When Heroes Don't Feel Heroic: An Oral History of COVID-19 Healthcare Workers

By

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ABSTRACT

This thesis is an expansion upon oral history interviews taken from medical professionals in regard to their experiences working through the COVID-19 pandemic. The individuals who provide most of the information from this study are Angela Pitman, who was an acute care nurse practitioner during the pandemic, Carole Lovering Kooi, an intensive care nurse practitioner during the pandemic, and Magan Rish, a charge nurse during the pandemic. Angela Pitman and Magan Rish worked in the same rural hospital in Middle Tennessee, while Carole Lovering Kooi worked in a hospital in a community surrounding Atlanta, Georgia. These interviews were taken in the Fall of 2022, using an interview protocol consisting of ten questions, with one to three follow-up questions per main question to encourage elaboration when necessary. Other sources used in this thesis will be cited and used as support to these oral history interviews. This document is divided into sections based on topics discussed by the interviewees.

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ABBREVIATIONS AND TERMINOLOGY USED

COVID-19/COVID- Coronavirus Disease first making its appearance in 2019

C-Diff- *Clostridioides difficile,* an infectious bacteria that is easily transmittable and causes diarrhea and colitis

Charge Nurse- supervising nurse of a medical unit

Intubate/Intubated- process by which a healthcare provider inserts a tube through a person's mouth or nose into their trachea in order to keep their airways open. This tube can then be connected to a machine that delivers air or oxygen.

Ivermectin- anti-parasite medication typically used in the United States to treat infections in animals caused by parasites

MacGyver- to make do or repair something with what is conveniently on hand, refers to a circa 1985 action fiction television series

MRSA- methicillin-resistant *Staphylococcus aureus,* a bacterium with antibiotic resistance

Nebulizer- drug delivery device used to administer medication in the form of mist delivered to lungs

NP- Nurse Practitioner, an advanced level practitioner who functions in a provider role

N95- mechanical filter respirator that provides protection against fine particulates in the air

Negative Pressure Rooms- a type of hospital room designed to prevent airborne microorganisms in the room from entering the hallways and corridors

PA- Physician's Assistant

Plaquenil- Hydroxychloroquine, immunosuppressive typically used to treat arthritis or lupus

PPE- Personal Protective Equipment, includes masks, gowns and gloves

Pressors- medications that raise the blood pressure

Proning- the act of placing patients in respiratory distress with their stomach and chests facing downward to increase blood oxygenation

TB- tuberculosis, an infectious disease of the lungs caused by bacteria

CHAPTER ONE: CHANGING PROTOCOLS

When COVID-19 spread, many countries faced a shortage of supplies, as well as staff, both of which were needed to combat such a pandemic. In the United States this resulted in “lockdowns” to try to limit the spread of disease and give the healthcare community and manufacturers time to build up the supply of things such as Personal Protective Equipment for frontline workers, one-use items for patients, and more. Carole Lovering Kooi sums up well how COVID-19 impacted many aspects of working within the medical field:

> “I think it kind of trickled down through all through all areas. I mean, staffing ratios, pay, use of resources, use of time. All of those things were affected by COVID in one way or another. And that's different institution by institution. But I think the landscape of medicine is different, and we just have to continue to adapt to it. And that is one thing that has- that surprised me when I first went into medicine was that they didn’t- we don't have it all figured out. What do you mean? Like, why do we need to institute new protocols in a hospital to, like, improve hand hygiene, for example?” (Lovering Kooi Oral History Pt.1, 2022, 29:51).

Throughout Carole’s interview, she communicated this idea that the medical field did not have everything figured out the way that we, as the public, so often would like to think. She reiterated time and time again the ways that those in this field are constantly learning and adapting to better help patients, but at the end of the day they are humans prone to mistakes just like anyone else.

While the lockdowns were meant to give everyone time to gather more supplies for treatment and prevention, these measures to prevent the spread of COVID-19 did not change the fact that the supply shortage called for changes in standard protocols that healthcare workers and providers normally followed. One of the most shocking parts of standard protocol that changed in the face of this pandemic and supply shortage was the

reusing of items that were typically one-time use to prevent cross-contamination. This is something that was publicized to an extent, but perhaps not in ways that truly showcased the dire situation that workers were put in. The reusing of masks was perhaps one of the only ways that the public was made aware of a shift in the standard protocol for dealing with an infectious disease

Angela Pitman recounted in her interview, the protocols before the COVID-19 pandemic:

> "So, as far as PPE, protective gear, the times that you wear protective gear in the hospital, prior to COVID, was the flu. You'd wear a mask and a gown. You go in the room, you take your mask for you to see the patient and [then] you take your mask, your gown off, you throw it away. C-Diff, which is an infectious diarrhea, you wear a gown, you wear gloves, you take them off, you throw them away. TB was the only time that we had to wear an N95 mask and- it was- and it was rare like we very rarely had patients that you have to have it N95. And it was so rare that you have- you have specialty rooms that you keep those patients in there. They're negative pressure rooms. And there's like, again, I mean, I was in a rural hospital during this time period, so there's only like two negative pressure rooms. And again, N95, which you were fit tested for, meaning that you had a special test you went through to make sure that that mask fit you with no air leaks with this special saccharin spray. So, you would wear this mask that you knew fit, you went through a fit test and once you went in the room and you came out of the room, you threw said mask away and then- MRSA, we wore gowns there." (Pitman Oral History, 2022, 7:12)

This interview gave some of the clearest information regarding what protocol was before the COVID-19 pandemic. How Personal Protective Equipment was used and when it was disposed of after use, with the normal protocol prior to COVID-19 being that things were only used once and promptly disposed of after use, was all concisely covered in Angela's response. Carole Lovering Kooi spoke similarly about the protocol before the pandemic, "So N95, masks were a single patient use supply. So were surgical masks-" (Lovering Kooi Oral History Pt.1, 2022, 11:50). This standard of many PPE items being single-use

may very well have come from a place of being overly cautious in protecting workers in this field, and those they would come in contact with, from sickness. Whether this was fully necessary or a standard that sprung from an abundance of cautiousness, it was something that quickly became clearly impossible to maintain with the supply shortages the healthcare field faced during the beginning of the pandemic.

Single-use protective gear was commonplace for hospitals to protect their patients and staff from infectious diseases, however when supplies became limited this changed drastically. Rather than using an item once and throwing it away, medical professionals were forced to reuse typically one-use items, modify PPE, and change many standard practices in order to conserve supplies. Protocols such as the negative pressure rooms and fitted N95 masks were not readily available, causing this change to occur rapidly as more patients infected with COVID-19 showed up at the hospitals. The World Health Organization released guidelines in December of 2020 on the reuse of PPE that had historically been used only once prior to being thrown away. WHO advised that in the face of the shortage that PPE could now be reused with the limitation of being in "scenarios where health workers are providing continuous care or assessment to a cohort of patients with confirmed COVID-19 who are not additionally suspected or confirmed of other healthcare transmissible infections." (WHO 3). So, the reuse of these supplies was recommended as a way to combat the shortage if it came to a point where single-use items needed to be used multiple times with a patient group infected with the same disease type.

The resulting outcome of these recommendations created an unprecedented medical work environment as described by Carole Lovering Kooi:

> "Without having an abundance of resources of those [PPE supplies], we essentially had to keep our N95s for weeks at a time, send them for cleaning where they would do some particalize and UV cleaning at the hospital. So, we'd use brown paper bags, like we're going to lunch at school and elementary school- um and put them in there and basically try to preserve what we could. Surgical masks became multi-use devices. They were used all day, potentially for days at a time. We ran through shortages of basic supplies like normal saline, which is an IV fluid that you use to expand a patient's blood volume. We ran out of pressors at one point, and you just have to make do with what you can with what you can have on hand and use. So, it was kind of an opportunity to MacGyver things in a way that you never would expect in the United States." (Lovering Kooi Oral History Pt. 1, 2022, 11:50)

Similarly, Magan Rish describes the ways in which members of the medical community tried to make do with what they had:

> "At first, we were trying to figure out what resources do we have and how to be the best stewards of those resources. Like as far as our PPE was concerned, we got kind of creative with the gowns that we wore, like pretty much wearing what appeared to be shower curtains. And we also had others that came up with ideas. My brother-in-law, for instance, 3D printed shields for health care workers. And I got him in touch with the folks at work, you know the big decision makers. And he was able to donate a bunch of shields that he had 3D printed for us. But we got kind of- We got pretty ghetto with some of our PPE." (Rish Oral History, 2022, 6:07)

In many ways, situations like these, where hospital staff had to source supplies from their communities and rely on their own ability to make what they needed for themselves, were unimaginable prior to the COVID-19 pandemic, especially in a country such as the United States. These drastic changes in protocol and the ways that hospitals normally operated occurred around the world, as many places faced extreme shortages in supplies, with lockdowns seeming to be the only thing preventing these hospitals from completely overflowing with COVID-19 cases.

Magan Rish further explained the ways that the shortage of supplies affected her and other nurses saying,

> "So, we went to a cloth type of gown, which we looked like Big Bird- pretty much, walking around taking care of these patients. And at first, it was, um, the protocols and policies were very fluid throughout this process. . . And we started using, like hanging our gowns outside of the rooms. And we would have separate masks to go over our N95s. We wore our N95s until the straps broke and wearing them all day- you would sweat and you would be gross and the insides of them would be disgusting. And we started to develop sores on the tops of our noses from the metal, and we would have to put separate mask over top of those. And so, we were at the beginning of our day, we would like- I know I would write the room number and my initials on my mask that went over my N95. And then we would have individual gowns hanging up outside of the rooms, or we would wear the same gown if we were going from room to room to room, as long as they didn't have any other sort of infectious process like they were on contact because they had C-Diff or MRSA or anything like that, kind of a like diagnosis, if you will." (Rish Oral History, 2022, 8:21)

Angela Pitman, who worked in the same hospital as Magan Rish at the time, also recalled the shift in protocols:

> "So, there's a few things. Okay, so COVID hit and there's not enough PPE. You are guarding your N95, that you probably bought for yourself, with your life. Like you're wearing it over and over and over again. We went from plastic- these like, weirdly airy gowns that you threw away to these weird materials that look like shiny sheets, which we still use, that we didn't even have enough of those, and those were getting laundered to reuse. So, I would be wearing my N95 that was not fit-tested and to be honest, probably didn't work. I mean, like some of them were KN95, so they were like from China. Our surgical masks were breaking because they were so poorly made. It was hilarious. We would- so to keep from having to change all this stuff, because we didn't have enough of it, or waste it. I would literally do my COVID patients all at once, so I would gown and mask up. So, I would have my gown that would at some point get laundered by a service. I would have the N95 that I bought for myself that I'd been wearing for weeks, well, maybe a week or two at a time, and then I'd switch it out. But you know how hard it was to buy N95 for yourself and the hospital was having a hard time getting them, and then you would have a surgical mask over your N95 to protect it so you could re-use it. So, I would put on my gown, my N95, my mask, of course, the goggles I bought for myself because they were anti-fog and what the hospital supplied were horrible and I would start rounding on patients. The only thing I would change is my gloves. I would do hand hygiene and gloves between patients. But yeah-again, not fit tested, bought myself, and we would reuse instead of throwing away. It was-it was interesting." (Pitman Oral History, 2022, 8:53).

In the face of the pandemic, it became necessary to not only reuse things that had been typically one-use items, but also to switch the materials of certain items in order to compensate for a lack of supplies. The World Health Organization mentioned in regard to PPE items that would be reused and cleaned for reuse, “Decontamination or reprocessing of single-use PPE is an evolving area that is undergoing research and development, in which additional studies are urgently needed. . . as more evidence becomes available, WHO will update these considerations accordingly.” (WHO 4). Many changes to the protocol were fluid, as healthcare workers and hospitals learned better how to conserve supplies while still protecting their patients.

Both Magan Rish and Angela Pitman worked in a rural hospital in the Middle Tennessee area, whereas Carole Lovering Kooi worked closer to Atlanta, Georgia in an Intensive Care Unit. However, they all faced similar supply shortages and changes to protocol due to said shortages. Carole Lovering Kooi also noted how, from a standpoint of handling infectious disease, she felt that many individuals working in the medical field were maybe even over-prepared in terms of knowledge about how to prevent spread and overzealous in trying to clean themselves before going fully back into their home. The main issue faced was that everyone was severely lacking in supplies to the point of becoming unsure of what services they would actually be able to offer their patients while at work. She stated in her interview,

> “And that's really one of the more memorable parts of the pandemic, was how, you know, scarce resources were, how we were reusing resources. And there was a lot of fear of how long we would be short- and supplies- and how much we could really offer to patients as a result.” (Lovering Kooi Oral History Pt.1, 2022, 10:34).

In regard to whether or not protocols returned to what they had been prior to the pandemic, Angela Pitman laughed in her interview, remarking,

> "There is less fear after what we've all been through. Now you have access to it. You have access to your PPE again. But it's just like, why not use this gown that's hanging on the door instead of getting your own gown? Yeah, there's a lot less there. It's not that- We are not as scared of anything anymore. And so, yeah, the PPE Protocols, although we have access to the stuff, we could definitely change it out. I would say that. We got-gotten into that COVID- that COVID land where we're used to saving supplies." (Pitman Oral History, 2022, 11:31).

Carole Lovering Kooi shared similar sentiments about what protocol was like following COVID-19:

> "We have more masks they're- They're not heavily policed the same way. Surgical masks- we typically wear all that all day. If you feel like you need a new one, you get another one. But gowns and things, you know, face shields, glasses, all that, they're back. You just- I think we're a lot more aware of how much we're using now. But I feel like we have what we need to stay safe. And I do think- I strongly believe that it works." (Lovering Kooi Oral History Pt.1, 2022, 13:48).

The shortage of supplies changed the way that hospitals operated during the pandemic in ways that have lived on after it. Healthcare workers feel more confident in their judgement in preventing the spread of disease. The virus was a complete unknown at the beginning that coincided with an unprepared global medical system; by the end our frontline workers had gone through things they never expected and emerged with greater confidence.

CHAPTER TWO: COMBATTING MISINFORMATION

Another aspect of working during the COVID-19 pandemic included healthcare professionals having to combat misinformation, as well as sometimes a lack of information, within the general public. From how to prevent the spread to how to treat COVID-19 if infected, the public held many views that were based on misinformation and/or lack of access to reputable information. All interviewees spoke on this issue, however Carole Lovering Kooi shared information that gave insight into how the public being susceptible to misinformation may have had roots in the policies early on in the pandemic that limited family members from seeing their sick relatives. She expressed how she believed this led to a lack of awareness as to how those family members went from seeming to be like they would survive the illness to on their deathbeds.

> "We would have the patients who had COVID- couldn't have any visitors initially and for months couldn't have any visitors. So, they were essentially isolated in their rooms. They were negative pressure rooms. And, you know, the nurses that had those patients were available only really when they could gown-up and get in the room. And families were spoken to over the telephone or sometimes over video chat on the hospital, iPads and tablets that sort of roved around the hospital. And then as time went by, they allowed, you know, a visitor to come outside, outside the room if the patient was like comfort care or actively dying or something. And it was just incredibly hard for families to be separated from their- from their loved ones. And there was a ton of anger and blame and mistrust of the providers in health care because they couldn't see for themselves what was happening. And so, I think it honestly perpetuated the, you know, the-the feeling that like, you know, this could be made up and that, you know, 'Y'all are withholding things from my loved one and you're not telling me things.' And, you know, phone calls that were meant to just be a five-minute update would turn into an hour plus because people were asking- families were asking questions about like Y-values and what ventilator settings were. And like Googling things at home, trying to figure out ways- things that they we should be giving or doing for their loved one that we- that they didn't believe we were doing. I had one family accuse us of never having changed the ventilator during her parent's hospitalization, that we were just leaving her-her parent on the same ventilator settings and not adjusting anything. And it was just it was really hard, I think, for

> families to comprehend the- the difficulty of taking care of those patients from the medical provider standpoint." (Lovering Kooi Oral History Pt.2, 2022, 1:00).

This background about the policies, especially those at seen early on, during COVID-19, that many of us have maybe forgotten or not considered if not kept apart from a close relative in the hospital during these times, provides massive insight on one of the ways mistrust towards medical professionals began among many individuals of the public. When thinking about how was it that people did not take this pandemic seriously, why they chose strange remedies to combat this disease rather than trusting professionals, and why they over- or under-reacted to the pandemic, it is important to remember this piece of information from a healthcare provider about the ways that this early policy negatively affected public opinion towards the medical field.

This aspect of policy she expressed as feeding into mistrust towards those tasked with the handling of the pandemic, as well as those working through it, likely did lend itself to mistrust of the healthcare field as a whole throughout the pandemic even after such policies were repealed. Carole noted her own feelings about these policies now that she could look back on them in hindsight:

> "And that's something that. I think we got it wrong, to be honest with you. I think that the restrictions for families of people dying from COVID went on too long when we learned that-what we could do to-to protect ourselves, what we could do for the family members to protect them. I think we should have acted on that earlier because too many people had to die without their families nearby. . . For the record, whatever record there is, it was extremely hard for people in medicine to isolate those patients from their loved ones. And- I'm glad that I wasn't in charge of making those decisions because I would have a lot of regrets. Because there's a lot of trauma that I think people will spend a long time overcoming by missing their- their family's last moments." (Lovering Kooi Oral History Pt.2, 2022, 5:07)

Angela Pitman mentions another aspect of dealing with the pandemic that may have further led to mistrust, when speaking on her experiences doing locum, where she traveled and worked at a bigger hospital in Indiana during some of her weeks off from her regular hospital:

> ". . .in one region we had women that were losing their babies because of COVID, and then in another region the women were dying, but the babies were surviving. It was-it was very interesting to see different regions of the country, how they handled it, but also- how people got sick or the people that did get sick and affected." (Pitman Oral History, 2022, 33:40)

Her description of how different regions had different demographics affected more or different outcomes for patients infected provides further insight into why the public may have felt it was getting varying information and in turn distrusted so much information.

In the same vein as the public receiving varying information, distrust was likely bred through the fact that medical professionals, and the medical community as a whole, only learned how to deal with this disease effectively as time went on. For many in the public, the pandemic is easily viewed as a singular event, rather than a series of events, caused by a "singular" COVID-19 virus, when it was in fact a series of events and multiple strains of this virus that occurred over the course of what we now readily refer to as "the pandemic." Magan Rish described how with each wave, the medical community was learning about COVID-19. She poignantly described how in the beginning, even many medical professionals feared the disease:

> "There was a lot of fear because we didn't know what we were walking into. And you had a lot of nurses that at first panicked and they said, 'I don't want to bring this home to my family. I don't want my family, my, my spouse, my kids, my brother, or sister. Mom, Dad, I don't want to bring this home to them.' And so, you had an initial freak out, like a, 'What the fuck?' moment. 'What are we walking into? What is this? I don't want to die'- kind of thing. But then there was almost like a call to action from some nurses. Like, we really felt we were going to be

> making a difference and we're going into battle and we're going to combat this virus. And- we're-we're going to give it hell and we're going to give it all we got. But some nurses were more stringent, if you will, as to their own personal practices, like some nurses would completely change clothes. I was not one of them that would just completely change clothes for a walk in the door. I'd wash my hands, of course, but my thought was, I'm wearing all of this PPE. I look like Big Bird going into these rooms. I'm safe. And then we got the lull, and we got a chance to breathe. It was like, Thank God. Oh, this is awesome. We're done. We're out of this. And then that second wave hit- and that's where a lot of our staff just said, 'I'm out. I'm done. I can't do this anymore.' I have to say, the second wave that hit September of last year [2021], was way worse than the first go-round." (Rish Oral History, 2022, 12:25)

Another aspect that caused the spread of mistrust and misinformation was the politicization of the pandemic by the media. Instead of COVID-19 being a disease that the medical field was trying to figure out, it became a talking point on either side of the political spectrum used to further whatever agenda each side wanted to push the public to believe on the matter. Through this politicization we saw different narratives on the vaccines formed and espoused by different political groups, as well as different remedies vouched for by each party. Carole Lovering Kooi spoke in response to her feeling on the politicization of the COVID-19 pandemic:

> "Not a fan. Not a fan. I think, honestly, medicine should be- Practiced by providers and not by politicians. And I do think the public was misinformed a lot of the time because of how political it became. And that was very frustrating from my perspective. I just, you know, I wanted people to be hearing about it and be, you know, at least know what was out there. But you can't get unbiased news. So, everyone was spinning it the way they wanted to support their side of an argument. And that's, you know, people are dying and y'all are just, you know, playing a game." (Lovering Kooi Oral History Pt.1, 2022, 26:51)

She also shared what she thought was some of the craziest misinformation that was spread in the wake of the pandemic:

> ". . .the one that's probably the most often referenced is that the-the vaccine would like implant some kind of tracking device in you or give you cancer. I mean, that the theories, the conspiracy theories about what the vaccine had in it,

> nanoparticles of X, Y or Z, we're going to be glowing from space. I don't even know, like the stuff people came up with to avoid, like, getting a shot just blew my mind." (Lovering Kooi Oral History Pt.1, 2022, 27:56)

The issue of vaccine mistrust seems to be somewhat of an ongoing issue for the public. While there had been movements before the pandemic against vaccines, as well as those who opted out of vaccines due to religious or personal reasons, the COVID-19 vaccine seemed to become a massively divisive topic. In Why Vaccine Confidence Matters to National Security one reason given as to why these fears were amplified is, "…vaccine fears were already present before the launch of OWS [Operation Warp Speed] , although the language of 'warp speed' has amplified concerns about COVID-19 vaccines being developed too quickly." (Larson et al. 9). It also mentions some of the conspiracy theories spread in regard to the vaccine: "These range from claims that Jewish scientists have created the vaccines to alter recipients DNA to rumors that vaccines cause women to become infertile. Another theory proposes that the vaccines are meant to insert microchips or other kinds of tracking devices into peoples' bodies." (9). It is also mentioned that these fears do not spring from nothingness, no matter how off-the-wall some may seem, as there is ample historical example of people being used as guinea pigs for experimental treatments, such as the Tuskegee syphilis experiments.

One of the conspiracies it would seem that all of us are aware of, in terms of the COVID-19 pandemic, was the promotion using Ivermectin to treat COVID-19. Magan Rish spoke on dealing with this and other "home" remedies patients tried to combat COVID-19 when they had it:

> "So, you did have your patients that swore on Hydroxychloroquine or Plaquenil. You had your patients that were taking ivermectin. And I would jokingly ask where they got it from? Did you go to Tractor Supply or did you go to the vet's

> office? And we had- we had to kind of tread lightly with some of those cases because it was like, 'Do we feel like fighting with this person? Do we really want to fight this battle?' So, I had one patient come in and there was this interesting symptom of the virus that really cannot be explained, as to what causes it, but people not understanding just how sick they were. And we called it like- COVID brain because they wouldn't-they couldn't understand just how sick they were. And they didn't think they needed all this oxygen. I'm like, 'Well, we take it off [and] your O2 set are going to be in the 70s.' So, we had to take so many things from school that we learned as far as respiratory function and just kind of throw it out the window. And we had a guy that came in that was unaware of just how sick he was. And I'm looking through his medications, getting his admission history and everything done and I see this fool has got a bottle of ivermectin; and his doctor has prescribed it to him. And I just looked at the bottle, and I looked at him. Granted, I had all my gear on my face so he couldn't see the facial expressions. Those are the one thing that N95s are good for. You can make all the expressions, and the patient wouldn't know as long as you didn't show it in your eyes. Like 'Are you Stupid?' But he swore by it and I didn't fight him on it. I said 'Okay. Here you go. But Imma let you continue taking this.' We even had. Oh, we had one family member, this patient's wife wanted to do nebulizer treatments of iodine. Like what? What do you think that's going to do? Clean out the inside of his lungs? What? Say it again. Out loud, slowly. So, you can hear what you just said. Iodine? Nebu-? No, no. That's- Bleach? No, we're not doing that either." (Rish Oral History, 2022, 31:46)

It seems especially pertinent that Magan mentioned choosing whether or not she as healthcare professional would confront patients about misinformation or not in these situations, as it highlights something that Carole mentioned occurring as a result of people not being able to see their family members:

> ". . . it was a public health threat for them to come into the hospital and give the staff potentially COVID, you know, people became violent and had to be removed from the hospital grounds because they would come in demanding to see their loved one and carrying weapons. And it was just it was a crazy it was crazy. . ." (Lovering Kooi Oral History Pt.2, 2022, 4:00)

It seems to highlight how misinformation can be dangerous to more than just health outcomes but can increase violence towards those who are trying to help in the face of tragedy due to public distrust and misunderstanding of reasoning.

Angela Pitman spoke of how fear about being infected with COVID-19 paired with distrust of the medical community during the pandemic led to hospitals seeing preventable health issues that had been allowed to get out of hand:

> ". . . this wasn't even at the Delta [variant of COVID] point, which is the bad-the bad version, which was that next summer [of 2021]. We weren't getting our normally ill patients. So, we would have like we weren't getting heart attacks, we weren't getting strokes, we were getting people [who] were letting infections go that they shouldn't have let go. It caused a lot of problems in other areas of health care because media had made people so scared that they were not getting near the doctor's offices or the health care facilities for things that really needed emergent medical attention." (Pitman Oral History, 2022, 21:48)

She also noted about the way the media spoke during the pandemic:

> "We got pitted against each other, and I don't know how the heck it became so- The media would spread and it would be, you know, right versus left, you know, conservative versus liberal. And they both had their own version of what you needed. So yeah, I had everything from well, I sure- I had patients that would be like 'I wore my mask' 'I wore it' or 'I did all this.' You're out frickin' in church surrounded by people?! No. Or your loved ones are out seeing people. And then Delta rolls around, and people are demanding drugs that are in no way helpful. Hell, some of them were sneaking their loved one in drugs and. . . that were not helpful. It was- yeah- media made things worse. . ." (Pitman Oral History, 2022, 46:44)

She further spoke on how she felt the public was misinformed about prevention of COVID-19:

> "And media to me was a tough thing because, you know. Is not that I am against masks. Masks saved our asses. And that's a medical term there, that first round, because it helped us. They'd helped the spread of flu, but it was not helping the spread of COVID. So, we had all these people that were going out in public with their little frickin' mask, whether they were cotton or surgical, and they're not protecting them because this was an aerosolized disease, which I still don't know that anybody ever talks about. So, it's up in the air just hanging out there. It's going to go in a surgical mask. So, we're like, oh, you could go out in your mask. And so, we're still out getting this stupid virus spread around, which, I mean, some of us were perfectly fine catching it and probably would have better immunity if we caught it the first time around instead of being trapped in our homes. But it was just. Yeah. Yeah. So frustrated. A lot of frustration." (Pitman Oral History, 2022, 43:29)

Magan Rish affirmed similar sentiment about the way the media and politics affected the public perception of the pandemic:

> "I think we did the best we could with the knowledge that we had and the resources that we had. I think the government has kind of made a joke out of it. And taking away focus on where it should have been, which were the people that were sick and the ones taking care of them. But I also I know that. Like news media. They're meant to romanticize. They're meant to give the biggest bang for their buck. And they want those shocking stories that are going to catch people's eyes and tune in. And they want that stuff. So, they did sometimes gas things up to be worse than what they actually were, or people in the general public maybe got alarm fatigue and they got tired of hearing of it. So, they just kind of tuned it out and I think that people should have a better respect for those of us that did work the pandemic. And understand that we walked through hell and we lost some of our own. Thanks to that, whether it be people leaving the bedside entirely or- our coworkers dying because they got sick." (Rish Oral History, 2022, 40:20)

Overwhelmingly, all interviewees attributed the mistrust and misinformation within the public to the media that different individuals had consumed about the pandemic. Whether that caused them to seek alternative ways to treat themselves upon getting COVID-19 or to avoid the treatment they needed for other conditions, it seems clear that the professionals blamed these issues on the media for making the pandemic a political issue rather than simply allowing medical professionals to treat their patients.

Magan Rish said about those who denied the virus in different ways:

> "I told people many a times, 'If you think this is a damn joke, then suit up, put your running shoes on and come follow me for a day, because I'll show you very much so it's not.' When you have four or five or even six patients and you're looking around going, 'One of you is going to die today, which one is it going to be?' Or you could look at a patient from the time that they were admitted and know whether or not they were going to live to be discharged home or to a funeral home. I would just tell people, 'Come to work a 12 in my shoes. Let me show you what's fake.' And also, I got so irritated with people saying this is a made-up virus. This is from an uncooked bat. I couldn't care less what started [it]. All I knew was people were dying and this virus was not playing with people. I couldn't care less where it actually came from. I just wanted to- help my patients live to see another 12 hours." (Rish Oral History, 2022, 30:24)

Carole noted the distrust during COVID-19 as being something that has changed the way that healthcare workers are perceived. Despite the outpouring of narratives that presented our healthcare worker as heroes, the distrust of them the media fed into during the pandemic, despite trying their best to help those who were sick, has manifested into a long-lasting distrust in the medical community. She stated in her interview:

> "But I do think that has had a lasting impact on the providers who worked during it and honestly, the public, because they people come in asking questions that they didn't ask before COVID and more pointed questions, they're more suspicious, I think, overall. Nursing historically has been a heavily like higher, highly rated as a trusted profession and- I do think, you know, it's-it's been a hard it was a hard period for people to go through without calling into question the motives of the people caring for their COVID infected loved ones." (Lovering Kooi Oral History Pt. 2, 2022, 7:15)

Angela juxtaposed this view in her own interview and stated, "I think it did put a distrust in the government, not necessarily the medical field, but the government. The information- like it- I think that's where the mistrust went."(Pitman Oral History, 2022, 48:44) However, she also stated, when speaking of what she wanted people to learn from the pandemic,

> "It's not about the pandemic per se, as much as it is about your nursing staff, your health care staff. And that's- we are trying to fight for you, not against you. So, like when we're asking for things, it's not because we're looking for more money. It's not because we're looking for less work. It's because we're looking for a safer patient environment." (Pitman Oral History, 2022, 39:35).

Getting the public to see what the pandemic was really like is still an uphill battle for the medical community There is an ongoing need to defend decisions made during the pandemic, the knowledge of the medical community about subjects pertaining to COVID-19, and the need for respect as well as better conditions for the professionals who worked during the pandemic. Misinformation has spurred mistrust for what was one

of the most trusted fields. This mistrust is based in ideas that healthcare professionals were not doing their jobs properly, that they were lying to the public, or that they were motivated to act in some way that was not rooted in protecting their patients and the masses. However, these professionals have only ever demonstrated deep devotion to trying to help their patients.

CHAPTER THREE: CONFRONTING DEATH AT ALARMING RATES

During this pandemic our medical staff were confronted with the deaths of people they were normally able to save, this included people who were generally able to survive respiratory infections. Demographics varied with each wave of the pandemic when it came to who was most susceptible to the disease. As this all occurred and healthcare workers were confronted with these unexpected deaths, there were simultaneously shutdowns that prevented many from going anywhere but to work and back. Through this chapter the words of the interviewees regarding this experience will be used to shed light onto what COVID-19 actually did to people who died from it, how medical professionals tried to comfort people, and will perhaps give insight onto how these situations affected the people working to treat those infected with COVID-19. “This crisis highlighted structural fault-lines in our society, as well as the strength and resilience of our communities, even as our society transforms in ways we do not yet understand.” (Incite Colombia University). Death from the virus has been a topic of debate and doubt, as well as something that heightened public fear about the virus. Hopefully, these stories about different individuals’ deaths told by those who worked to save these people, will provide further clarity about the pandemic.

Magan Rish stated that one thing she would like for people to understand and consider when thinking about the pandemic was:

> “Covid wasn't playing with anybody. It didn't care if you were young and it care if you were older, it didn't care if you were the healthiest you've ever been in your life, or you're some 90-year-old grandma. . . I would like for people to have grace for health care workers that have walked through this, because we have seen things that we were never prepared to see and, um, we have encountered death and encountered sickness and heartbreak in ways that we could not have

> anticipated. When you're zipping people up in body bags daily." (Rish Oral History, 2022, 22:11).

This pandemic was atypical from similar diseases in the populations affected and the extent to which they became ill from it. It is quoted by the World Health Organization, "Disease and deaths from infections typically affect some groups more than others... For instance, there is evidence that people who live in crowded conditions and those who lack access to basic services, such as safe water and improved sanitation, face greater risks of infection." (WHO 2). However, during this pandemic the interviewees cited unexpected as well as expected groups affected by each wave. Through each of my interviews with these healthcare workers, there was a theme that much of the death was something these professionals felt would not have normally occurred, even in demographics that traditionally were more susceptible to infectious disease. Angela Pitman stated of demographics that were affected more throughout the whole of pandemic that after a while:

> "There were so many people that you knew were just going that that when they came in, just based on their body frames, that they were likely not leaving this hospital, even though they might not look that bad when they got there, you knew they weren't leaving." (Pitman Oral History, 2022, 17:25).

Carole Lovering Kooi spoke of what she would want people to learn from this pandemic and the unexpected deaths that occurred:

> "I want people- to be okay talking about death- because it's coming for all of us. And there is a stigma about talking about our end. People don't want to think about losing their loved ones. They don't want to think about what happens to their loved ones when they die. And COVID was really-was like playing Russian roulette. People died- in inexplicable ways. I mean, why would one 30-year-old guy die from COVID when all of his friends had a mild case and recovered and did fine? It gives me chills to think about that. I had patients who I'll never forget- young, otherwise healthy who just- who left this world because of it. And no one was prepared and no one had talked about it. And it's not that I expect 30-year-

> olds necessarily to sit down and write a- write up a will and their advance directives, but everyone should at least be thinking about the care that they want if they were to get sick and not leave that burden on their family members, because it can really tear people up to think, what would Mom want- to live on a ventilator? Would Grandma want us to do chest compressions and break her ribs? I mean, that stuff that gets it gets really hard to deal with. And I just wish that people would just be able to sit down with each other and say, tell their loved ones, you know, 'This is what I would find acceptable. This is not what I find acceptable.' And then for their loved ones to love them enough to honor those wishes, because if they're left to their own devices, often people suffer unnecessarily." (Lovering Kooi Oral History Pt.1, 2022, 21:40).

Through most of the interview Carole spoke from a place of more hope for the future and seemingly avoided talking too deeply about the deaths she witnessed, choosing to speak of happy patient survival stories rather than patient stories about death. This particular portion, speaking about what she would like for the general public to learn, exemplified the amount of death she witnessed during this pandemic, as well as how frustrating it must have been to deal with those deaths when they were unexpected and families were put into positions of medical decision making sooner than they normally would have been for their loved ones.

Magan Rish characterized the general attitude she and her coworkers in the face of the deaths that occurred as being one in which they tried to provide any comfort that they could to those who would otherwise die without family present, "Like we get suited up to the best of our abilities, because nobody deserves to die alone. . . But there were times where I was the only one in the room, because I refused to let a patient die alone." (Rish Oral History, 2022, 27:15). She also mentioned how she held the hand of one of these patients in treatment prior to their becoming unconscious, for what she knew would be their last waking moment before they died:

> "And I remember one sweet little lady where I knew- Sorry if I get emotional- I knew that me holding her hand, that was going to be the last human contact that she knew of. And so, I held her hand as we put her on a ventilator. And I said this- this is gonna be the last time she knowingly holds somebody's hand, and I know she's scared. I'm going to be the last human contact that she gets to have and that she can remember. And she wound up dying a few days later." (Rish Oral History, 2022, 19:20).

Carole Lovering Kooi took the opportunity of speaking on patient stories that affected her to speak on a positive patient story, rather than one that ended in that patient's death:

> "There are the ones that were hard and people died. I did have a 26-year-old Hispanic male who was in the ICU [during] early COVID. So, one of the early variants- vented, paralyzed, ended up getting trached, was super-duper sick. None of us thought he would survive. And five months later he walked out of the hospital. And that's- especially in early COVID when we didn't have medicine, that everything was experimental and we didn't really have a lot of hope for the patients. He was one story of hope, and his family- stuck with him. And it was, you know, it was a really- a really neat win for the ICU folks who had really just been seeing death after death after death." (Lovering Kooi Oral History Pt.1, 2022, 24:14).

Angela Pitman shared a story that occurred during the delta variant wave of the pandemic of her trying to save a patient's life and giving CPR:

> "It was a morbidly obese patient, so he is on a special bed. So, our- our guys that were in the room were doing CPR. And he- and you get tired out really quick and you're still- you know, it's not going to end well, but you're still giving it your all. So, I'm normally one that's running a code more than actually in doing the CPR. But Covid- but we all did all the parts. You just did what you had to do. So, at this point, I'm trying to wear this slick gown on the side of the bed, trying to do CPR on this guy. It's not working. So, at this point, I've ripped off my gown because who cares about a gown when you're trying to keep somebody alive? At this point, I don't care if I got Covid germs on my gown- on my clothes. I don't care. I just try to keep somebody alive as long as we can. So, we actually ended up like somehow- I end up straddled over this guy's head because the bed- we can't do CPR in. So, we're doing CPR in this really weird way where I'm over his head doing chest compressions. My face is over his face just to try to keep this guy alive. Like we just- we were working with whatever we could to try to keep these guys alive, even though we knew they weren't going to be alive." (Pitman Oral History, 2022, 37:45).

Magan Rish shared another story of a patient who had passed from COVID-19 who she suspected wanted to die based on how everything happened:

> "We had this guy. He was in his forties and he had a soon-to-be ex-wife, he had a girlfriend who was pregnant. Yeah. He's messy, but he was- he made himself what we call a DNR, do not resuscitate. And it was really weird because we're like, 'Why? You're- you're fixing to have a baby, bro. Like what? Are you sure that you don't want to fight harder than this?' But he was very much against going on life support or going on a ventilator. And he made that abundantly clear. He said, 'Any of my friends that have gone on a ventilator have died.' You can't argue that logic because a lot of times they did. Seldom did they come off and get to go home- that we would do what's called terminal extubations, which means we're going to take the tube out with the expectation that you were going to die right after it. So, this guy was on a machine called a BiPAP, which is this big, bulky mask over your face. And it pushes- it rhythmically, pushes air into your lungs and forces them open, which that in and of itself caused other problems, which I can talk about here in a second if you want to hear about it. . . And this this patient was doing proning. He was laying on his stomach, and we would watch his oxygen saturations. Oh! His body just loved it. He would be up in the high nineties. Well, the nurses were doing handoff and- The nurses were doing handoff and the night nurse had come in, checked on him. He was fine. She left. She came back in later to do her assessment. He had pulled his mask off, was lying face down in the bed, dead. . . So, in essence, he committed suicide -because he had pulled his mask off thrown it and was done. . . With how compliant that he had been with wearing it. I almost seem to think that he thought maybe he didn't have any other way out. And like it was going to happen, so he was just going to make sure he was in control of the situation." (Rish Oral History, 2022, 41:50).

Angela Pitman encapsulated how she felt about her job after facing the pandemic and the massive amounts of death:

> "I think I'm a little more- I'm a little more cynical. When I say cynical, I mean. I mean. Yeah, I it, it, it has. It's definitely impacted personal relationships. And when I say personal relationships, I mean just like how you judge people. You judge people based on how they react to things. And it's not saying that I judge people for being overly scared of- something that they don't know. But yeah, you judge people, so I'm more withdrawn. I'm still out there doing things, but I need my personal time. I need my personal space. I need time to recover. Yeah, it's definitely changed things. It's changed me. I don't- I don't look at the media anymore unless it's just for pure entertainment value." (Pitman Oral History, 2022, 40:16)

Carole Lovering Kooi spoke about how dealing with COVID-19 deaths influenced her decision to have kids:

> "I was on the fence for a long time about whether I wanted children and whether I wanted to have more extended family. My family's very small, my husband's family's a little larger. But I watched people come in with no family. No one was calling to check on them. No one knew that they were hospitalized and dying and that- it was eye opening to think about having- no one. And that's a very selfish reason to have to decide to have children. And it certainly wasn't the only reason that I decided to have children. But it was a- it's a stark reality when you are super sick to have no one to answer for you. No one to say this is what he or she wants. This is how he or she would-would want to die or live or no one- And that's just that's I wouldn't wish that on anyone to die alone and to have no one calling." (Lovering Kooi Oral History Pt.2, 2022, 10:49)

Though this pandemic came in as a lion it seems it is leaving as a mouse, there is not as much panic in the public over it and it seemingly does not cause as much damage to the populations that get it as it once did. Angela Pitman spoke about what she felt COVID-19 would be like going forward, she stated feeling that going forward it would likely become a seasonal virus that would not carry the same effects as it originally had:

> "I think it's going to be very much like the flu. It's going to be very, very much like the flu. Oh, and to go back to comforting patients, in the beginning, it was that you knew who would do good and who would do bad. And so, you would try to have these conversations- and in the beginning, you were like, it's really not that bad. Most of us do fine. La, la, la. Come around to Delta. Like literally, we would have patients come in the hospital that would look okay and we would start having conversations right then and there. 50-year-old men that were not necessarily unhealthy having conversations of, 'Hey, there's a good chance that you're going to get super sick. And if you get intubated, you're probably not going to make it. How do you feel about that? Do you want to have that happen? I mean, like, do you want to do that? Would you want to do comfort?' And we're having that conversation right as they come into the hospital. It was just a very, very surreal situation." (Pitman Oral History, 2022, 18:14).

Overall, the interviewees dealt with their feelings about the deaths they faced in different ways. They spoke of their views of these deaths from different points of view as well, sometimes avoiding speaking too deeply on the subject, sometimes recalling stories

with sorrow, and sometimes laughing through the stories to lighten the burden of the experience. The deaths of the pandemics deeply affected those working through it because at the end of the day these people are not fictional superheroes, they are real people who witnessed traumatic events.

CHAPTER FOUR: TAKE-AWAYS FROM COVID-19 PANDEMIC HEALTHCARE WORKERS

The COVID-19 pandemic was the first time many of our healthcare workers experienced anything of this nature and due to the circumstances surrounding it, such as lockdowns, there is very little comparison to be made between it and past pandemics that would truly do justice to what our healthcare workers faced. “The COVID-19 pandemic is the gravest infectious disease crisis the United States has faced since the Influenza pandemic of 1918. . .” (Incite Colombia University), making this an event extremely foreign for the average American. Due to this being such a unique event to have worked during, there are many different take-aways that the interviewees had in relation to it.

> “I've had conversations with my fellow providers, the docs I work with, as well as the nurses. And I'm like, you realize in a decade we're going to look back and talk about this just like the people that went through HIV/AIDS in that beginning time and how people reacted to it. And it's going to be really interesting to be able to- I can look back how I always said that if I had been around early on in HIV/AIDS, that I'd be one of those people on the front lines taking care of people. I'm not saying that there isn't some type of fear, but would I? I accepted this like this was what I chose to do. So, I feel like I would be in there taking care of patients and not in the background scared, and having went through COVID. I know that's- that's very true.” (Pitman Oral History, 2022, 23:05).

The unexpected demographics affected, mass panic by the public, and the medical community’s lack of knowledge on how to treat the diseases at first, seemed to be a major reason as to why these two pandemics were readily compared. All interviewees spoke of how people dying, who would not have normally died from an illness such as this, and there was a major emphasis by all in regard to how this pandemic was going to be an event remembered in history. In “Rebuilding Our Daily Life after the Crisis” regarding how the pandemic effected the world as a whole it is mentioned, “Infectious diseases are

one of the most important emerging security issues that go beyond simple diseases… COVID-19 may not be the last infectious disease." (Asan Institute for Policy Studies 107). This means it is even more important to understand what our healthcare professionals have learned, what changes they would make in hindsight, and how they were affected by this event. When speaking on if she felt some of the changes COVID had caused would have long term effects on the medical field, Carole Lovering Kooi stated, "COVID has shifted the track a little bit in some good ways and some bad. But regardless, it's here to stay. And we're going to be telling our kids that, you know, what it was like to live through a pandemic." (Lovering Kooi Oral History Pt.1, 2022, 29:51). Magan Rish spoke similarly, pondering a future where this is considered a major historical event that she had firsthand experience of:

> "I'm curious to see how this is depicted and played out for when my daughter gets older and both of my daughters get older and start learning about this in the history books. Kind of like- those of us that lived through 9/11 and now we're seeing it in the history books." (Rish Oral History, 2022, 16:14).

Though it seems that much of the public sphere has tried to move on or forget about this pandemic at this current point in time, it also seems to be clear that the COVID-19 pandemic was undoubtedly a formative event that will be mentioned to future generations. Beyond just the acknowledgement that this pandemic is something for the history books, there is a need for collective understanding on the effects this pandemic has had on people who lived through it. Magan Rish mentioned a few different groups of people who she believed would be majorly affected by it, namely children who did not get to experience normal childhood experiences and the healthcare worker who worked through the pandemic. Speaking on those who worked through this pandemic she stated,

"And I know that a lot of us health care workers, there's going to be everlasting effects, like I said, from PTSD [Post Traumatic Stress Disorder], from anxiety, depression, panic disorders, substance abuse." (Rish Oral History, 2022, 43:36). The effects of working during such a stressful time were likely magnified by the lack of resources and staff. In a February 2021 report the World Health Organization opined, "Health workers may be working long hours with heavier workloads and insufficient time for rest and recuperation. These demands can result in chronic fatigue and lack of energy, with decreased alertness, coordination, and efficiency; increased reaction time; impaired cognition and emotional blunting or mood changes." (WHO 7). This report also found some factors that could lead to increased negative mental health outcomes for healthcare workers:

> "Personal risk factors for health workers' mental health include lower levels of education, inadequate training, less clinical experience, working as a part-time employee, increased time in quarantine, social isolation, having children at home, lower household income, younger age, female sex, comorbid physical health conditions and the impact of the pandemic on their personal lifestyle." (9).

These factors are particularly interesting when taken into consideration that "Women comprise 70% of the global healthcare workforce. . ." (Miyamoto 1). This means the majority of healthcare workers already fell into at least one of these factors that predisposed them to worse mental health outcomes. This article added that women only held 25% of senior roles in this field and globally many women held, "lower-status roles, many of which are underpaid or unpaid." (1). Though these particular interviewees were comprised of two providers and one charge nurse and perhaps did not necessarily fall into this demographic, it is important to note that some of these interviewees did express feelings that they were not being paid well enough for the work they did. They all faced

social isolation as the lockdowns took away many social activities that would otherwise be available as a way to unwind from a stressful work environment, and sometimes fell into other demographics that made them more susceptible to worse mental health problems due to working through the pandemic.

Magan Rish fell into a demographic of someone who worked during this pandemic and had small children at home to worry about as well. In regard to children being affected by the pandemic and policies during it, she referenced her own daughters missing out on a normal education experience for their ages:

> "She was only in- she never got to finish kindergarten, so she went into first grade. And they're trying to teach these kids how to read. And you can't show them how to form letters and words and everything with your mouth because you've got to keep it covered up. So, there was those added components that we couldn't have anticipated." (Rish Oral History, 2022, 23:04).

Through her tone in the interview, it was clear that the way this pandemic had affected the normal experiences of her children had been another aspect, beyond the expected traumas from working the frontlines of the pandemic, that affected her deeply.

Angela Pitman spoke of how she felt in regard to her job after COVID and her decision to change specialties, "So, I loved my hospitalist job prior to doing it. I was super burnt out. I was looking at going and being a psych[iatric] NP instead and towards the end I actually chose to go critical care. So, I'm actually out of said field and in a different field." (Pitman Oral History, 2022, 24:06). She expressed this decision as being partially driven by having already experienced a much more stressful environment during COVID-19 that made her confident in her ability to do a field that was notoriously stressful even prior to the pandemic. She added how she felt many things had changed after the pandemic:

> "Unfortunately, I don't think it will ever be the same. People aren't listening to-to-health providers and nurses' needs. It's not- yeah, it's needs- and we're not doing it because, oh, we want to make more money. We're literally doing it because A, we're tired of being burnt out. B, we want patients to be safer. So yeah, it's completely different [than] pre-COVID. There was already some- grumbles about- we need to make things a little safer, and then we pushed the envelope during COVID. And then people had these opportunities because the staffing needs were so, so strong at other places that there were these travel positions and you could go travel and make a crap ton more money than you were making in your regular job. So, people had the opportunity to leave and lots of people left. And now there's these big empty holes in health care, in the in-patient setting, big, big empty holes. And then we have people who just left altogether this people that were done." (Pitman Oral History, 2022, 24:57).

Looking to a more positive outcome about the way COVID-19 changed the medical field, Magan Rish spoke of how she felt that the pandemic made providers value and respect their nursing staff more:

> "We were the ones that were constantly at the patient's bedside. You know? [Angela Pitman] would come see patients and then go back to her office. We didn't have that luxury. We did not have that luxury. But they also- the providers relied on our keen assessment skills to be able to detect changes and detect 'Is the patient getting better or are they getting worse?' So, they gained a new respect for us as well. Like, if I tell you this patient's crashing, I mean, get in here now. We're- We're on borrowed time." (Rish Oral History, 2022, 45:30).

She added how she felt that one of the positive things that came from COVID-19 was new nurses gaining confidence in themselves. She stated that:

> "I have watched nurses that were very unsure of their ability to make decisions and the ability to trust their gut and trust their instincts and now they have become some of the best nurses that I know. There was one nurse in particular. She was coming off. She was a new grad, and- she kind of got thrown into the middle of this. She got oriented in a pandemic, and now I get to watch how well she can make decisions as far as patients. And yes, the patient has X, Y, Z, but what do they look like? Do they look like shit? Or do they not? And then she even commented one day she goes, 'All I know is COVID. I don't I don't know these other diagnoses. I get to relearn all of this stuff now.' But she is hands down one of the best nurses we got because we raised her- in this pandemic." (Rish Oral History, 2022, 36:27).

Carole Lovering Kooi made a point that when looking at people who chose to leave the medical field, she felt the reason that fewer Nurse Practitioners and other providers left their positions during the pandemic was likely because they had to do more years in schooling and training to get into their positions than nurses:

> "I was considered essential personnel working in the ICU. And there is- there is a little bit of a feeling of like, I matter, you know, like- that they can't do certain things without me that I actually make a difference. And I think if you- if you looked at it that way, doing the job, it was a lot more gratifying than just the grind of seeing patient after patient and death after death. So, I do think within my team of NPs and PAs. No one left. The nurses turned over like hotcakes. I mean, in and out the door. They were just worn out. And I think the type of work that we do, in a way, the investment in it, like the amount of time that we spent in school and preparing ourselves to do the work- matters. And I think nurses just realized that, you know, they could do a lot less lower acuity things and still get paid fine. And so, they were more than happy to make the shift. For the advanced practice providers, we could see that we were making a difference, and we liked the work that we did, and we'd worked for years to get there. So, we were invested in trying to continue to help. And I don't slight the people who left. I really don't. It was extremely stressful." (Lovering Kooi Oral History Pt.1, 2022, 32:42).

Angela Pitman felt that much of the reason that providers did not necessarily leave the positions they held prior to COVID-19 as easily as other positions in the healthcare field had to do with the lack of mobility that they had in terms of doing a different specialty or travelling for work during the pandemic. She summed up this difference:

> "I'll be honest, we- there's lots of us that made changes during this time. I don't think it mattered if you were. I mean, at least as a provider. Well, I can't even say that- I would say I'm less likely to change because I don't have those travel nurse opportunities that they had. I mean, I can locum and go travel, but I, I wouldn't be making as much as they are like we're pretty they- they've kept us in pretty tight check. So, if there had been more opportunities out there, I may have been more likely to leave. So, me- me being a nurse practitioner and staying was more because I didn't have as many opportunities as others." (Pitman Oral History, 2022, 28:58)

Angela also worked a locum job during the pandemic and therefore had some more insight to provide as to how different areas were dealing with and being affected by the virus. This locum job allowed her experience in different regions of the country during the pandemic, as well as gave her experience as both a hospitalist and as someone working with an infectious disease team.

> "One day I was completely burnt out at work and I was getting all of these texts - to go locum- and I looked at my coworker and I said, 'Hey, since I hate life right now anyways, do you think I should go make a lot of money and go work somewhere else on my week off?' And we laughed and I went ahead and responded to one of them. So, I ended up in Indiana. For a year- about a year and a half- and that's intermittent- it wasn't like super regular was a few months at a time. A few days on my week off. So, I was in Indiana with Infectious Disease at the time. So, with the guys that were knee deep in COVID, I didn't intentionally sign up with infectious disease- so grateful for that experience. So, I went from a real hospital on my regular workweek, my regular seven days, and then on my week off, I would go help out infectious disease in this big hospital system. It was IU Health, which is up in Indiana. So, I got to see both sides of it. I got to see rural medicine and I got to see university medicine. I got to see hospitalist. I got to see infectious disease side. So, we didn't have access to as much stuff as they did at our rural hospital. So up in Indiana, I got to see people that were- man, A) they were they had access to more resources than we did up there, which was good, like PPE and things like that. They had more resources as far as how to take care of patients. I'm not saying that's necessarily a good thing. Some of these people we just kept on holding on to. So, in our rural hospital, one of the things you did for these really sick COVID patients that developed ARDs, which is essentially inflammation fluid in your lungs, one of the things that they that you could do is something called proning, which is where you turn them on to their stomach. Well, in big universities, they have these tables that rotate the patient. We didn't have that. Like we had to learn how to turn these 2-300 pound men with just people and they're intubated- like they're on all these machines and equipment. So, to go up into Indiana and see these tables in action that we didn't. . . they were full of COVID as well, like they had I don't even know how many floors that they were able to open up as ICUs. They're like it was insanely full of COVID. And they had- and that's where I really saw during Delta, all these super young people, people in their twenties, pregnant women." (Pitman Oral History, 2022, 30:16)

The observation of pregnant women getting sicker during the Delta wave may have been a side effect of the scaling back of certain services, such as women's health, in order to

better focus on addressing the pandemic. In a May 2020 report by the World Health Organization, the potential effects of the pandemic on women in particular was examined and it was hypothesized: “Experience and evidence from previous outbreaks. . . indicate that sexual and reproductive health services. . . are likely to be scaled back. This can result in an increased risk of maternal mortality, unintended pregnancies and other adverse sexual and reproductive health outcomes among women and girls.” (WHO 2). This observation was of particular importance to Angela as Carole Lovering Kooi, a longtime friend of hers, was pregnant during the pandemic while still working through it. Of the experience Carole Lovering Kooi stated,

> “I definitely was extra cautious. I went to great lengths to avoid getting sick. You know, when you're thinking about another human being- everything that you do, it impacts another human being. You get real conservative about what you're doing. So, I'm glad that- I was pregnant towards- during the time that I was if I had been- if I had had my son- earlier in the pandemic, I'm not sure that I wouldn't have been a little bit more of a basket case. But at least, you know, by the time I got pregnant last summer, I kind of knew the drill. I knew- I knew the PPE worked. I knew how to work around COVID. I wasn't afraid of, you know, doing the procedures on patients who were super sick and had viral loads just beyond count floating around in the room. So, yeah, it's different when you have- when you got a baby, you- you think like a mom. So, at least, I was extra cautious.” (Lovering Kooi Oral History Pt.1, 2022, 35:10).

Though this pandemic was stressful for the healthcare workers who worked in it, their lives continued on alongside it. They juggled raising families, relationships with those in their lives, and personal problems, while still coming to work and trying their best to save the lives placed in their hands. While everyone seemed proud of the work they did, there was a general sense that nobody felt like the mythical “heroes” that the media sometimes pushed as an image of them. They often spoke of their own humanity, how they were just trying their best, and how they had often felt overwhelmed by not

being able to do more in different situations. It seems important that the public should strive to understand that while these people are trained professionals, they were under massive amounts of stress from the situations that COVID-19 put them in. And ultimately, they are people just like the rest of us who deserve grace, understanding, and thanks for how willing they were to keep helping in the face of the unknown.

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