suggest assimilation into white, cis-normative culture is required

(Acholonu and Oyeku 2020). The unique perspectives brought by minority groups deviate from white, cis-normative hospital leadership expectations. When white, cis-normative leaders disapprove of deviations from the presumed appropriate roles of 'nurturing' or 'professional,' they do not employ traditional solutions like human resources, leadership, or policy changes to solve the problem. Handling deviations may occur through leadership microaggressions and the imposition of corresponding feelings of imposter syndrome to those who are non-compliant with traditional white cis-norms. Feeling embattled on the job due to microaggressions, and the corresponding racial battle fatigue and feelings of imposter syndrome, are additional burdens to the demanding nature of healthcare (Acholonu and Oyeku 2020).

Microaggressions are typically associated with racial discrimination. In healthcare, they are deployed as a power maneuver to extract more labor, used against any HCW deployed to the basement and mid-level stories of the glass hospital. Microaggressions may be employed as a form of control when there is a perceived lack of adherence and assimilation to a standard white male heterosexual identity, or within healthcare, a traditionally white feminine heterosexual identity (Cottingham et al. 2018; McMahon et al. 2021). Microaggressions directed at men may question a man's sexuality. A gendered microaggression may occur when questioning a woman's skills as a nurturing caregiver.

A Gendered Crisis

The pandemic is a crisis occurring on two fronts, work, and home. As women represent 76% of the healthcare workforce and usually are the primary caregiver for children, the COVID-19 pandemic has placed a heavy burden on female HCWs (Cheeseman Day and Christnacht 2019). For female HCWs, COVID-19 is a gendered dual crisis occurring on two fronts, increasing both work pressures and familial expectations. Under added pressure to care for their

families with school closures, about one in five ended healthcare work, some planning not to return (Masson 2021; Robinson, Engelson, and Hayes 2021). During the early phases of the pandemic, schools were canceled, causing children to require a caregiver at home. Ensuring in-home schoolwork occurred placed an additional burden on families. HCWs experience the dread of infecting their families with COVID-19 due to the increased demands at work.

Women respond to these unique intersections of work demands and familial responsibilities by adapting their careers around gendered role expectations (Bear and Glick 2016). Women who prioritize familial responsibilities over their careers are at a disadvantage compared to men. Women's careers suffer when they take time off related to childbirth and childcare. At the intersection of gender, race, and family demands, the likelihood of problems with employment increases. These problems include low wages, reduced work hours, undesirable shifts, or job loss. Family demands may be interpreted by those in power as a limitation to work achievements.

The lack of female representation may continue the structural systems that keep women from being promoted. White men occupy top leadership roles despite representing the minority of HCWs (Boyle 2021; Kacik 2019). While 76% of HCWs are female, women hold an unrepresentative 20% of top healthcare leadership positions (Cheeseman Day and Christnacht 2019; Kacik 2019). The lack of representation in healthcare leadership likely contributes to inequalities women experience in healthcare.

Status Shields

Men have a "status shield" when working in the service sector, protecting them from emotional demands and harsh treatment (Cottingham, Erickson, and Diefendorff 2015; Hochschild 2012). While this shield may seem beneficial, men in nursing experience

stereotyping of both homosexuality and heterosexual hypersexuality (Cottingham, Johnson, and Taylor 2016). Male HCWs benefit from their privilege through the "status shield," which protects them from criticism and abuse from patients, leaders, and other HCWs. Women in healthcare serve as shields for male nurses when assigned to hands-on care roles, while male nurses work in roles considered less nurturing and more physical (Cottingham et al. 2015, 2016; Hochschild 2012). Marginalized HCWs, considered to have less privilege and autonomy, are responsible for emotional and nurturing care. The gendered nature of healthcare assumes women are responsible for the emotional work that protects the feelings of patients, co-workers, and supervisors. Men's emotion work is different, even when working the same job, to ensure the presence of the status shield. Appearing too nurturing might be interpreted as sexualized when performed by male HCWs. Healthcare's expectation of cis-normative nurturing creates emotional labor for women and creates unique emotional labors for male nurses to avoid these accusations of hypersexuality or homosexuality. Men must remain vigilant in their caregiving to ensure it is seen as non-sexual (Cottingham et al. 2015, 2016).

Gender and race serve as tools for making quick decisions. These shortcutting mechanisms make assumptions about staff when making decisions about work placement, promotions, and staffing. These decisions, made rapidly with little information, are critical in determining each HCWs trajectory within the facility. HCW’s are visible when placed in the best shifts or units or invisible when sent to the glass basement. Being visible within the glass hospital increases the likelihood of being seen as a candidate for a better shift, unit, or promotion. Invisibility in the basement increases the likelihood that the HCW is unseen by leadership for advancement. The shortcuts that result in invisibility are based on racial and gendered biases and are a type of microaggression used against marginalized employees.

Employees who are critical of shortcut decisions may use emotional labor to address the issue with their supervisors carefully. Black women considered non-conforming to the expectations of traditionally white feminine heterosexual identity may take on the performative act of the "loud black girl" as a means of micro-resistance (Cottingham et al. 2018). If the HCW does not manage the emotions of those in charge while protesting unfair placement, they risk demotion to the glass basement or termination. HCWs may feel pressured to comply when employers make demands, such as working overtime, due to concerns about job security (Couch, Fairlie, and Xu 2020). The demands for overtime, long hours, and the emotional work of healthcare lead to burnout (Bakhamis et al. 2019)

Burnout

Stress, burnout, and COVID-19 magnify the convergence of racism, microaggressions, and gender inequities. Work-related emotional exhaustion and feeling overwhelmed at work contribute to burnout syndrome in HCWs (Bakhamis et al. 2019). Staffing shortages require HCWs to work long shifts, sometimes 12 or 16-hour stretches. They may work these long shifts for many days in a row without time off. HCWs may work shifts or units they do not usually cover. Requested time off or routine time off, such as weekends, are canceled. There is pressure from multiple employers for those HCWs working at more than one hospital to ensure they have continuous employment. The demand for crisis-level coverage was a frequent concern of employed during interviews. The pressure to work more and acts of retaliation such as microaggression and guilt contribute to HCW burnout. Burnout and demands to work more were discussed as reasons for leaving employed healthcare by TICs.

Healthcare Heroes

HCWs train to react in a crisis, whether heart attacks, childbirth, disease, and fractures. During short-term crises, such as hurricanes, tornadoes, and influenza outbreaks, HCWs expect to perform extra work. They may even relish the opportunity to help their community in crisis, many immediately reaching out to their facility to volunteer. HCWs in the early part of the COVID-19 pandemic volunteered to help, even as they became victims of the pandemic. Knowing the risks, HCWs continued to do their job.

HCWs were called courageous and heroes during the initial phases of COVID-19. An expectation exists that certain workers, such as HCWs, police, and firefighters, will respond to periodic short-term crises with a sense of obligation to protect and care for the victims (Fernandez et al. 2020; McNeill et al. 2020; Specht et al. 2021). HCWs followed their crisis training and jumped in to work hard but felt betrayed by the government and their employers when shortages, uncontrolled disease, and mortality continued out of control. The early feelings of doing meaningful work are replaced by the feeling that they were not appreciated for their sacrifices. Initial feelings of heroic do-gooding that propelled HCWs into the fray became an expectation, even a demand, increasing burnout among HCWs.

Distressed Hospitals Create the Door

In the early 1990s, quality improvement methods such as Total Quality Management (TQM), Continuous quality improvement (CQI), and Lean methods, previously applied to vehicle manufacturing lines, were introduced in healthcare (Radnor, Holweg, and Waring 2012; Shortell et al. 1995). These process improvements are tools applied to hospitals intended to identify problem areas, reduce costs, increase efficiency and improve their bottom line (Alzoubi et al. 2019; Radnor et al. 2012). These improvements focus on streamlining wasteful, redundant, or complex processes, including excessive supplies and staff. Just-in-time inventory processes

rely on fast and reliable shipping processes and external warehousing of healthcare supplies (Milewski 2022). Similarly, staff streamlining processes increasingly rely on employment agencies to fill openings. Streamlining of unnecessary HCWs involves actively eliminating HCWs or allowing jobs to go unfilled due to attrition. Hospitals, unlike factories, due to the unexpected nature of healthcare crises, may require redundancies as safeguards for emergencies. Hospitals have processes in place for emergency needs, such as on-call staff, phone trees, surge staffing, and reducing non-essential services (Brown, Carrera, and Stanley 2021). These processes are designed for short-term, geographically specific crises. As COVID-19 continued and spread across locations, just-in-time staffing issues became problematic.

The COVID-19 pandemic produces shifting dynamics within healthcare, affecting the interactions between HCWs and healthcare institutions. The low levels of staff pre-pandemic due to quality initiatives, combined with the loss of staff during COVID-19, left hospitals in distress. Staffing needs rose, but the staff was disappearing, infected with COVID-19 and burned out. Staffing shortages increase pressure on HCWs to work more hours, work in units they are uncomfortable with, and requested time off cancellations. While HCWs initially responded, as the pandemic wore on, HCWs experiencing burnout looked for alternatives to working too much. Some HCWs have quit healthcare altogether; some attempt to regain control of their schedules by reducing their hours, while others turn to travel contract work. As attrition and COVID-19 patients rose, hospitals responded by hiring TICs and applying pressure, microaggression, and guilt to glass basement workers to increase productivity. Burnout correspondingly rose in response to these pressures. The loss of employed HCWs with facility-specific corporate knowledge creates a chaotic environment for those HCWs who remain, as the existing HCWs who know policies leave, and the quality of patient care is impacted (Kinner 2021).

Rise of the TIC

The TIC emerged as a potential alternative for HCWs feeling out of control and burnout. The TIC can move between healthcare facilities under short-term contracts, which vary in length. Each contract is unique, allowing the TIC to adjust the contract length, days off, and what shifts they will work. Contracts stipulate a specific timeframe they are bound to work (usually ranging from 4-13 weeks), and breaking a contract has a monetary penalty. TICs may elect to have a break between contracts, allowing time for holidays or mental health recovery as they choose. The TIC can plan for holidays, school breaks, or even preferable work locations through contractual negotiations. Some TICs arrange for private benefits such as health insurance or retirement plans, which assists in disconnecting from traditional employment. Once a contract is signed, the relationship is pre-defined, and the facility is limited in overruling contractual agreements to compel TICs to work. The emergence of the gig economy, centered around temporary work, provides an opportunity for HCWs.

Gig Work Leads to the Existence of the TIC

Gig work emerged after the collectivism of World War II, corresponding with a rise in individualism with a focus on identity and lifestyle (Naghieh 2020). Personal enterprise represents the self in the new identity-focusing world, and labor is a personal commodity. The gig economy provides a place to sell the commodities of individualism by segmenting work into 'micro-tasks' that can be accomplished in an on-demand manner, in which time and location of work are no longer relevant. Although TICs are not project-based like gig workers, some aspects of healthcare, such as home health care and laboratory technicians, are outsourced like gig work. Fleming and Head anticipate that nursing and teaching roles, traditionally considered women's roles, will become dominant in the gig economy (2021).

When pressured to perform excessive levels of labor without time for recovery, the HCW experiences burnout. In this, the HCW is unlinked from feeling personal investment in their work or a "vocational calling" (Kalberg 2001). Becoming a TIC may allow HCWs to regain the feeling that their work has value. The TIC, like the gig workers, operates as a small business, making decisions about how they perform their labors through the contract process.

HCW resentment, in and out-groups

While TIC work is lucrative and beneficial for TICs, their exodus from the hospital has left employed HCWs carrying the burden. Employed HCWs experience additional pressure to cover the shifts left open through TIC departures. Many interviewed TICs had arranged their contracts to take much of the month of December off, leaving employed HCWs covering the holiday during the Omicron wave. Employed HCWs are aware that TICs make significantly more money doing the same jobs. Some TICs work at the same hospital they left, working alongside their former co-workers. Some employed HCWs feel betrayed by the departure of the TICs. Some of those who felt betrayed are now consulting with TICs to become travelers. The remaining employed HCWs work in understaffed facilities due to the exodus of TICs, covering more patients and concerned about their patient care quality. TICs arriving as rescuers and heroes after the opportunistic abandonment of their co-workers further increase HCW resentments.

The employed HCWs and TICs are at odds with each other even as they perform the same job. They are uncertain if they should help each other, which is concerning in the hospital where an emergency requires team efforts. Hospitals already have a staffing shortage, and those who do work face this divisive workplace. Employed HCW in-groups are unsure if they will accept TICs out-group, according to William Sumner's in and out-groups theory (1940).

Employed HCWs, as the existing in-group, expect that TICs will assimilate to existing structures and hierarchies. However, the temporary nature of the TICs' role does not require assimilation, as their short tenures require performing their required duties, but participation in the customs and traditions of the specific hospital is not required (1940).

Several factors increase animosity between employed HCWs and TICs. The exodus of HCWs to the TIC life leaves few frontline employees with long-term corporate knowledge, increasing the strain on those who know the hospital's policies and procedures. Employed HCWs may need to provide training or help to newly arrived TICs. In some locations, TICs work as strikebreakers in pandemic-related healthcare strikes (Catlin 2020; Faller, Dent, and Gogek 2017). Crossing the employed HCW picket lines, who are striking due to pandemic-related concerns including staffing issues, contributes to the animosity.

For good patient care outcomes to occur, communication lines must be open, and healthcare teams must communicate about their patients. Anything impeding communication could cause an adverse outcome for a patient. The nurse describes employed HCWs as the "in-group" privileged to be in the know, and TICs as the "out-group," excluded from important knowledge (Sumner 1940). At the beginning of the pandemic, employed HCWs were grateful when TICs arrived to assist healthcare facilities in the COVID-19 crisis. As the number of TICs along with monetary incentives, animosity from employed HCWs rose.

As HCWs are dividing into factions, healthcare organizations, lobbying groups, and the federal legislature enter the scene. They accuse TIC staffing agencies of committing price gouging during a crisis (Anon 2021, Anon 2022; Brusie 2022; McClendon and Levine 2022; McClendon and Proctor 2021). Because the epidemic is currently in a downward trend, these allegations seem late for concerns about price-gouging. This concern about price gouging

focuses on the TICs staffing agencies, intended to push HCWs back into their pre-pandemic gendered, hierarchal roles.

What is a Travel HCW or TIC?

As COVID-19 sets in as a long-term problem, HCWs seek alternatives to regain control and autonomy over their work. COVID-19 exposes multiple issues in healthcare work, such as power dynamics, discrimination, and just-in-time processes that require working understaffed routinely. While some HCWs respond by going on strike, others quit their healthcare jobs permanently or become TICs (Essex and Weldon 2021; Kinner 2021; Masson 2021). This new term describes the various types of contract HCW roles. The Traveling Independent Contractor or TIC describes the various types of HCWs in non-traditional work roles. In interviews, these roles were described as agency, contract, or traveler. HCWs in roles as diverse as RNs, LPN/LVNs, and CNAs have become TICs. Not all TICs travel significant distances; some work locally, traveling to multiple facilities. Some TICs return to the facility they left and work with the same people. The TIC is similar to the gig worker as defined by Watson et al. in that it is "temporary, project-based, and flexible" (2021). Like gig work, TIC workers have the autonomy to make their schedule around personal obligations. Flexibility is the key area where gig work and TICs meet, the draw for both.

The Rewards and Risks of Being a TIC

TICs find their new work model empowering, as they can make it what they want or move on. She considers her work at multiple facilities over a short period beneficial to her long-term career. The majority of HCWs describing TICs talked about the financial rewards. TICs describe autonomy in choosing whether to stay at a facility or move on. In the interviews, Black TICs place a greater emphasis on avoiding workplace politics, whereas white TICs emphasize

money.

Concerns about employment insecurity compete with the desire to find work that allows for independence and leisure (Yerby 2020). Taking the risks of quitting employer-based jobs during COVID for contract work means disconnecting from the usual employment incentives, such as health insurance, stable income, and retirement packages. These benefits exist under a social contract between workers and employers, assuming good jobs in the United States include a benefits package (Kalleberg 2009). Fear of job and benefit loss may drive employees to stay even when employers modify the social contract (Keeley 1995). Social contract modifications may include lowering wages, removing incentive pay, or changing required work hours/days. Modifications occurred due to COVID-19, as some HCWs took pay cuts, were furloughed, or were laid off (Bebinger 2020; Bhandari et al. 2021). Even when an employee agrees to change their social contract with their company, the risk remains of job loss. The financial risks of disconnecting from traditional employment and the loss of benefits are concerns. Many feel the risks are worthwhile. Even if the COVID-19 bubble bursts, they made a significant amount of money taking the risk. When comparing the potential benefit of being a TIC to a typical job, there are factors to consider, including the expectation of working COVID-19 units and working more than the traditional 40-hour week. TICs willing to work COVID-19 crisis contracts can make up $10,000 weekly (Walker 2022).

According to the Bureau of Labor Statistics, in 2021, employed nurses in the United States made an average of around $75,000 annually (Anon 2021). Nursing pay varies according to the physical location, years of experience, area of specialty, and shifts. Compared to the employed nurse, a motivated TIC nurse could earn $480,000 with four weeks of vacation and as long as COVID-19 keeps hospital beds full. Because of the substantial wage disparity, employed

HCWs resent TICs profiting from the COVID-19 situation and making more money doing the same job.

Methods

Grounded theory allows the inclusion of theoretical concepts throughout the data collection process rather than before beginning data collection (Charmaz 2006; Glaser and Strauss 1967). The Qualtrics data supply preliminary information about each participant to direct interviews. I utilized an incident-by-incident coding method, comparing an entire described incident or situation with other subject responses (Charmaz 2006). A wealth of information for comparison and review came from interview notes and the Zoom recording and transcript. As new ideas arose, interview questions were added or adjusted to see if other subjects found the topic significant.

In a constant process, a comparison of new ideas and themes from interview participants were analyzed with information acquired from prior interviews. An emerging theme, the traveling HCW, prompted adding questions to the interview guide to understand this theme further and prompted a review of previous interviews. Focused coding allowed a side-by-side comparison of terms as they emerged, such as "traveling nurse" and "COVID-19," to sort incidents into groups for comparative purposes (Charmaz 2006). Qualtrics data and the interview guide provided a series of prompts that created directionality during the interviews. In both the Qualtrics survey and the interview questions, terms such as "discrimination," "gender," "sexual orientation," and "race" assisted in creating a shared narrative between research and participant for coding.

Descriptions of incidents were combined with existing sociological theories to create the notion of the glass hospital. The components include the hospital landscape, the impacts of

COVID-19, the changing descriptions of HCWs, including the traveling HCW, and how discrimination impacts each of these elements. The subjects provided a holistic perspective of the current healthcare landscape. Their interviews cast fresh perspectives on healthcare situated within the landscape of COVID-19, discrimination, and the structures of the glass hospital. The interviews also provided directions for future research into the interactions between HCWs and their situation in their organization. Theoretical notions were interwoven with the interviews to create a comprehensive notion, the glass hospital, to drive new research.

Recruitment and Interviews

The study identified 87 HCWs who work in facilities and provide around-the-clock care. Oversampling of minority groups ensured representation. Participants completed an electronic informed consent, including assurance of privacy, the purpose of the study, and the voluntary nature of participation. Once the consent was signed, participants completed a Qualtrics survey designed as a starting point. Loss of potential participants occurred at each phase of the pre-interview process; they dropped out without completing the consent, the Qualtrics survey, or setting an interview time. Zoom interviews were conducted with all 21 participants who completed all required components, except for a few outliers. These were potential participants whose Qualtrics survey identified them by IP Geo locator as outside the United States. Two potential participants made it to the interview stage, but their inability to answer questions about their demographics, as obtained through Qualtrics and basic questions about healthcare, made them likely imposters. These interviews were promptly ended.

Study enrollment and interviews took place between October 2021 and January 2022. Participant recruitment occurred through Facebook Groups and Twitter. The recruitment attempts via social media (Facebook Groups) tended to attract RNs. Self-selection into the study

via Facebook Groups increased the likelihood of participants being professionals. Recruitment attempts for groups identifying as Certified Nursing Assistants (CNAs), mental health techs, or night shift workers were unsuccessful. Some night shift groups were actively policing their group and responded to social media recruitment posts with memes intended to discourage interlopers into their group. A possible reason for the different interactions is that nurses use Facebook Groups to seek jobs and opportunities while those in other groups are more interested in a safe, supportive place. Recruitment of other groups such as physicians was unsuccessful.

Semi-structured interviews were conducted with selected participants. The open-ended interview questions include a review of the Qualtrics survey responses, and a follow-up interview guide expanded open-ended questions. Each interview began with a review of responses to the Qualtrics survey. Additionally, the participants answered a series of follow-up questions using the interview guide. Appendix 1 and 2 provide the Qualtrics survey and the interview guide.

Interviews were conducted in a private setting, recorded via Zoom videoconferencing technology, and lasted between 30 minutes and one hour. Participants were able to speak freely beyond the interview questions. The interviewer followed new topics introduced by participants, updating the interview guide in preparation for future interviews to clarify and continually foster a deeper understanding of the participant's experiences. The interview guide updates allowed interviews to evolve as new patterns emerged.

Data collection ceased after saturation when no new themes emerged. The emergence of the COVID-19 Omicron variant and the holiday season of 2021 drastically reduced interest in participation. The reduction of viable volunteers coincided with saturation. Zoom Transcription converted the interviews into written text. At the end of each interview, each participant was paid

$50.00 for their time using a web-based payment application (app). The Auburn University Institutional Review Board approved this study on 10/22/21 (Project #21-427). COVID-19 safeguards prompted the use of social media for recruitment purposes and Zoom for conducting interviews.

Findings

The glass hospital requires an intersectional consideration, as within the glass hospital, gender, race, ethnicity, or sexual orientation impact placement in the basement, the mid-level floors, or the penthouse (Hill 2019). Specific examples of microaggressions and gendered aspects are discussed in examining intersectionality within the glass hospital. COVID-19 and burnout are layered upon HCWs already impacted by the issues of gender, race, and sexual orientation in the glass hospital. HCWs are also experiencing the gendered dual crisis of COVID-19 at work and at home. Burnout contributes to the rise of the Traveling Independent Contractor, or TIC. Relationships with TICs, the experiences of being a TIC, and how TICs impact the glass hospital since COVID-19 are considered, including how TICs as an out-group within the glass hospital by employed HCWs.

Intersectionality

HCWs are 76% female in the glass hospital, making HCW a gendered occupation for either gender (Cheeseman Day and Christnacht 2019). Women tend to remain on lower floors as basement HCWs or mid-level supervisors who still work the basement units. White men in the glass hospital may begin in the basement but will likely have access to the keyed elevator to the penthouse (Williams 1992, 2013). Black or immigrant men may remain basement workers (Wingfield 2009). For HCWs who are racially, ethnically diverse, or LGBTQIA+, those in power use this as an opportunity for microaggressions and guilt tactics to extract additional labor

(Crenshaw 2017; Hill 2019). HCW's descriptions of microaggressions and guilt to work more include examples, such as the Black travel RN from Texas, overlooked for training through a series of microaggressions.

> When I first got to the ICU and where I was, I was the only black person in the whole unit, and it's little microaggressions, like I can't pinpoint…[leaders]...made sure they [new grads] would go to the specific classes for training for different equipment that we need to learn in the ICU. They would never ask if I'm ready.

This microaggression serves to keep this HCW in the glass basement; without additional training and skills provided to other new graduates, she is less likely to be considered for promotion to mid-level floors. A female African American RN from Georgia provided a similar story, "I feel like as a minority – healthcare is predominately white, [I am in] a constant battle with staff members of having to prove myself…when 90% of the time I'm the one with the highest education on the floor." This RN is working on her master's degree, but co-workers ignore her input when patients present challenging cases. Silencing her, negating her qualified opinions, keeps this HCW in the basement. Validating her experience level, allowing her to prove herself as competent, would make her visible for promotion. A lesbian OB/LD RN shared, "At a previous rural hospital I worked at…my boss insinuated that I shouldn't do labor and delivery because, you know, that's basically just what I do at home is look at vaginas." The microaggression implies that being a lesbian disqualifies her from being a good labor and delivery nurse. Her opportunities for advancement beyond the glass basement were limited in this hospital.

Gender

The gendered dual crisis means HCWs are not only concerned about their jobs but their families as well. An ICU RN from South Carolina said, "I was determined not to bring it [COVID-19] home to my family. You don't want this virus…I see [it] every day, and I saw way too much death." She describes wearing three face masks simultaneously and only eating or drinking when outdoors during her twelve-hour shifts. She places her health at risk, as her work in the COVID-19 ICU is physically demanding, yet she describes shifts where she would not eat or drink. Her dedication to her family's protection prompted her to exercise significant caution while at work.

Female HCWs described men as having an easier workload, even when working in the glass basement. A female CNA from Pennsylvania described this situation, "male employees they are always working the easier units…why do you always have the women working the harder ones (units) where there's heavier people, heavier lifting." A female ICU RN from Texas said, "The male nurses definitely get more respect than the female ones." Another female RN from Texas stated, "male nurses make more [money], and male nurses got treated better, they got better assignments." Men described their own gendered and intersectional issues with their work; as this Asian-American RN from California reported, "[it] can be problematic whether it's a patient who doesn't want to work with me because I am male…it could be a patient doesn't want to work with me because of my ethnic background…mostly it's gender-related I would say." The intersectional role of being an Asian- American man in traditional women's work left him uncertain if his patient refused his care due to his gender or ethnicity. A white midwestern psychiatric RN who is gay described his new employment,

> I feel pretty heavily kind of courted and catered to…like they want to make sure things are going really well for me, because they would like me to be around for a while, and I know that also has a little bit (to do) with my gender.

While he may feel "courted" as a new male employee, there is a chance that if he is outed, his success will be contingent on conformity to cis-normative standards and adherence to professional expectations (Connell 2012; Wingfield 2009). A status shield and emotional labor specific to male HCWs may be required to protect them from accusations of hypersexualized heterosexuality or homosexuality (Cottingham et al. 2015). Male HCWs and their status shielding result in additional labor for female HCWs who must pick up the labors men do not perform.

Burnout and The Exit Door

As HCWs were pushed to work more due to the pandemic, many felt pushed beyond their limits. A surgical RN from Miami said, "I have been working every single holiday. I've actually been working, seven days a week, sometimes 16 days straight." An employed RN from Texas describes working in two different cities, each about a 40-minute commute from her home. As COVID-19 increased nursing shortages, she felt pressured to work at both facilities, and each shift was twelve hours. She was in a car wreck as she pushed herself to work to her maximum. She described leadership cursing and yelling at her for taking time off due to her accident. Following this, she was forced to work shifts she had requested not to work as a form of retaliation. A TIC LPN from Michigan also described burnout, "a year ago I was going where the [pay] incentive was, I was working 70-80 hours a week…and now I feel like everyone's just hit that burnout." When the money was good, she pushed herself to her limits, but like other interviewed nurses, she was burned out.

The long hours contributed to burnout. HCWs did not appreciate being sent to work in the glass basement once they achieved a nursing specialty, a role similar to mid-level floor assignments. An Obstetric/Labor and Delivery (OB/LD) RN from Pennsylvania described working outside her specialty,

> We were being used to supplement the ER nurses, and I've been an OB nurse for ten years; I shouldn't be triaging your sick grandfather… Our director of nursing came up with this thing that basically said a nurse is a nurse, so get in there.

A neonatal intensive care unit (NICU) RN from Texas describes a similar situation, "We were "voluntold"…[to] go to other units and…like take vital signs and give meds." Both of these RNs with specialties in working with new babies and mothers find that their expertise does not matter; in the glass hospital, they are considered both functional basement laborers as well as skilled workers. Working their way up to a better position, a mid-level job, for a woman in the glass hospital does not exclude a HCW from being sent back to the basement. Being sent to the basement has elements of both intersectionality and gender.

A Registered Nurse (RN) from Texas in the process of ending employment as a HCW and beginning as a TIC shared the following,

> I just really didn't want to deal with what was going on, and this was even pre-pandemic…The extra things that they would impose on staff…a lot of policy changes, and if you didn't do them right away, they would write you up. It just started to become a very toxic environment, so I would call out [sick] because…I don't want to deal with it…There was just a general consensus of, it seems like nobody higher up cares about us…a lot of people were getting very burned out,

> and so people that used to be super helpful and always will go out of their way to help you out kind of stopped doing that because they were just done.

These burned-out HCWs describe significant issues with working too many hours, outside their specialty area, and what one calls a "toxic environment." The demands are overwhelming, and when an exit door presents, TIC work presents as an attractive alternative. What these HCWs describe is similar to what Max Weber called "a system of controls that trap the individual within an 'iron cage' of "subjugation and containment" (Gabriel 2016; Weber 1978). An exit door exists from the glass basement, and that exit for many HCWs during COVID-19 is TIC work. A travel licensed practical nurse (LPN) in Michigan described this new paradigm in this way,

> COVID started to shine the light on the problem that's been going on for many years…When you see some of these contracts posted for four or five grand a week, you know it would be hard to say I'm going to stay put and not going to leave...It's like everyone is jumping to do that, so now you have facilities that…were already short (staffed) that and now those staff members are leaving to go help other short (staffed) places and make more money…So I really do think that it like started to shed a light on how big the health care problem is and just the pay gap between people.

The HCW is unlinked from feeling personal investment in her work, or a "vocational calling," and by exiting the glass hospital, she may regain the feeling that her work has value (Kalberg 2001). Whether or not she values her work as a vocational calling, she has a financial incentive to leave the hospital. While exiting the glass hospital may seem lucrative, TICs re-enter under their own terms, but find the conditions are at times even more perilous.

COVID-19 illness infected the entire staff of some hospitals. TICs were brought in to keep the glass basement functional when that occurred. A travel RN working in Texas describes what that looks like,

> My first travel assignment, it was in San Antonio…the whole hospital was made up of travelers. It was an inner-city, very poor hospital; I guess you can say, and COVID had just overwhelmed the whole area, so the whole hospital was just travelers. They tried, but it was chaos. COVID it is just; it was a whole other beast, and this is not something we studied in nursing school, so it was just a huge learning curve for me. We were all travelers, so truly we didn't know protocols with it, you know where things were, who to talk to…chain of command and communication, it was just pure just chaos, I have no other word for that we were just trying to keep our patients alive.

She describes working in a hospital system in failure, relying on TICs, and struggling with healthcare's primary mandate to keep patients alive.

The TIC

TICs see a lucrative opportunity. They describe their new roles as a Traveling Independent Contractor as an opportunity. A Critical Care/ICU travel RN from South Carolina said,

> I kind of got tired of climbing the clinical ladder as a staff nurse, and so I decided to start traveling and then realized how lucrative it was…hospitals are so short on staffing right now there's a million jobs out there, and I work with several different agencies, so I can have a job the day my first job ends.

A Texas RN planning to start as a traveler the day after the interview said, "Travel nursing is…definitely for the money, I'm not going to lie, money. When I worked in ICU…half of our staff left to do travelers. They are the ones who I went to talk to…for their recruiter's number, (to) talk to their (recruiting) agent." This nurse saw a financial opportunity. A traveling ICU RN from Texas shared her goals to advance her career,

> I think about my long-term plans and long-term, I want to be a professor and nursing school, and I will teach their critical care classes. So for me, travel nursing is also a way for me to expose myself to other types of ICUs at other facilities so that way I can have a more well-rounded knowledge of critical care.

She considers her work at multiple facilities over a short period beneficial to her long-term career and sees the opportunity to advance her career. The majority of HCWs describing TICs talked about the financial rewards. TICs describe autonomy in choosing whether to stay at a facility or move on. Another opportunity is avoiding work-related politicking, described by an African American travel med-Surg RN from Georgia who said, "traveling allows you to not get involved with the politics, you [are] there for a short period of time, and then you leave." In the interviews, Black TICs emphasized avoiding workplace politics, whereas white TICs tended to emphasize money.

An ICU RN from South Carolina who was about to begin travel work suggests that "… a lot of people are scared to travel because they're not sure when they're going to have another job or when their first contract ends how they're going to get another one." This nurse reported that her next one-month contract would be paying around $12,000 for a 60-hour workweek in California. Some TICs arrange for private benefits such as health insurance or retirement plans, which assists in disconnecting from traditional employment. An ICU RN from South Carolina

explained how she manages her benefits,

> They (agencies) do offer benefits, I don't always work with the same agency, and I don't always take contracts back-to-back, so I'll take time off between contracts, which would cancel my benefits. So, in order to keep them throughout the year, I'll just do private insurance.

In and Out Groups

Some employed HCWs' animosity towards TICs creating division, interfering with unit communication, and impacting patient care. A black travel ICU RN from Texas said, "It is this feeling of not belonging, and you can see it in the way they talk to you and the way they treat you." According to an employed med-surg RN from Texas,

> Including them (TICs) in something new that you learned that day or, if you have something interesting going on with the patient, you wouldn't talk to them (TICs) about it. Or if there is an issue going on with the pod (unit), you don't really include them…kind of keeping them excluded from certain things that are happening to the unit.

This travel RN describes the division between HCWs and TICs from South Carolina,

> Staff nursing hangs out with staff nursing, and travelers hang out with travelers; it's kind of like going to a new school and starting off with no friends…And that relationship is just never built, and a lot of times, you'll find travelers helping travelers, and you'll find staff helping staff.

These HCWs worked together prior to the pandemic, and while animosity increased due to TIC pay and autonomy, as the pandemic eases and pay equalizes, these issues likely will decrease. Employed HCWs may find unexpected allies in the TICs, coming together

over issues related to the glass hospital.

Limitations

The research proposal anticipated discrimination during interviews. However, an unexpected finding was the description of discrimination between HCWs and TICs. Discrimination described between the TIC and employed HCW was staff to staff, requiring more information to understand who is involved in acts of discrimination. Important details are the types of discrimination observed or experienced and if the discrimination is racial or gendered. Discrimination occurs at multiple levels, patient-staff, staff-staff, and supervisor-staff. Age or ability was not included, which could also impact the experiences of discrimination.

Discussion

This study examined the effects of racial, gender, sexual orientation, and COVID-19 on health care workers. An intersectional framework suggests that gender and race/ethnicity, combined with healthcare's hierarchal nature, pose glass obstacles for HCWs inside (Hill 2019). Microaggressions, discrimination, guilt, and manipulation ensure 24/7 staff coverage and limit access to the top floor (Pierce 1970). Strategies to maximize HCW labor include microaggressions, guilt, and other tools of power intended to extract labor from marginalized HCWs. COVID-19 arrives in hospitals already pushing HCWs to work to excess.

Marginalized HCWs work in the glass basement, able to see out but invisible for promotions. White women may advance to the mid-level stories of the glass hospital but are under threat of being sent back to the basement for non-compliance to gendered expectations or when the hospital needs to increase basement staff. White men have access to the glass penthouse by way of the glass elevator, which propels them to leadership roles rapidly,

advancing past the marginalized HCWs (Williams 1992).

Women experienced a gendered dual crisis during the COVID-19 pandemic. The demands of COVID-19 impacted both home and work, as children were unable to attend school, and HCWs were under pressure to increase their workload. Female HCWs perform emotional labors at work, alleviating negative feelings among patients, co-workers, and supervisors by portraying calmness regardless of their own emotions or the situation (Cottingham, Erickson, and Diefendorff 2015; Hochschild 2012). The gendered expectations of being nurturing at home and work, combined with the physical demands of healthcare, and emotional labors, increased burnout among the predominantly female HCWs.

The just-in-time supplies and staffing processes that came out of quality initiatives implemented in the 1990s were not up to the challenges of caring for a population during a pandemic (Radnor, Holweg, and Waring 2012; Shortell et al. 1995). COVID-19 dramatically increased the urgent need for staff and PPE supplies. Garbage bags became PPE gowns, and OB nurses became emergency room nurses. HCWs lacked the resources needed to treat COVID-19 as it moved across the United States and the rest of the world. The stress of COVID-19 on HCWs ' work and home life, combined with the demands for more work, pushed HCWs until they were burned out and seeking alternatives.

The hospital is a complex and fragile glass structure, where white male HCWs are propelled up to the glass penthouse on elevators, moving efficiently towards leadership positions (Williams 1992). Staff at the intersections are sent to the glass basement, working the units, and unlikely to be visible for promotions. Some HCWs find an exit strategy, exiting and re-entering through a glass door as TICs. TICs discovered a way to enter the hospital, avoiding the traditional entrances while increasing their pay and autonomy.

Traditional employed HCWs feel abandoned due to the TIC's renegade conduct. While the TICs gained as individuals, they left behind their struggling colleagues. The arrival of the TIC into the COVID-19 healthcare landscape brought relief and created division among HCWs. TICs have autonomy and make more money, and some dissatisfied HCWs become TICs. TICs are leveraging their advantages, obtaining advanced education, and making plans for their future. Some TICs will avoid returning to traditional employment. Those who have used this opportunity to advance their education will likely move into leadership or teaching roles. As either leaders or professors, it will be interesting how they address traditional employment models against their TIC experiences. Other TICs, if the healthcare landscape can return to a previous time, will return to traditional employment. The experience they bring with them may encourage them to advocate for new employment models, less dependent on squeezing HCWs for labor. Unions will benefit from the rise of the TIC. This newly empowered group, flush with cash, more educated, and accustomed to autonomy, threatens the glass hospital.

Lobbying groups and legislators are alarmed by the new paradigm and focus on returning to the traditional healthcare employment model for frontline HCWs (Anon 2021, Anon 2022; Brusie 2022; McClendon and Levine 2022; McClendon and Proctor 2021). While TICs provided options during the pandemic, they are not optimal long-term solutions. They are expensive and do not have the corporate expertise that a permanent HCW does. Finding solutions to staunch the steady loss of HCWs requires considering new ways of staffing healthcare facilities and increasing the number of HCWs available significantly to replace those lost. Currently, the current situation does not seem sustainable for healthcare. As a CNA in a California psychiatric hospital said, "no one lasts… Now we have nothing but travel nurses."

Conclusion

The glass hospital examines interviews with HCWs during the peak of the Omicron

COVID-19 variant in the United States. Gender, race/ethnicity, and other areas where power intersects within individuals are mirrored in the glass hospital structures, limiting elevator access to some and using microaggressions, discrimination, and guilt against those on lower floors. This study expands knowledge of HCW's experiences with intersectionality, gender, and race, in the COVID-19 healthcare landscape. The results show that those who exist at the intersections were further marginalized through pressure to work more, experiencing burnout. An unexpected result occurs when the exit door appears, the opportunity to become a TIC. HCWs left their traditional employed healthcare to become TICs, altering HCWs' relationships with hospitals.

The changing roles within healthcare due to the pandemic are a microcosm of the power plays occurring in greater society. As laborers gain power by escaping the confines of traditional employment, increased pressure is applied by the powerful on the remaining staff. In healthcare, the pressure occurs both within, from the in-group of employed HCWs who ignore the TICs, and from above by those in power, seeking a return to the traditional hierarchical model.

Sociological theories focusing on structural discrimination were utilized to evaluate the interviews. These theories were combined with the interviews of HCWs to construct the glass hospital, in which some HCWs have access to the glass elevator and are promoted, while others are restricted to lower floors. Gendered and racial shortcuts form the foundations of the lower stories; these shortcuts are methods of rapid decision-making for staffing a hospital open around the clock. TICs have found a way around hospitals' staffing shortcuts similar to other gig workers. Employed HCWs are restricted to the glass hospital, but TICs have located the exit door. TICs operate in the background of hospitals, unconnected with a specific facility and traveling between understaffed facilities in search of financial rewards. While TICs resolved staff shortages, they brought a significant financial burden to healthcare facilities.

The arrival of the TICs further complicates the structures of the glass hospital.

The current animosity between employed HCWs and TICs will likely evolve as the COVID-19 pandemic enters a new phase as a routine part of healthcare. Wage disparities between the two groups will stabilize over time, reducing animosity. If the two groups were to resolve their differences, the potential power of diverse healthcare workers if they band together becomes a threat to the structure of the glass hospital. Healthcare may struggle to re-contain HCWs into the glass hospital. It seems unlikely that TICs are eliminated from the future of healthcare without significant governmental intervention. The glass hospital, like Pandora's Box, cannot be closed again. The glass exit doors have been opened, due to COVID-19 and the TIC, and it is unlikely these doors can be closed again.

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Appendix 1

Qualtrics Data

Table 1: Demographics of Participants* (n=21)

Gender	
Male	9.52%
Female	90.48%
Non-Binary/Third Gender	0.00%
Other	0.00%
Sexual orientation	
Heterosexual	90.48%
Gay/Lesbian/Queer	9.52%
Bisexual	0.00%
Asexual	0.00%
Preferred response not listed	0.00%
Prefer not to say	0.00%
Other	0.00%
Race/ethnicity (participants could select more than one).	
Asian/Asian American	9.52%
White/Caucasian	42.86%
Black or African American	38.10%
LatinX, Hispanic, or Spanish heritage	9.52%
American Indian or Alaska Native	4.76%
Native Hawaiian or Pacific Islander	0.00%

Middle Eastern/North African	0.00%
Other	0.00%
Immigration Status (participants could select more than one)	
I was born outside of the United States	14.29%
I was born in the United States	85.71%
I attended college &/or obtained a professional degree outside of the US.	0.00%
I am licensed in another country but unable to obtain the same certification in the US.	0.00%
Other	0.00%
Licensure, if applicable (participants could select more than one)	
RN	85.71%
LPN/LVN	4.76%
Nurse Practitioner	4.76%
CNA	9.52%
Travel or employed	
Employed	47.62%
Travel	52.38%
Years of healthcare experience	
One to three years (2)	19.05%
Three to five years (3)	19.05%
Five to ten years (4)	33.33%
Over ten years (5)	28.57%
Subject location by state	

California	4.76%
Florida	4.76%
Georgia	4.76%
Michigan	4.76%
Missouri	9.52%
Mississippi	9.52%
Pennsylvania	9.52%
South Carolina	9.52%
Texas	38.10%
West Virginia	4.76%

*All above demographic information was provided by the participant in their Qualtrics survey prior to the interview.

Table 2: Number of jobs participants work (n=21)

How many Healthcare facilities are you affiliated with, including on-call, PRN, part-time, full-time	
One	42.86%
Two or more	52.38%
No response	4.76%

Table 3: Variables Describing Discrimination*

I have experienced discrimination at work.	
Never	28.57%
Sometimes	28.57%
Occasionally	19.05%

Routinely	14.29%
In specific situations	9.52%
I have observed discrimination occurring at work.	
Never	19.05%
Sometimes	42.86%
Occasionally	14.29%
Routinely	23.81%
In specific situations	0.00%

Appendix 2

Qualtrics Survey Questions

Demographics

What is your gender?

Male
Female
Non-binary / third gender
Prefer not to answer
Other, please list below

What is your sexual orientation? Check all that apply.

Heterosexual
Gay/Lesbian/Queer
Bisexual
Questioning
Asexual
Preferred Response not listed
Prefer not to say
Other, please list below

How would you describe your race/ethnicity? Please select all that apply.

White/Caucasian
Black or African American
American Indian or Alaska Native
Asian/Asian American
Native Hawaiian or Pacific Islander
Middle Eastern/North African
LatinX, Hispanic, or Spanish heritage
Other, please describe below

Are you an immigrant? (choose all applicable)

I was born in the United States
I was born outside of the United States
I attended college &/or obtained a professional degree outside of the United States
I am licensed in another country but unable to obtain the same certification in the United States
Other, please describe

What is your Professional License(s), if applicable.

No license
LPN/LVN
RN
MD/DO
Other, please list below

What is your current employment status?

Employed full time (40 or more hours per week)
Employed part time (up to 39 hours per week)
Unemployed
Primarily a student and work in healthcare
Work more than two jobs
Other, please describe below

How many years have you worked in healthcare?
Less than one year
One to three years
Three to five years
Five to ten years
Over ten years

How many Healthcare facilities do you work, including on call, PRN, part-time, full-time

One
Two or more (write in how many and include part-time, full-time, PRN and on call

Staffing
I have signed up to work extra shifts because (choose all that apply)

I do not sign up for extra shifts
Need for extra money
I liked the team assigned to that shift
I liked the unit
I liked the pay for that shift (shift differential for evening/weekend/holiday)
My friend(s) or people I enjoy were working
I have called off a shift because (choose all that apply)
I do not call off shifts
Illness
Other personal conflicts
I did not want to work that shift
I did not want to work that unit
I had a better offer from another facility, such as better shift, pay (describe)
I did not want to work with the assigned team/specific other staff

Consider your schedule and pick all of the below which are applicable.

I know my schedule months in advance
I know my schedule weeks in advance
I know my schedule days in advance
My schedule is generally routine
My schedule is chaotic
I never know when or where I will be working
I usually work the same shift
I usually work the same unit
I work wherever I am assigned
I am asked to work units or shifts that I do not usually work
I usually know what units/shifts that I will work in advance

Resources

Do the people you work with know how to find necessary equipment in a crisis?

Yes
Sometimes
Rarely
Never
Depends on the shift/unit

I feel I can find necessary equipment or resources in a crisis at all the facilities I work.

Yes
Sometimes
Rarely
Never
Depends on the shift/unit

Team

People I work with know how to do their job well.

Always
Most of the time
About half the time
Sometimes
Never

My team has after-hours interactions.

Frequently
Sometimes

Never
Other, please describe

My team works well together.

Always
Usually
Sometimes
Never

How would you describe your role within your team/unit? (Choose all that apply)

I am considered an important team member
I work multiple units and teams
I feel valued in the teams I work
I do not feel like a member of a team
I feel bounced around
I get called for shifts/units no one else will work
I have certain skills the team needs performed to be successful
My team is happy when I show up
I introduce myself every shift
Other, describe below

Do you feel like a member of a team?

Always
Never
Sometimes depending on schedule & facility
Depends on who else works on the shift/unit
Other, describe below

When I work a shift or unit, I do not know anyone assigned to work with me.

Frequently
Usually
Routinely
Rarely
Seldom
Never

Indicate your feelings when you work with a team or on the unit. Choose all applicable options below.

I feel valued
I feel respected
I feel out of place

I feel like my teammates listen to my opinion
I feel no one listens to my opinion
I feel like we work well together
I feel like we do not work well together
I feel we work well in crisis
I feel disrespected
I feel like I am not valued
I feel like my team 'clicks'
I feel like certain teams work well together
Some teams do not work well together
Some shifts I look forward to
Some shifts I feel will go poorly
I always look forward to work
I never want to go to work
Sometimes I am happy to go to work
Sometimes I do not feel like working

Outcomes

If a crisis or adverse event were to occur (Choose one)

I am confident in my team
The outcome might depend on who is working
I lack confidence in my teams abilities during a crisis

Recognition

My team is recognized for good work by leadership.

I agree with the above statement
The above statement is sometimes true
The above statement is false

Discrimination

I have experienced discrimination at work.

Never
Sometimes
Occasionally
Routinely
In specific situations (may describe below)

I have observed discrimination occurring at work.

Never

Sometimes
Occasionally
Routinely
In specific situations (may describe below)

When staff are scheduled for shifts and units (choose the best response)

Agree
Usually the schedule is fair
Sometimes certain staff receive preferential treatment in their schedule
Certain staff usually receive preferential treatment in their schedule
In specific situations (may describe below)

I feel I am a member of a work team.

Always
Most of the time
About half the time
Sometimes
Never

Appendix 3

Interview Filter Questions

CAMERA ON!	Scheduling	Patient Safety	Teams/teamwork	Leadership	Discrimination
Review Qualtrics survey- were any of the following categories met?	Staffing	Adverse Outcomes & Resources	Teams/teamwork	Recognition	Discrimination
	1. Talk about your experiences with being staffed to units or shifts. What shift(s) do you work usually? Is that when you want to work?	2. Talk about a crisis situation, and without using patient, staff, or hospital names, tell me how it went.	4. Talk about your team. Do you feel you are part of one? Do you interact after hours? How do you perceive them? How would you say they perceive you?	5. Do you feel recognized by leadership? Do you feel your team is recognized by leadership?	Have you experienced discrimination in your healthcare job?
		3. Talk about important equipment in a crisis. Do you know where the equipment is located? Do others?			Language?
Dead end responses Move on	Know in advance, routine, satisfied, same as everywhere, fine	Successful, happen, rarely, part of it	bond, love, enjoy, great, supportive	Supportive, analyze, appreciate, understanding, present	I don't feel/observe discrimination, No, Never, doesn't happen, very supportive, everyone gets along
Shift and focus	Never know, always calling me, unpredictable, annoying, unreliable, chaotic	routine, shortcuts, intervention, mistake, patient safety, error, resources/equipment, adverse event, blame, shift change/hand-off, patient transfer, working long hours/too often, rushed	don't care, apathetic, lazy, not supportive, always different/changing, not reliable	authoritative, written up/counseled, lack of support, don't understand, no appreciation, never around	I don't feel/observe discrimination, Yes, are you kidding?, sometimes, frequently, usually, depends on who is working, (observe for physical tells; side-eye, dropped eyes, pauses, etc.)
Focus questions	What factors are involved in scheduling problems? What were you thinking when you were scheduled in those ways?	Describe an event where things went wrong. I don't need any names, but details such as time, place, and how the team operated are helpful. Was the equipment needed available in a timely manner? Did everyone know their role?	Can you describe more about how your team interacts? Do you get alon well? Do you like your team?	Can you describe more about leadership? A specific event? Was scheduling involved? An incident? What was the reason for the write-up/counsel?	Do you find yourself working times you don't want to work? Do those around you complain of working when they do not want? Are you scheduled for shifts you have asked not to work? Are incident rates higher when you or others do not like to work? Why do you think you are scheduled when you do not want to be?
	Don't know, just how hospitals are	Cannot provide detail, cannot recall, refuses, says things go well, no concerns, routine, details support an event going "as well as can be expected"	Get along fine, I like them, mostly get along, we know each other, we interact outside work, friendly, care	That's just how they are everywhere. It's just the way it is. Cannot/does not provide	Fine, I don't care, just how it is, doesn't matter, refuses, cannot recall
	Covid, discrimination, unfair, hostile, you wouldn't understand, certain people/groups, incompetent	Event goes poorly, happened at night, weekend, holiday, staff/equipment late, did not follow procedures, blame, angry, leadership doesn't understand how these events happen, nobody knows what they are supposed to do	Don't know them, always different, undependable, don't know what they are doing, not reliable, concerned about certain people, feel discrimination, feel unliked, feel unwelcome, feel like an outside, feel different	Compliant involves scheduling, an event, or discrimination. Concerns sound like they may include discrimination. Unliked, not respected, treated differently, unfair systems, others get treated differently	
Additional Focus questions	GO TO NEXT QUESTION	GO TO NEXT QUESTION	GO TO NEXT QUESTION	GO TO NEXT QUESTION	

END

Where are you located? What is your job title?
What college? Would you describe that college as prestigious? Student debt?
What shifts? Nights/wknds/holidays?
Do you Travel? Do you work with travelers?
Do you work with Covid patients? Have you had Covid?