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Vulnerability during the Pandemic and the Disruption of the Medical Gaze

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엄마, 아빠, 언니, 루나, 너무 많이 사랑해.

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INTRODUCTION

My sister has always been my number one, in spite of the distance between us. We are ten years apart in age, live over 2500 miles from each other, and lead lives so different from each other. But still, every time I think about my childhood and the formative experiences of my life, I think of my sister. As the oldest daughter in a family of immigrants, she took responsibility for taking care of me. I would come home to her, eat meals made by her, and have my homework checked by her. My school supplies still have her handwriting on the labels, and I still have all of her motivational sticky notes pinned on my wall. It's no surprise that I look up to her; I love her with all my heart.

My sister is also a doctor. Medicine has always been her passion, even before I was born, and she worked tirelessly to achieve that goal. I watched her go through the trials and tribulations of medical school, and I was so excited to cheer her on during her graduation, her white coat ceremony, and her residency match. But then, the COVID-19 pandemic started. We still spoke frequently, but her voice sounded different. She sounded exhausted, drained, almost apathetic at times. She called us the day the first COVID patient was admitted into the hospital. She was the resident on-call for that patient. She had no mask on, no protective equipment on, and we still didn't know much about the disease. I can still remember the false bravado she forced into her voice. She told us not to worry about her, but then, the pandemic worsened.

Lockdown started, work and school came grinding to a halt, and COVID deaths started rising. Our TV was constantly inundated with news about COVID. One night, I overheard my sister sobbing on the phone to my mother during this time. She had to watch multiple patients die right in front of her, wheel lifeless bodies out to make room for more patients, and try to treat people without a single cure. I cannot imagine the kinds of stress and trauma that she had to

endure in order to give each and every one of her patients the care that they deserved. I love my sister, and it is with a heavy heart that I admit that I could not help her during these hard times. It is for my sister that I write this ethnography: for all the times she spent in the hospital, for all the patients that she took care of, and for all the times she could not take care of herself.

At the start of my research, I set out to understand how position within the hospital labor hierarchy influences the way healthcare workers (HCWs) experience, manifest, and address COVID-19 pandemic-related stress. At first, that was all my interviewees and I talked about. Kristen, a graduating resident, primarily blamed the administration for the stresses caused by the pandemic. She said, "Our chair of medicine makes over a million dollars a year. It's not the lack of funding, it's that they don't want to spend the money to hire these extra attendings or extra NPs and PAs because it costs more money to do that than to have residents handle the rest. It's the worst." Another graduating resident, Mia, also blamed her supervisors and administrators for issues with over-scheduling and lack of support.

However, as I continued to interview various HCWs, I began to notice how they talked more about how they perceive their patients and their work differently as the pandemic progressed, and that became a greater focus throughout the interviews. Even though these HCWs witnessed patient deaths before, each and every one of them reported that the COVID deaths impacted them to a greater extent. The increased workload and unprecedented nature of the pandemic weighed on them far more heavily than their previous work had, and stress became an inadequate term to describe these experiences.

But in the same breath, they would talk about how individual patient deaths significantly impacted them while referring to them as bodies, cases, or numbers. It was hard to wrap my head around how these HCWs could care so deeply about their patients and be so emotionally affected

by them while reducing them down to their body parts and problems. There seemed to be some sort of cognitive dissonance in the way they perceived their patients, simultaneously describing them as people and objects in the same conversation.

Foucault describes the latter as being part and parcel of the medical gaze: a phenomenon where HCWs reconfigure a patient and their illness in order to fit it within a biomedical paradigm (Foucault 2003). Under the weight of this gaze, the patient's body becomes objectified and separated from the personhood of the patient. Learning how to adopt and deploy the medical gaze is a key aspect of becoming a "proper" HCW and the science of biomedicine operates largely on this objectification. However, biomedical institutions also demand that HCWs also offer humanized, emotional care to the patients they treat. These two dimensions of biomedical care are expected to exist in balanced tension with each other, and it also explains how and why my interlocutors described their patients as such.

This tension, however, was ruptured by the unprecedented nature of the pandemic: the number of cases, the rapid spread of the virus, and the sheer amount of deaths. HCWs became more vulnerable to emotional problems such as grief, anger, and trauma in the face of these events, and this emotional vulnerability led them to intensify and accelerate their deployment of the medical gaze. I specifically define emotional vulnerability as the exposure to events that impairs one's ability to function emotionally, and by extent, the emotional disturbance resulting from that exposure. In trying to understand what HCWs experienced during the pandemic, I examine multiple dimensions: the tension between the affective demands of care and the medicalization of patient bodies as well as the institutional flaws in the healthcare system that led to this disruption. FIrst, I ask: how did the pandemic disrupt the tension between affective care and medicalization and how does it differ from previous instances of emotional vulnerability

among HCWs? Second, how did this increased period of vulnerability affect the way HCWs see and reconfigure their patients? Third, how do HCWs describe and interpret these experiences of vulnerability and do they differ from one another?

I argue that the chronic emotional vulnerability instigated by the pandemic and exacerbated by flaws in the American healthcare system significantly impacted the way HCWs perceive and treat their patients. In an effort to answer these questions, I built upon the work of others in medical anthropology and sociology as well as studies on science and technology.

Literature Review

The COVID-19 Pandemic in the Healthcare System

COVID-19, a severe acute respiratory viral disease, emerged in Wuhan, China in 2019 and quickly spread across borders, earning the title of global pandemic in February 2020. On March 13, 2020, the US president declared a national emergency in response to the pandemic and shut down all nonessential activities across the country (US Federal Emergency Management Agency 2020). As of October 2022, there have been over 90 million cases and over 1 million confirmed deaths from COVID-19 in the United States (Anon 2022a, Anon 2022b).

Although hospitals were considered essential, the rise of COVID-19 cases placed unprecedented strain on HCWs and interrupted the way they normally operated. The foundational practices that shape biomedicine were completely disrupted. For example, the American College of Surgeons and other major surgical societies recommended canceling or postponing surgeries due to the strain they might put on the already-compromised intensive care units (ICUs) (American College of Surgeons 2020; Mattingly et al. 2021). Another example is the increase in telehealth appointments in response to the spread of COVID019. Prior to the

pandemic, most psychologists saw their patients in person, but afterwards, the percentage of telehealth appointments skyrocketed to 85% — a 12-fold increase compared to what it was before (Pierce et al. 2021).

The combination of the changed work environment and the uncertainty of the COVID-19 virus created an entirely new landscape for HCWs to deal with. First, HCWs were at increased risk for catching and spreading the disease by virtue of their job. As essential workers, many HCWs did not have the luxury of working from home. For example, most physicians had to work on-site while many jobs in a similar salary range such as engineers, consultants, and lawyers were able to work remotely and avoid the risk of exposure (Adisa, Ogbonnaya, and Adekoya 2021; Buchanan et al. 2021; Dunatchik et al. 2021). Second, HCWs had to deal with scientific miscommunication and the lack of a cure at the beginning of the pandemic. This meant dealing with patients who insisted on receiving unpromising treatments such as ivermectin and hydroxychloroquine (Zimmer et al. 2022). Former President Trump also contributed to the panic and uncertainty about the virus by promoting the use of bleach, disinfectants, and “just very powerful light” to cure the disease (Broad and Levin 2020; Zimmer et al. 2022). Right wing-led protests against COVID-19 safety measures also contributed to further spread of the virus and increased numbers of patients for HCWs to manage, resulting in heightened workloads and increased exposure to emotional stress (Edmondson 2021; Qiu 2023; Weisman 2021). This contributed to the ways in which HCWs deployed and utilized the medical gaze during the pandemic.

Perception and Practice: the Medical Gaze

From the very moment a patient steps into a hospital, they are actively reconfigured under the weight of the medical gaze. Michel Foucault initially described the penetrating "gaze"

of biomedicine in his 1963 work, *The Birth of the Clinic*, and details how the patient is transformed into an object of science, an "endlessly reproducible pathological fact" (Foucault, 2003, p.119). This gaze is both perception and practice; the HCW must actively see the patient in this manner and name the disease as the object rather than the patient.

The medical experience, from diagnosis to treatment, is specifically constructed to be objective. As a result, HCWs must actively reorient themselves to view individuals as bodies and bones while overlooking the cultural nuances and diverse experience that inform the patient's illness narrative. Byron Good ascribes this reorientation to the formative nature of medical school where the priorities of medical students are shifted from healing and helping people to efficiency and the notion of curing disease (Good 1993). Healing is differentiated from curing disease in that the former engages in a more holistic overview of the patient, including their lifestyle, families and personal desires in terms of care, while the latter is enmeshed in the profit-driven models present in the modern biomedical industry (Ehrenreich and English 2010; Porter 2004). Medical students are generally trained to enter large-scale medical systems rather than the small-scale models of care seen in practices like midwifery or Indigenous healing traditions, and thus, they must be reoriented to suit the industry-standard model of biomedicine. This model demands its students and workers to view people through the medical gaze and to medicalize bodies and conditions. Patients are transformed into objects of medical scrutiny and have their different symptoms medicalized for the HCW to fix, much like how a mechanic fixes a car (Greenhalgh 2001). People are no longer people but cases, bits and pieces of anatomy, and problems to be solved.

Irving Zola specifically describes medicalization as the “attachment of conditions” to biomedicine, meaning that certain conditions become associated with biomedicine and in doing

so, legitimates medical control over them (Zola 1972). Through this attachment process, Zola argues that medicalization pins issues and disorders to the individual body and individual responsibilities while "infinitely expanding" what in life can be considered medicine (Zola, 1972, p.497). For example, conditions like childbirth and death used to be ascribed to cultural traditions, but over the past century, they have been fully attached to medicine instead (Conrad and Potter 2000). In the case of childbirth, the work of midwives and doulas, who provided care at mothers' homes, was denounced as unscientific, dangerous work in order to prop up the development of gynecology as a specific biomedical field (Ehrenreich and English 2010). This then enabled the medical and pharmaceutical industries to exert more control over mothers' bodies and the process of birthing.

However, Zola also argues that biomedicine is slowly transitioning from a specific etiological model of disease to a multi-causal model of disease, specifically through the advent of technology. He cites the collection and storage of medical data as a way for machines to analyze patients without bias, but I argue that this phenomenon is actually an extension of the medical gaze because there must be a HCW to operate the computer and utilize the data. In reference to Donna Haraway's concept of "situated knowledge," data collection is inherently a reflection of existing systems of power, and biomedicine's use of data serves as a form of social control, further enabling the HCW to enact the medical gaze on the patient (Haraway 1988). This also demonstrates that the medical gaze is not just a standardizing, impersonal process, but rather, it exists as a form of social control over the patients it reconfigures.

Aside from these formative practice and generative processes that fuel the medical gaze, the medical gaze also draws upon scientific paradigms to support itself. Susan Greenhalgh identifies this reliance on science as a way to obscure how biomedicine asserts social control

over its patients. Through its use of scientific knowledge, the medical gaze transforms patients into objects of medical scrutiny, and patients' symptoms are transformed into problems for the HCW to fix (Greenhalgh 2001). This emphasis on objectivity and science is the reason why Janelle Taylor posits that biomedicine is a "culture of no culture" where Western biomedicine believes that its cultural features are objective facts rather than subjective beliefs and traditions (Taylor 2003).

Taylor is correct in that this supposed objectivity is a myopic fallacy that enables HCWs to depersonalize their patients but fails to recognize the role of the medical gaze in this phenomenon. It is the way that HCWs perceive their patients that enables this "objectivity." Anne Fadiman documents this gap between cultural competency and scientific objectivity as well as the role the medical gaze played in this gap within her book, *The Spirit Catches You and You Fall Down: a Hmong Child, her American Doctors, and the Collision of Two Cultures*. She specifically describes how HCWs are taught that their medical knowledge and perception — essentially the medical gaze — is universal truth, making it difficult to grasp alternative forms of medicine or knowledge-making (Fadiman 2012). It is precisely these facets of biomedicine — the supposed objectivity, the reliance on scientific "truth" and social control over patients — that are wrapped up in the medical gaze, thus allowing HCWs to formulate realities in specifically "medical" ways.

Through the medical gaze, biomedicine — and by proxy, HCWs — is able to intervene and interact with its subjects in specific ways that realign their bodies and disorders into biomedical paradigms. Annemarie Mol ascribes this phenomenon to the shift in science, and by extent, biomedicine, from representation to intervention (Mol 2002). I interpret this to mean that patients are now molded by a set of practices that shape reality rather than a set of statements.

These practices are still "objective" in the culture of biomedicine, but they transform patients' complex illness narratives into simple bullet points of observations and diagnoses on a chart. The experience of illness becomes a set of procedures and protocols in the hands of HCWs. Patients are not only objects, but they exist as articulations of the practices that produce them, and this is seen in Mol's theory of the body multiple, where the enactment of a body changes depending on the goals and perception of the person that is seeing the body (Mol 2002).

Following Mol, I specifically use the term *enactment* to clarify that the body holds both staging and acting within it, much like how Judith Butler describes gender as something that is both imposed upon the body and reproduced in daily practices and performances (Butler 1988; Mol 2002). In biomedicine, bodily performance in the clinic determines the disorder. For example, a patient may have a chronic illness, but if they do not articulate or perform their pain in a way that is deemed biomedically adequate, they may never obtain a diagnosis. Through this phenomenon, the patient's agency is distributed among themselves, the hospital institution, and the HCW. By this, I mean that the patient must enact a performance of illness that satisfies the requirements of both the HCW and the institution providing care, whether that be the hospital itself or the insurance company that funds their visit. This distribution of enactment is accepted and normalized within healthcare, which encourages compliance and renders the patient's body docile under the HCW and the hospital. Ultimately, these practices of perceptions are taught to HCWs and reinforced through their daily work routines. HCWs must enact the medical gaze on their patients in order to diagnose and treat them the way biomedicine expects them to.

Biomedical institutions demand that this mode of medicalization threads through the work that HCWs engage in, including the care that HCWs provide to their patients. Although most HCWs approach their work from a place of empathy and consideration for their patients,

this tension between the medical gaze and the affective demands of care fundamentally changes the way in which biomedical care is provided.

The Dimensions of Care

The very word, "care," in English carries multiple connotations of both affective concern (caring *about* something) and physical action (caring *for* something), which contributes to beliefs that caring actions are motivated or best done with caring feelings (Tronto 1993; Ungerson 1990). Irving and Dickson also echo the same sentiment when they assert that empathy and care in a biomedical setting should be considered a process that involves affective, cognitive, and behavioral dimensions (Irving and Dickson 2004). Specifically, they clarify that there must be a skill (caring *for* something) associated with the cognitive demands of the emotion (caring *about* something).

Although the culture of biomedicine demands objectivity and medicalization of patient bodies, the practice of healthcare demands care. The labor involved in the hospital blends care in two different dimensions: care as practice and care as emotion. Medicine, as a practice, breaches the boundaries of the personal and the private via the act of caring for patients and the examination of their bodies. The close interface between HCW and patient required for care thus results in a unique form of intimacy and provides more opportunity for the HCW's emotional vulnerability. For example, witnessing patient deaths can place HCWs in a state of emotional vulnerability, especially if the HCW has spent time with the patient, treating their maladies and getting to know them as a person. Handling patients with infectious diseases at such close contact can also place the HCWs at both physical and emotional risk due to the exposure to the disease.

Kleinman builds upon this notion of care in the hospital setting by defining it as a moral practice that makes HCWs more empathetic, loving, and more human (Kleinman 2009). Mol utilizes the notion of "tinkering" to describe how daily care practices are embodied and attuned to the individual body that is involved (Mol 2008). For example, nurses must ultimately ensure that their patients receive the correct medications, but different nurses may tinker with how they approach the patient, describe the treatment or medication, and how the medication is delivered (ex: oral, intravenous, etc).

Through both Mol and Kleinman, I interpret the care practices required in a hospital setting to require an attunement to morality and negotiation with the patient in order to be effective. The Hippocratic oath that doctors commit to is an example of these two aspects: the former involves beneficence and non-maleficence while the latter requires a commitment to patient autonomy. The science of biomedicine may demand that certain disorders require certain treatments, but the care involved in biomedicine requires that the HCW work with the patient to meet these demands. For example, a patient with an autoimmune disease like rheumatoid arthritis and lupus has a variety of options when it comes to treatment but ultimately must work with the HCW to choose a treatment plan that aligns with their lifestyle, health, and preferences. Bo Kyeong Seo utilizes a similar notion regarding care by considering it to be a practice that is constantly remade by those who participate in it, resulting in different ethical and political expressions depending on the situation (Seo 2020).

This ultimately means that care entails a significant amount of social resources and effort from HCWs in order to sustain patient health and lives. Emotional labor, as first described by Arlie Hochschild, is the effort employers require from workers in order to shape emotions in both themselves and others around them (Hochschild 2012). Other theorists have built upon

Hochschild's work to demonstrate that emotional labor is an aspect present in all jobs and that emotional labor is embodied in the very physicality of the work involved (Korczynski 2003; Ogbonna and Harris 2004; Roseman 2019; Wolkowitz 2006).

Current literature on emotional labor and care in the healthcare field differs slightly from Hochschild's work in that care work in the healthcare setting demands a moral obligation. Other scholars imply that a mere performance of emotion is not enough to provide adequate care. For instance, Larson asserts that the relationship between HCW and patient must be warm and friendly in order to assure quality care, drawing upon the HCW's morals, and Kleinman repeatedly emphasizes the importance of incorporating the very emotion of empathy into healthcare (Kleinman 2009; Larson 2005).

Arguably, this nuance could be explained by integrating Hochschild's work on deep acting — where the person must invest considerable effort into altering their internal emotions — with her theory on emotional labor (Hochschild 1979, 2012). However, I do agree that Hochschild's original conception of emotional labor cannot be perfectly applied to the emotional work that HCWs do while caring for their patients. This is due to the surveillance involved in a hospital setting and the influence of the medical gaze. The very nature of healthcare work involves a deep entanglement of power within the positionality of the HCW. HCWs are simultaneously given power over patient bodies while being subjugated and surveilled by their own biomedical institution.

Foucault describes this notion of institutional surveillance in his work, *Discipline and Punish*, where he argues that discipline and surveillance are used by institutions to make citizens and populations obey social rules (Foucault 1995). He specifically uses Jeremy Bentham's conception of the panopticon — a circular prison that leaves its prisoners under the constant gaze

of a central watchtower — as a metaphor to demonstrate that these methods of surveillance create citizens and populations that comply not under the threat of corporal punishment but rather through internalization of social rules and norms (Bentham and Božovič 2010; Foucault 1995; Lyon, Haggerty, and Ball 2012). In the case of the panopticon, the guards can see all the prisoners, but the prisoners cannot see the guard. Thus, they must always act as though they are being watched from the central tower, rendering them into a state of conscious visibility.

Ayse Ceyhan builds upon this Foucauldian notion by arguing that contemporary forms of surveillance extend and reinforce biopower. Biopower is also part of Foucault's *oeuvre*, defined by Foucault himself to be a "power that exerts a positive influence on life, that endeavors to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations" (Foucault 1990, p.137). Ceyhan specifically argues that biopower is not just a power of the state, but rather, can be implemented by any organization through methods such as information gathering, data management, and surveillance of populations (Ceyhan 2012). Although this notion is commonly applied to patient populations, I believe that management and administration of hospitals is also applicable to HCWs.

HCWs are constantly surveilled within the hospital, both by others and by themselves. American hospitals are spatially organized into departments, and those departments are further subdivided by hierarchy, resulting in a continuous monitoring of everyone involved. Safety procedures and protocols further ensure that HCWs are monitored and that their work is double-checked. HCWs are also trained in a biomedically specific manner, incorporating them into the hospital milieu but also forcing them to internalize the social rules and norms of the hospital. As such, HCWs can discipline themselves when they break from biomedical norms and expectations of care and the deployment of the medical gaze.

Thus, HCWs must undertake the ordeal of embodying emotional care in their daily work practices while negotiating the demands of enacting the medical gaze as well as the surveillance of their institution. The medical gaze reconfigures a patient into an object of science while emotional care necessitates that the HCW recognize the personhood of the patient and fully embody an empathetic, emotional response to that personhood. All of this takes place within the hospital setting, where biomedical institutions demand both from the HCWs they employ. Typically, this is a tension that many HCWs learn how to acquire. Many HCWs manage both the affective and biomedical dimensions of a patient without consciously experiencing significant cognitive dissonance by virtue of their biomedical training. But this embodiment of affective care and the demands of medicalization can exert a seemingly invisible toll on HCWs and make them susceptible to overwhelming emotional responses to the work they must do.

This is further compounded by the HCW's position along the biomedical labor hierarchy. The effort required from emotional labor is pushed downwards along labor hierarchies particularly towards women; as a result, lower-ranked workers must engage in more emotional labor without the typical shields of status, power, and gender that their upper-level counterparts possess (Macdonald and Sirianni 1996; Steinberg and Figart 1999; Wolkowitz 2006). Hospitals are typically organized under a combination of hierarchical and divisional structures to further increase efficiency and profit-making, and the creation of the hospital under modern-day capitalism has intensified the need for financial gain (Hearld et al. 2008; Kleinman 1997). The hospital hierarchy is notorious for its segregation by status and power, and the income distribution among HCWs is more unequal compared to other industries (Butter et al. 1987). As a result, HCWs fall along different levels along the hospital hierarchy, which is primarily divided by labor and indirectly divided by gender, class, race, and education. The kinds of

responsibilities, expectations, privileges, and anxieties also differ from the top of the hierarchy to the bottom. As a result, those at the bottom of the healthcare hierarchy come into the most contact with patient bodies, which intensifies their enactment of the medical gaze as well the emotional labor required from the care they must give.

Methodology

There is already a wealth of literature on the ways in which the pandemic changed the work environment and on the ways the pandemic affected people emotionally. However, the vast majority of these studies are statistical in nature. For instance, a national survey of HCWs showed that out of 1685 participants, 63% experienced some form of anxiety and 47% experienced some form of depression (Young et al. 2021). The closest I have found in current literature that bears similarity to my methodological approach are studies that utilize surveys and ratings on workplace satisfaction and mental health. Some studies have asked their correspondents for a few words, but none of what I have currently read goes further than a short conversation. Thus, my ethnographic venture into this topic is unique in that it draws upon HCWs' experiences on a deeper anthropological level.

I interviewed 12 HCWs who had a variety of roles from clinics in Southern California. I drew upon the methodology used in Dr. Lise Rosendal Østergaard's anthropological work in Burkina Faso and Adrienne Strong's work in Tanzania, which both utilized individual interviews to gain information about their participants' workplace and personal experiences (Østergaard 2016; Strong 2018). These in-depth interviews offered many ethnographic insights into the challenges that confront HCWs before and during the pandemic and the ways in which the pandemic changed their embodied experiences of stress.

I recruited interviewees via emails sent out to clinic listservs, and all interviews took place over the phone. This was to protect private information about the clinic and personal information about the interviewee from being overheard at a public place like a coffee shop., This also worked for the majority of HCWs since their work schedules typically could not accommodate traveling out to another location for interviewing purposes, and I did not want to violate HIPAA or personal privacy by holding the interviews at their workplace. I exclusively interviewed HCWs who were at least 18 years old and had work experience during the pandemic. Any participant who chose to be interviewed was informed of the study's purposes and was provided with a consent form prior to the interview. I then walked through the form with them in a conversational style, invited questions about the interview and the interviewing process, and obtained verbal consent prior to beginning.

I interviewed five men and seven women, all between the ages of 27 and 48 years old. All except for two identified as Asian-American with the two exceptions being a man and a woman who did not fully disclose their ethnic identity. To ensure the anonymity of my interlocutors, I removed all identifying information and used pseudonyms throughout my thesis. Since some of the information my interviewees shared with me may affect their job security and stability, ensuring their anonymity was paramount to me in order to prevent any possible retribution from their institution. Their workplaces and organizations are also described via their pseudonyms and all identifying information is omitted. Their professions, ages, and pseudonyms are all compiled in a table in the appendix.

Most of my interlocutors were lower on the hospital labor hierarchy: mostly nurses, residents and technicians. The only three interviewees who had higher positions — attending physicians or dentists — were all men. I was surprised that mostly nurses and residents chose to

be interviewed because they tend to work more hours and do more labor compared to attending physicians and administrators. I would have expected higher-ranking HCWs to have more time to be interviewed. I was also surprised that no ancillary staff such as janitors, security workers, and administrators replied to my interview requests. Perhaps I did not make it explicitly clear that I was interested in interviewing workers across the entirety of the biomedical labor hierarchy, including ancillary staff.

I was originally interested in exploring how the biomedical labor hierarchy differentially distributes stress and risk across its levels, so I primarily investigated three components of working in the biomedical field: work experience before, during, and after the COVID-19 pandemic. I asked questions including: What is your current workload like? How would you compare this to the start of the pandemic? How has the development of new COVID strains and the vaccine affected the way you feel about your work? How does your work affect your relationships with your coworkers and has the pandemic changed that in any way? In doing so, I hoped to gain a better understanding of the specific ways in which the pandemic changed the ways in which HCWs perceived and mediated their work-related stress.

However, I soon found that there was a much larger phenomenon of vulnerability underpinning the expressions of stress, risk, and exposure that I initially asked about and affecting the way they perceived their patients and their work. Because of this, I chose to focus on how the pandemic disrupted HCWs' ability to deploy the medical gaze as well as their ability to negotiate with this period of heightened, chronic emotional vulnerability. Perhaps I would have acquired more specific information in the ways emotional vulnerability manifests in HCWs had I asked different questions during my semi-structured interviews. However, I am grateful

and deeply appreciative of what they have shared with me, and I hope to honor that through the themes I explore.

Researcher Positionality

What originally drew me to this research was, as stated in the beginning, my sister. I idolized her as a child, wanting to follow in her footsteps, and to some extent, I still do. Like her, I decided to pursue medicine as a career and actively engaged in many clinical experiences leading up to this research endeavor, including the tail-end of the pandemic. As a result, I do have some experience interacting with both patients and HCWs during this time and gained insider knowledge into how different hospital departments, wards, and codes work. I found this to be immensely helpful when talking with my interlocutors since I already knew what they were referencing when they talked about certain procedures, medications, and work shifts.

In addition, the majority of my interlocutors were Asian-American. As a daughter of immigrants who migrated from South Korea in the 2000s, I identify as Asian-American — more specifically, a 1.5 generation Korean immigrant — as well. I think I shared more similarities than differences in my interviews: identity as an Asian-American and as a Korean, similar immigrant backgrounds, and similar cultural values of sacrifice and hard work. These identities and sociocultural understandings gave me a unique insight through which I could understand their emotional experiences.

However, I am also cognizant of our differences in how I was educated and how I perceive biomedical institutions. As a college student at Swarthmore, and more specifically, as a biology and medical anthropology double major, I have been formally trained to both embrace and reject scientific "objectivity." I have been taught how to interrogate and understand systems of power, including that of biomedical institutions, and how to participate in a scientific,

biomedical community. As a result, I understand where many of my interlocutors are coming from. They did not have the privilege of my education in anthropology and instead, have spent years training to become HCWs and to think in biomedically specific ways.

As a result, I struggled between accurately describing my interlocutors' experiences while acknowledging how their perspective has been shaped by biomedicine. This was exacerbated by the fact that I had to rely totally on what they were telling me; due to certain circumstances, I was not able to fully engage in participant-observation at these clinics. Throughout this process of writing, I had to negotiate with what my interlocutors said, what the literature describes, and what the reader may interpret from my writing. To this day, I still struggle with accurately portraying my interviewees; I do not wish for their feelings, experiences, and traumas to be misinterpreted as a poor reflection upon them. Rather, I hope that this thesis elucidates how their individual experiences arose from a rupture in the biomedical system and how the expectations of the biomedical institution actively harms HCWs like my interlocutors.

A Roadmap: Structure of Thesis

In Chapter 1, I begin by describing how HCWs acquire the medical gaze through theory and praxis in order to contextualize the state of medicalization during the COVID-19 pandemic. I then describe how the pandemic contributed to the acceleration and intensification of the medical gaze among HCWs. I also explain how the staffing shortage in American hospitals contributed to the increased medicalization of patients and how this intensification of the medical gaze may financially benefit biomedical institutions.

Chapter 2 explores what care looks like in a biomedical setting and how and when HCWs experience periods of emotional vulnerability. I go on to argue that the nature of the pandemic

caused HCWs to feel emotionally vulnerable in an unprecedented, chronic way. I also describe the structural issues in the American healthcare system that exacerbated and extended this period of pandemic-induced vulnerability.

Chapter 3 offers some potential interpretations of the ways HCWs described their experiences of emotional vulnerability, especially those provided by male vs female HCWsl. Although my analysis is more speculative than empirical, I argue that the intersection between language used by HCWs, authority, and gender lends an insight into the societally sanctioned ways in which people express distress and vulnerability.

Finally, my conclusion situates my thesis within the larger context of biomedicine as a field. In addition, I discuss future directions for my research and certain limitations I encountered during my work.

Conclusion

In summary, this chapter explored the pre-existing literature on the medical gaze and the dimensions of care present in healthcare. Both medicalization and emotional care are required within the context of biomedicine, but these two facets of medicine exist in tension with one another. This is a specific tension that HCWs must navigate on a daily basis, but the changes COVID-19 brought to hospitals disrupted this in ways that HCWs have never had to experience before. How did the pandemic change the way HCWs perceive their patients and the care they have to provide? In what ways has the pandemic disrupted the kind of emotional labor and care that HCWs must enact? How do people verbalize their experiences of this newfound vulnerability? These are questions that we will take forward in the following chapters.

CHAPTER 1:

Deploying the Medical Gaze

Anish, an internist, starts his work day when the sun goes down. It's rare for him to ever see the light of day during work hours; the most he'll ever get is the sunrise when he leaves the hospital the next morning. He arrives at the hospital just when his colleagues are getting ready to head out, and he collects the charts of every patient who must remain in the hospital for the night. He cross-covers the hospital, walking through the empty hallways and checking in on both the emergency room (ER) and the intensive care unit (ICU). On such nights, he is the main doctor responsible for the patients.

Being the sole doctor on the front line at the hospital was the only thing that remained the same for Anish during the pandemic. During that time, the only sounds that would echo in those long hallways would be the whooshing sound of the ventilators, the beeping of his pager every time a patient would code, and the muffled crying of those who lost another loved one that night. Anish had to take care of forty to sixty patients every night, and while they struggled to breathe on the ventilators, Anish struggled to keep them alive.

There are a few nurses and technicians who work the night shift with him, but otherwise, Anish is the sole doctor for the night. The hospital where he works is on the smaller side, and thus, they have not hired another nocturnist for several years. Combined with the pandemic, it means that Anish has far more work to do than the average nocturnist in his area, but there's not much else he can do about it. There's a slight resignation to the way he talks about his work. He always describes his activities at the hospital as things that he "has to do" or things that he "must get done" before he can go home. It's odd, especially since it's such a stark contrast to the reason he went into medicine in the first place: to help people. "I really enjoy helping people, especially

the ones who want to be helped," he says while laughing. But Anish never mentions the patients as people to help but rather, "admits" that he has to take care of.

For many HCWs like Anish, the pandemic was a long period of grueling work with no end in sight. Even with the development of vaccines, COVID surges continued in the United States and caused more patient hospitalizations and deaths. This only extended the period of vulnerability that HCWs were forced to experience while working on the frontlines of the pandemic, and for some HCWs, this disrupted the balance HCWs normally attempt to maintain between the emotional and biomedical aspects of care. For Anish, this meant viewing his patients as things to handle rather than as real people. Even though he entered the medical field in order to "help other people with [his] skills", the emotional vulnerability caused by the pandemic forced Anish and other HCWs to rely more heavily on medicalization and the deployment of the medical gaze to preserve his own well-being.

As we have seen from our discussion of medicalization and the medical gaze, HCWs are trained to transform patients into objects with diseases to treat. The culture of biomedicine is grounded in the establishment of disease as a purely biological phenomenon, and patients must be relegated to the position of biological object in order to be treated (Charon 2008; Taylor 2003). To Anish, patients are simply "admits" rather than "people" and he even used "it" to refer to a patient when he recalled,

> "It's like, well, there was one guy [a homeless heroin addict] who came in and refused treatment I offered and then left without any of the nurses or doctors knowing, and then 20 minutes later, security dragged it back in because it had respiratory failure on the sidewalk outside the hospital."

This was similar to how Samantha, an ICU nurse, described her own patients as well. She largely referred to patients as "cases" — although she used "he" and "she" to describe them rather than "it" — and utilized the same detached tone as Anish did to describe her patients.

But unlike Samantha, Anish was in the middle of his medical training when the first COVID surge flooded his hospital with new admits. I was surprised when Anish told me that he was in the middle of his residency during the pandemic because he spoke more like the attending physicians and seasoned nurses I interviewed. Most other HCWs in training that I spoke to referred to their patients as patients or people rather than as admits or cases to deal with. Anish referred to patients using words like "bodies" and "it" without any hesitation, making me think that he spent more years in the workforce than he actually did.

Kristen, another resident, also referred to patients as cases and problems rather than people to treat and to care for. For example, she called her patients by the time they arrived at the hospital (ex: "a 4:50" or "a 3:00") rather than by their names, gender, or other personal identifying characteristics. While attending doctors and nurses like Samantha had years to develop a distance between herself and her patients, residents like Anish and Kristen took mere months to get to the level of Samantha's deployment of the medical gaze.

In this chapter, I look at the accelerated acquisition of the medical gaze during the COVID pandemic. I first argue that the deployment of the medical gaze is an experiential process that HCWs begin during medical training but continue to develop during their time in the workforce. I then posit that the experience of emotional vulnerability caused by the pandemic forced HCWs to accelerate their acquisition of the medical gaze, particularly for those who were still in training. I also hypothesize that this accelerated acquisition of the medical gaze served as a method of emotional self-preservation for many HCWs. In addition, I point out previously existing structural issues within the American healthcare system that exacerbated the medicalization of patient bodies during the pandemic

Theory and Praxis: Refining Ways of Seeing

Within the hospital setting, the medical experience is constructed to be as objective and scientific as possible. Part of this phenomenon arises from the fact that biomedicine obtains its power in society by symbolically aligning itself with science (Moerman 1998). This association between biomedicine and science is the basis for the development of the medical gaze, where patients are reconfigured into individual aspects of their bodies. This scientific objectivity is also reproduced in medical training, where different aspects such as cadaver labs, patient charting, and history all provide ways to further re-interpret people according to the medical gaze, whether it be a body, case, or lab sample (Good 1993). Through these different methods of perception, HCWs are trained to experience both self and other in a complex, culturally shaped way that is specific to biomedicine.

However, that medical training is only the beginning of a long process through which HCWs transform their perceptions and relationships with their patients. Although medical training does provide HCWs with the formative practices to engage with and formulate reality in a "biomedical" way, HCWs must further hone their abilities to deploy the medical gaze. HCWs must actively and constantly practice enacting the medical gaze, and through practice and time, HCWs become more and more accomplished at deploying it upon their patients.

This arises from the adoption of the "proper" habitus of a HCW. Habitus is a set of embodied dispositions and methods of interacting with others that are determined by the specific field that the individual inhabits (Bourdieu and Nice 2019). Habitus encompasses the embodied rules of this social world that we reproduce within ourselves and is, as Bourdieu puts it, a way that "society [is] written into the body" (Bourdieu 1990). Annette Lareau, in her analysis of Pierre Bourdieu's work, also points out that a habitus acquired later in life, such as one required

of a professional setting, is harder to acquire and requires more time to become established in a person (Lareau 2011). Saba Mahmood also expands upon Bourdieu's notion of the habitus and argues that the habitus can be shaped and transformed through both mimetic and pedagogical processes (Mahmood 2012). After HCWs finish their training, they continue to refine their habitus as a HCW by observing others in their field deploy the medical gaze and attempting to enact it themselves. These clinical experiences and observations are what lend a HCW the ability to acquire and further refine their medical gaze.

Take Samantha, for example. As an ICU nurse, she works in a high-stakes environment where the patients are often in critical condition and are intubated, ventilated, and on multiple IV drips. Compared to her peers who work in other departments, she has more experience with patient deaths and the resulting consequences. Even though she and other nurses in different departments had the same medical training, Samantha became more adept at utilizing the medical gaze to transform patients into bodies and sites of disease compared to other nurses.

Samantha herself did not see this as a particular skill or talent. In fact, she just saw it as a by-product of her experience in the career and said, "As an [ICU] nurse, you just have to expect to be on your toes…you learn throughout. I've seen more deaths [than my colleagues in other departments]. It's just how a hospital works." Given her 15 years in the ICU, Samantha is the perfect example of how training and experience interacted to provide the basis for gaining the medical gaze.

As such, the acquisition of the medical gaze is something that requires exposure and a combination of medical training and praxis to enact. The medical gaze is also part of the ingrained habits and skills expected of a HCW and further develops the professional habitus of a HCW in the field.

Acceleration & Intensification

The pandemic was unique in that it altered the timeline that is normally associated with the experience required to acquire the medical gaze. In comparison to Samantha, who took 15 years to develop and refine her deployment of the medical gaze, Anish took only a matter of months. Charlotte, who was a pediatrics resident at the start of the pandemic, expressed a similar sentiment when she said, "It got easier to treat the adults and deal with the situation and make them into patients as time passed, but I would say that's because of the pandemic and not because of my residency training. I'm supposed to be trained to treat kids, after all." For Charlotte, the unique work environment of the pandemic accelerated her acquisition of the medical gaze, and this is a phenomenon that she would not have experienced had she been a resident pre-pandemic.

HCWs also demonstrated an intensification of the medical gaze with some completely disregarding the personhood of their patient entirely. This is observed with Anish's reference to his patients as "it" or "bodies" or with Kristen's reference to her patients as time-slots. By virtue of the heightened emotional vulnerability caused by the pandemic, HCWs like Anish, Charlotte, and Kristen gained an enhanced ability to deploy the medical gaze in a fraction of the time that it would normally take.

Increased patient volume certainly contributed to this phenomenon. Simply put, taking care of more patients gives HCWs more opportunities to put theory into practice, and as we have already discussed, both training and experience enable the acquisition of the medical gaze. However, there are additional factors behind the acceleration and intensification of this capacity.

For Kristen, the emotional vulnerability caused by the pandemic was a major influence behind the intensification of the medical gaze. The profoundly unsettling experience of watching

her patients die, the helplessness she felt when there was no vaccine or cure, and the sheer amount of demand she felt during this time affected her in ways that continued to persist past the first COVID-19 surge. As she termed it, it was "one of the most traumatic experiences" that she ever had. For her, medicalizing her patients served as a form of emotional self-preservation and allowed her to continue working as a HCW during the pandemic. She acknowledges that this is not the way she wants to treat her patients when she says,

> "I'm a bad person, so I lost a lot of empathy and sympathy for them [the patients]. Why did you do this? And why did you make this decision? And now you're here, I have to take care of you. I hate that I don't care about them as people, I care about them as work. I just don't have the same kind of empathy in me anymore."

As a result, Kristen continues to view her patients solely under the medical gaze, even more so than how she did prior to the pandemic.

Mia, an internist like Kristen, also identifies emotional vulnerability as a major reason why she medicalizes patients more than she used to. She describes the experience of working in the pandemic as something that caused her PTSD. In an effort to ward off additional grief and trauma from her work, she constantly forced herself to view her patients as nothing but bodies and numbers in order to separate them from herself.

Mia also recognizes the ways in which this has impacted the way she views her patients, but unlike Kristen, she believes that the intensification of the medical gaze has made her "a very effective worker who can multitask." Lauren, a physical therapist, also admits that medicalizing her patients streamlines her work and makes her a more efficient HCW. It is difficult to assess the veracity of these statements nor do we know what the patient perspective of this "efficiency" is. But, this is particularly interesting because typically, the embodiment of emotional labor and the enactment of the medical gaze are supposed to exist in balanced tension with each other. This preference that Lauren and Mia show tip the balance in favor of medicalization. Both Lauren and

Mia even acknowledge that their overuse of the medical gaze came at the cost of their ability to provide emotional, affective care. However, they prioritized the self-perceived efficiency and productivity that came with the deployment of the medical gaze.

One could argue that their amplification of the medical gaze may have also been an attempt to avert or mend the problems and tragedies caused by the pandemic. Medical training offers the medical gaze as a way to efficiently solve patients' maladies (Good 1993). Each variable, separated out by the medical gaze, can be dealt with individually by a HCW that is specialized to treat that specific variable. It is one of the reasons behind the establishment of different specialties and departments such as oncology, hepatology, and endocrinology within the American healthcare system. Lauren and Mia may have intensified their use of the medical gaze in an effort to treat pandemic patients more efficiently. Through this perspective, their intensification of the medical gaze is another method of self-preservation in the face of great emotional vulnerability.

Structural Issues in the Hospital

The pandemic also exacerbated the previously existing issue with staffing shortages in the American healthcare system. This exacerbation then contributed to increased emotional vulnerability for HCWs as well as the acceleration and intensification of the medical gaze. Data from the Census Bureau and the Bureau of Labor Statistics show that prior to the pandemic, the healthcare workforce was diminishing due to the aging workforce and the limited availability of training, which put strain on hospitals who needed more HCWs to sustain patient demand (Zhang et al. 2018). Non-metropolitan hospitals also struggled to recruit enough HCWs compared to their metropolitan counterparts due to lower wages, unappealing locations, and availability of skilled staff (Seago et al. 2001; Smith, Sim, and Halcomb 2019). This staffing

shortage is just one out of many health disparities between urban and non-urban populations and contributed towards increased mortality in non-urban areas, both before and during the pandemic (Shi et al. 2005; Smith et al. 2019; Yu 2020).

The additional pressures and consequences of the pandemic resulted in an increased demand for care, including testing, vaccination, and treatment. However, there were not enough HCWs in primary care to meet those demands, and the HCWs that were left were forced to accelerate and intensify their deployment of the medical gaze in order to keep up with increased numbers of patients.

For example, Anish works at two hospitals, henceforth referred to as Hospital A and Hospital B. Anish is the sole nocturnist at both hospitals and is responsible for all in-patient care for the night. As a nocturnist, he is expected to complete any tasks that the day team requests from him, including follow-ups on certain patients, changing medications at a given time, and keeping track of patient conditions. As a result of this work, Anish covers patients from a variety of departments — hematology and oncology, hepatology, gastroenterology, etc — depending on the kinds of patients staying overnight. At the height of the pandemic, Anish had to take care of 300 patients per night by himself. There was no other nocturnist or any other doctor from the day team on-call to help him take care of his patients. This additional work caused by the hospital's lack of available staff resulted in Anish's accelerated ability to configure patients under the medical gaze.

These staffing shortages may also be due to institutional policies from the hospital rather than just the lack of HCWs. Studies demonstrate that prior to the pandemic, the pressure to prioritize profit from hospital management and financing resulted in more restrictive staffing policies and strategies that involve overworking current HCWs (Seago et al. 2001; Winter,

Schreyögg, and Thiel 2020). During the pandemic, most revenue-accruing treatments such as surgeries were suspended for the first half of the pandemic (Mattingly et al. 2021; Office of Health Policy 2022). In comparison, primary care, which was utilized most often to treat COVID-19 patients, is not as profitable for hospitals. As a result, many hospitals furloughed or temporarily suspended HCWs involved in postponed procedures in order to maintain profits.

Even though HCWs from departments such as general surgery are not accustomed to providing primary care, they still would have been capable of providing other forms of care such as testing people for COVID-19 or providing vaccinations. They also could have been trained to provide specific care for COVID-19 patients, which could have alleviated the staffing shortage in primary and intensive care units, which were the most utilized during the pandemic (Auerbach et al. 2020). However, many hospitals chose to furlough or suspend these HCWs instead, making it even harder for HCWs on the frontlines.

Hospitals also forced their HCWs to work more and achieve higher productivity levels during the pandemic in order to maintain profitability and revenue. Lauren, the physical therapist, said that her department was demanding individual productivity increases for every clinical therapist and quantifying their work in order to measure their performance rather than hiring more physical therapists to meet patient demand. According to her, they measured it based on "how many patients we see and how many units we bill per patient." However, this came at the cost of spending less time per patient and intensifying the way Lauren used the medical gaze on her patients.

Anish's experience at his worksites also reflects an institutional hesitation to directly address the staffing shortage. Hospital A and B are both in suburban Southern California and specialize in acute services. However, Hospital A is larger than Hospital B, boasting more beds

and greater patient revenue. Yet, Hospital A refused to hire another nocturnist even at the height of the pandemic, forcing Anish to manage 300 patient beds on his own. This was not a budgetary limitation but rather an independent choice by Hospital A in order to maintain profits during the pandemic. Because of this lack of staff, Anish had to accelerate and intensify the way he transfigured his patients under the medical gaze. Recently, Hospital A also closed down their behavioral health unit because of its lack of profitability, resulting in 27 clinical staff members being fired. This is just another example of Hospital A's prioritization of profit impacting staffing.

Kristen also identifies hospital management as a source of her increased workload and by extent, her increased ability to deploy the medical gaze. When asked about the staffing shortage and her thoughts on it, she said,

> "It's not a lack of money. [My hospital] has a lot of money. *(laughs)* Our chair of medicine makes over a million dollars a year. It's not the lack of funding, it's that they don't want to spend the money to hire these extra attendings or extra NPs and PAs because it costs more money to do that than to have residents handle the rest. It's the worst."

For her, the increased amount of work caused by the staffing shortage forced her and her colleagues to medicalize their patients more for the sake of efficiency. The administration specifically asked Kristen and her colleagues to release as many patients as possible in order to decrease the patient turnaround time and increase profits and care the hospital could produce.

In this sense, the hospital actively benefits from the intensification of the medical gaze. Their reluctance to hire more HCWs demonstrates that the institution is willing to sacrifice the affective component of care and well-being of their workers in favor of increasing productivity and profitability. In the eyes of health administrators, the emotional vulnerability and its resulting consequences among HCWs may be a beneficial feature of the pandemic rather than a

detrimental side-effect. After all, it is precisely this pandemic-induced vulnerability that enabled HCWs to accelerate and intensify ongoing transformations of patients in healthcare. If this acceleration and intensification of the medical gaze continues post-pandemic, it could potentially increase hospital revenue and profitability without the need to hire more staff.

Conclusion

The deployment of the medical gaze is a practice that is essential to the habitus of a professional HCW. As such, HCWs acquire the ability to gaze at their patients in a biomedical way through medical training and clinical experience, and they hone their abilities over time. However, the pandemic fractured the typical tempo at which the medical gaze is acquired and instead, accelerated and intensified the ways in which HCWs medicalize patients. The unprecedented nature of the pandemic certainly contributed to this acceleration with some HCWs utilizing the medical gaze as a form of emotional self-preservation in the face of increased emotional vulnerability.

However, the pandemic also exacerbated previously existing flaws in the American healthcare system, which further contributed to the acceleration and the amplification of the medical gaze. This phenomenon then contributed to the rupture between medicalization and affective care among HCWs. In the next chapter, I elaborate on this rupture by describing the ethos of proper care that HCWs rely on and how the pandemic fundamentally challenged that ethos as well as the biomedical institution as a whole. I also define what emotional vulnerability looks like in the medical setting and how it was exacerbated.

CHAPTER 2:

Navigating Vulnerability During the Pandemic

It is 8 pm when Oliver checks on his last patient, and he is so tired that he stumbles and falls on his way. His vision blurs when he tries to get up, but he forces himself up and collects his fallen charts before he finds his final patient for the day. It is several hours past when he was originally supposed to leave, but too many doctors and nurses are out sick with COVID this week, so he has to stay longer to pick up the extra work. But this is the last patient and he tells himself that he's going to be okay.

However, when he steadies himself, there's a code ringing through the ward. His patient is dying. Oliver starts to run, heedless of his previous fall. There isn't much he can do when he arrives though. The nurses are already there, trying to stabilize the old man. Another nurse tries to reach the patient's relatives, hoping for someone to be there with his last moments, but no one picks up. The nurse and Oliver share one long look before Oliver sits down beside the patient and holds his hand. At this point, there is nothing else that Oliver can do other than to make sure that the patient does not die alone, and so, he holds the patient's hand until the machines let out a long, loud beep. Dead.

Oliver stays there for a few minutes more, but then, a technician forces him to leave. They have too many patients and not enough beds; they must make room for more. Oliver leaves the ward and passes his charts onto the next doctor here for the night shift. They make small talk — how are you, how was your day — and Oliver takes his leave. When he gets into his car, he lets out one long and heavy sigh and he begins to cry. He ultimately ends up arriving home at 10 pm — 8 hours before he has to be at the hospital again.

I heard many stores of care from different HCWs during this endeavor, but this story from Oliver struck me in particular because of its simplicity. We were about halfway through our conversation when he first relayed this story, and he told it in two sentences: “My last patient was dying, and I remember tripping on my way to find him. His family wasn’t picking up the phone, so I stayed with him and that’s how my shift ended.” When pressed for more detail, he offered descriptions of codes, respiratory procedures, and different kinds of steroids and antiviral medications instead of any admission of grief or guilt. But after Oliver told me this, he lapsed into a long silence and I waited there with him during that lingering moment. He then moved on to talk about his training, the kind of work he typically did during his shift, and his experience in medical school. We did not talk about care again until the very end of the interview. I was about to end the call when he suddenly admitted that he still thought about that old man from time to time. “This is why I keep practicing medicine,” he said. “To help people like him. I hope I did something right for him. I feel bad that I couldn’t do anything more.”

For Oliver, this was not a proud moment. His training taught him to prioritize scientific objectivity in order to diagnose and treat various maladies and to balance emotional moments with that same kind of objectivity. Based on these expectations of a proper doctor, there should be no time nor space for him to languish in this kind of emotional distress. Yet, the dimension of affective care was what motivated him to continue his work and what connected him most to his patients. This reflects the larger phenomenon within healthcare where the actual practice of medicine requires the performance of emotional labor as well as the investment of emotional care. In order to care for their patients, HCWs must also care about their patients, blending both the behavioral and affective aspects of emotion that the act of care demands (Irving and Dickson 2004; Kleinman 2009; Larson 2005).

In most contexts, emotional labor is used to reference the kinds of performances that workers must practice in order to properly do their job. In her formulation of the concept, Hochschild specifically uses the example of flight attendants — who are hired to smile and be friendly even in stressful situations — to explain the concept of emotional labor as the work involved in managing one's emotions and essentially producing a *performance* for others to witness (Hochschild 2012). She then divides emotional labor into two elements: surface acting vs deep acting. Surface acting is when employees display emotions required for a job without altering their true feelings while deep acting is a process that requires conscious effort to change their internal feelings towards what their job demands (Hochschild 1979, 2012). The latter is what biomedical institutions demand from the HCWs. HCWs must *embody* the loving, empathetic, and caring response in order to provide proper care for their patients (Kleinman 2009). It is not simply a matter of performance or giving some sort of signal to their patient.

However, I argue that Hochschild's theories on emotional labor and deep acting do not fully encompass the kind of emotion work HCWs do. This is due to several reasons. First, there is an inherent tension that exists between the medicalization of patient bodies that HCWs are expected to do and the care that HCWs must provide. A HCW must use the medical gaze to transfigure their patient into an object of science — which is inherently a depersonalizing experience for the patient — while transforming their emotional state into something that can respond empathetically to the patient as an individual person. Second, HCWs must navigate this tension while being surveilled by their own institution. HCWs are in a unique position in that they possess positions of great power over patient bodies while simultaneously being surveilled and governed by their biomedical institution. Authority and power permeate their positionality, creating a network of power relations between them, their patients, and the hospital as a whole.

The hospital's spatial and social division into departments and hierarchies enables the institution to enclose and partition HCWs into specific places for further monitoring. Even biomedical training instills a form of discipline within HCWs, causing them to surveil themselves and their performance at work. Oliver is an excellent example of this; he self-admitted that he was not proud of disrupting the expected balance between medical objectivity and affective care.

Typically, these issues are not obvious. HCWs are taught to balance medicalization and affective care from the very first day of their biomedical training, and healthcare work is institutionally defined through its moral and ethical obligations to doing good. Every HCW I interviewed cited "wanting to help people" as a reason for entering the medical field. For instance, Lauren, a clinical physical therapist, specifically mentioned that she loved helping her patients get better and cited it as a major personal motivation. For her, the blend of biomedical science and emotional care allowed her to derive enjoyment from her job, and prior to the pandemic, she claimed that she was able to easily manage both the emotional and biomedical realities of the patient without experiencing any cognitive dissonance. Whether or not that is a true statement is not as important; the key thing here is that the HCW, such as Lauren, perceives themselves as being able to manage it easily.

However, the unprecedented number of patient deaths during the pandemic ruptured this tension between emotional care and medicalization. Although Oliver still expressed the desire to help his patients, the affective component of the care that he provided began to be emotionally overwhelming for him. According to him, he could no longer balance the need for scientific distancing along with emotional care as easily as he could before, and the act of embodying emotional care made him more susceptible to overwhelming grief and anger. Although HCWs have experienced moments of emotional vulnerability before — losing your first patient, making

a deadly mistake, etc — these instances are temporary, not chronic. That is precisely what sets the pandemic apart from other experiences of emotional vulnerability in the hospital.

In this chapter, I first describe what proper care looks like in a biomedical setting and why HCWs must embody an empathetic and emotional response for their patients. I then demonstrate that the COVID-19 pandemic disrupted the typical tension between the enactment of the medical gaze and the embodiment of emotional labor in an unprecedented way, resulting in chronic emotional vulnerability among HCWs. I specifically define emotional vulnerability as a state of exposure to events that impairs one's ability to function emotionally and to navigate emotional landscapes, both in professional and personal contexts. In the context of HCWs during the pandemic, these events range from watching COVID-19 patients die to the emotional stress resulting from working in proximity to the COVID-19 virus. I also describe structural issues within the American healthcare system that exacerbated this period of chronic vulnerability as well as administrative responses to pandemic-induced emotional vulnerability.

What constitutes proper care?

The National Academy of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes" and more specifically, clinical quality of care refers to the quality of the interaction between healthcare providers and patients (Centers for Medicare & Medicaid Services 2021; Hanefeld, Powell-Jackson, and Balabanova 2017). Most metrics of quality care revolve around the effectiveness of said care whether that be positive patient outcomes, consistent and timely assessments, and effective medical interventions (Allen-Duck, Robinson, and Stewart 2017).

Although emotional care is not directly mentioned, the American Medical Association's code of medical ethics states that physicians must provide medical care "with compassion and

respect for human dignity" (Riddick 2003). Institutionally speaking, hospitals benefit from emotional care that focuses on the patient's needs and illness narratives (Kleinman 1997; Reynolds 2009). The implementation of patient-centered, emotional care has been shown to contribute to improved outcomes for patients, higher patient compliance, more cost-effective care, and increased patient satisfaction (Gluyas 2015; Reynolds 2009). Despite not being formally acknowledged in institutional policies, every HCW I interviewed mentioned emotional care and comfort as being a large aspect of what constituted proper biomedical care.

For Amelia, a dental technician, proper care for her patient was always paramount. In spite of the stresses of the pandemic, she used her own time and money to provide extra safety precautions for her patients such as buying extra masks and face shields and taking extra time to sanitize her work space and tools twice. Most importantly, she emphasized the emotional comfort that she offered her patients during their visits. She would ask them about their lives, their family, and what they looked forward to. "It's really important to me that they know that I care," she said with a laugh. "It's so hard for everyone and they're probably scared to even show up for their appointments. I just want them to know that I'm here to take care of them."

Jonathan, an internist, struggled with working in the ICU, since he felt like he couldn't comfort the patients as much. The only thing he could do was call their relatives and offer them as much comfort and information as he could. "It just sucks, you know? I can't tell them [the patients] they're going to be okay because most of them are sedated," he commented. "So I call the family and tell them about the procedure, say that we're trying our best, and be there for them as much as I can."

This demonstrates that proper care is ultimately about a certain kind of ethos. Whether it is a deep passion about their work or a method of deep acting, the idea of proper care lends itself

to the value system that the medical profession uses to bring people into the profession and to present itself as. Even though biomedical institutions formally demand that its workers scientifically and dispassionately describe what is wrong with patient bodies, they also recognize that this ethos must be present to make healthcare work palatable for both patients and HCWs. As for the HCWs themselves, this value of "proper care" is what they use to tell a story about themselves and their work: what it means to be a doctor, a nurse, a technician. This is why empathy and emotion are irreplaceable aspects in what HCWs deem to be proper practices of healthcare. However, this kind of ethos began to break under the strain of the pandemic.

Emotional Vulnerability in the Hospital

Although empathy is in high demand within the contexts of patient-centered care, there is also the possibility of vulnerability. Young doctors often mention how the emotional burden is overwhelming at first, and it takes several years of practical experience for the balance to emerge (Irving and Dickson 2004; Thompson 2003). The emotional vulnerability brought on by the pandemic is unique compared to the emotional vulnerability that newly trained HCWs experience when entering the workforce. For the latter, it is a transitional state of vulnerability that fades away with additional training (Irving and Dickson 2004; Thompson 2003). For the former, it is a state of vulnerability that was experienced nation-wide, regardless of prior work experience or position within the hospital hierarchy. COVID-19 spread globally and caused millions of deaths (Anon 2022b; US Federal Emergency Management Agency 2020). No amount of training could wipe away the grief and stress from the surges. The increased level of emotional vulnerability then contributed to an increased level of occupational stress, compassion fatigue, and for some HCWs, different forms of post-traumatic stress.

The HCWs I interviewed commonly used the words and phrases such as "trauma," "PTSD," and "traumatic grief" to describe their emotional experiences. The literature on trauma and PTSD is rich and extensive, both within the realms of anthropology and biomedicine. Although it is possible that my interlocutors are drawing upon their medical expertise and utilizing the language of trauma in a biomedical fashion, I refer to trauma and PTSD as local categories rather than their theoretical or scholarly definitions.

Instead, I utilize vulnerability to describe the exposure to events that undermine HCWs' abilities to manage their emotions and the subsequent emotional turmoil resulting from that exposure. Although vulnerability is most commonly used within the anthropological contexts of economies, climate change, and disasters, I use Chambers' definition of vulnerability as having two sides: the external side of exposure and the internal side of loss and defenselessness (Chambers 1995). In the case of HCWs, they experience constant exposure to the COVID-19 virus as they treat patients, and in doing so, they risk catching the disease themselves and spreading it to their loved ones. The only way to escape this exposure is to stop working, which prevents them from earning their paychecks and supporting themselves. It also prevents HCWs from fulfilling their vocation of helping people and providing people proper care the way they were taught to. In the context of emotional vulnerability specifically, HCWs risk experiencing complicated, traumatic grief which significantly impairs their ability to function in work, health, and social settings (Zisook and Shear 2009).

I also specifically name this phenomenon as vulnerability rather than emotional precarity due to several reasons. First, precarity implies that there are specific social and political factors that differentially distribute vulnerability among HCWs. Although my data suggests the presence of certain factors such as authority, power, and gender that influence the distribution and

experience of vulnerability, there is not enough data nor did I have enough interlocutors to definitively define this phenomenon as precarity. Second, previous literature on states of precarity do not adequately include the resulting emotional turmoil with the event of exposure. I believe that there must be that combination of the external and internal sides of exposure, as described by Chambers in literature regarding states of vulnerability, in order to fully explain and understand this occurrence (Chambers 1995).

During the pandemic, patient deaths became a daily aspect of hospital care. HCWs have witnessed more deaths during the COVID surges than they ever have, and as they plunged into new, uncharted territory, it became increasingly more difficult for HCWs to maintain the separation between providing emotional care and shouldering emotional burdens. Jonathan, an internist, described the emotional toll of the pandemic as being "absolutely brutal" and said, "I've seen more intubations in the past year than I ever have before."

Mia, another internist, cited the COVID surges as being one of the most vulnerable experiences that she ever had. She recalled a particular week she worked in the NICU where "six, eight people were passing away" and how they were deteriorating so quickly compared to what she was used to. Although the patient deaths were difficult to process, Mia found that the most difficult part was talking to the families. She had to discuss the health trajectory of the patient all while knowing that there was, at the time, no cure and no vaccine. The families would then sob and scream. Some threatened to sue the hospital. Some tried to bargain with her, offering to pay more money in exchange for some miracle drug or solution. Others broke down completely and became unresponsive. This caused Mia to experience, as she described it, compassion fatigue and PTSD. During our interview, her voice was shaking when she said, "It was just so bottled up inside me and I was afraid that if I unbottled it and started telling people

about how I was feeling, I would not be able to go back to work the next day. And I have to go to work." As a result of her increased emotional vulnerability, she had difficulty sleeping, intrusive thoughts about her patients, and a diminished ability to empathize or feel compassion for her patients.

One could argue that we have experienced previous outbreaks of disease before, such as the 2003 SARS (severe acute respiratory syndrome) outbreak and the West African Ebola virus epidemic in 2013. However, the effects of emotional vulnerability were less severe because HCWs experienced shorter and less intense periods of exposure. In general, HCWs who worked during the SARS outbreak experienced less symptoms of PTSD compared to their COVID-19 counterparts (Koh et al. 2005; Lee-Baggley et al. 2004; Marjanovic, Greenglass, and Coffey 2007). As for the Ebola outbreak, statistical analyses of HCW surveys found no difference between HCWs who treated Ebola patients and HCWs who did not, particularly in respect to their fatigue or emotional side effects such as depression and anxiety (Lehmann et al. 2015).

This is a contrast to the COVID-19 pandemic, where HCWs experienced longer and more intense periods of emotional vulnerability due to the severity and length of the pandemic. The SARS outbreak had around 8000 cases, 774 confirmed deaths, and ended in 8 months (Wilder-Smith 2021). The same goes for the Ebola outbreak: less cases, less deaths, and less transmission (Wilder-Smith 2021). In contrast, COVID-19 claimed millions of lives and lasted for three years with the USA only recently announcing the end of its coronavirus public health emergency (LaFraniere and Weiland 2023). Overall, the duration of the pandemic in addition to its intensity contributed to a heightened sense of emotional vulnerability and left HCWs in a state of grief and trauma that they still have not fully recovered from.

Shortages in the System

Aside from these personal experiences that led to heightened susceptibility to grief and trauma, there were several structural factors within the American healthcare system that led to increased emotional vulnerability among HCWs.

First, the prioritization of profit by hospitals contributed to a lack of critical resources — personal protective equipment (PPE), ventilators, medications, etc — during the pandemic. When it comes to PPE, the Occupational Safety and Health Administration (OSHA) legally requires all employers to provide HCWs with free PPE (Barniv, Danvers, and Healy 2000; OSHA 2007). PPE in particular is unique compared to other medical supplies such as catheters and medications because they are not billed to either the patient or the insurance company (Bai and Anderson 2016; McLellan 2017). Instead, PPE is a mandated product that must be provided by the employer according to OSHA regulations. This makes PPE an expenditure hospitals must budget for. In order to minimize costs and maximize profits, many hospitals prior to the pandemic did not maintain PPE inventories and relied on just-in-time production and ordering instead. The pandemic completely upended this model by disrupting the manufacturing and supply chain for medical supplies and resulted in a severe shortage of PPE, including masks, gloves and gowns ((Emanuel et al. 2020; Livingston, Desai, and Berkwits 2020).

Furthermore, global demand for these products drove up their prices, making it harder for smaller and rural hospitals to obtain medical supplies. The severity of the pandemic prompted a surge in panic buying, hoarding, and resales of PPE, which impacted the availability of PPE for purchase by hospitals (Cohen and Rodgers 2020; Kamerow 2020). Smaller hospitals already struggle with resource and staffing shortages because they must deal with the disadvantageous economies of scale compared to their larger, urban counterparts (Weisgrau 1995). For instance,

they may not be able to afford the minimum order requirement for certain medical supplies because of their limited budget. This exacerbated the PPE shortage and placed HCWs in greater physical and emotional vulnerability.

Amelia, the technician, works at a small, privately-owned clinic in Southern California, and she reported that her clinic provided limited PPE due to the shortage. "I was afraid!" she told me. "I asked them, 'Do you have all the KN95 masks and equipment ratings?' They said yes, so I came back, but when I came back to the office, they didn't have any KN95s." As a result, Amelia bought her own KN95 masks, face shields, and additional hand sanitizer for her personal use. However, that lack of protection at the office unsettled her and heightened her level of emotional vulnerability. As a result of this fear, Amelia continued to purchase and use her own PPE, even when the clinic later provided more PPE.

Charlotte, a pediatrics resident, also commented on the lack of PPE. The local rural hospital was inundated with COVID patients, so many adult patients were transferred over to her children's hospital. Charlotte and her coworkers were all startled by the sudden change and were unprepared to take on the adult patients, both in terms of resources and education. "We were sorta forced to see adult patients, so that was a serious disaster," she said. "That's not what we're trained to do, and not having enough PPE really stressed me out and scared me, especially since I live with my mom." Charlotte specifically talked about how the exposure to the virus from inadequate PPE combined with a new patient population increased her emotional vulnerability and made it harder for her to provide embodied affective care. First, she felt that her PPE prevented her from providing non-verbal emotional cues to her patients such as facial expressions. Second, she mentioned that her fear inhibited her from interacting with her patients as much as she would have. She rushed through patient intake and minimized contact with them.

Third, her unfamiliarity with adult patient populations made her more hesitant to prescribe certain medications and provide certain treatments.

Another contributing factor towards heightened emotional vulnerability during the pandemic was the use of travel nurses. Travel nurses are registered nurses who are employed by independent agencies and work in short-term positions at hospitals. Because of the lack of resources and staff members required to meet COVID patient demand, some hospitals resorted to hiring travel nurses (Chervoni-Knapp 2022; Hansen and Tuttas 2022). Unlike hospital staff nurses, travel nurses tend to make significantly more money and during the pandemic, their salaries increased significantly more than their hospital counterparts. Hospitals have a difficult time competing with the salaries provided through travel nursing agencies, and as a result, staff nurses are paid less and have less schedule flexibility than travel nurses (Hansen and Tuttas 2022; Office of Health Policy 2022). Although the availability of travel nurses temporarily solved staffing shortages at some hospitals, their overall presence negatively affected the morale of staff nurses.

For instance, Samantha is a seasoned ICU nurse whose department hired travel nurses to accommodate the increased number of COVID patients. She expressed frustration with the time it took to train travel nurses in how the unit operated, and she was also frustrated by the differing levels of compensation and work time. According to her, this was a common sentiment expressed by other nurses in her hospital as a whole. “No one likes wasting time,” she said. “And they [travel nurses] waste our time.” She felt like the travel nurses “got off lightly” compared to her and her colleagues’ experience. That comparison between herself and the travel nurses produced a heightened state of emotional vulnerability in Samantha.

For instance, she felt like she was being exposed to the virus more than the travel nurses due to their ability to leave the hospital at any point in time, and that caused her emotional stress in the form of increased irritability. Her animosity towards travel nurses was also accompanied by the feeling that hospital administration was doing nothing to alleviate the emotional vulnerability and duress that she experienced from the pandemic, resulting in heightened frustration with her workplace and her own efforts. Although she did not specifically mention how this impacted her relationships with her patients, it is possible that this increased dissatisfaction influenced the way she treated and interacted with her patients, thus affecting patient care. The travel nurses may have temporarily provided some relief in terms of workload for staff nurses like Samantha, but that came at the cost of exacerbated vulnerability in the form of decreased morale for the staff nurses and potentially other ancillary HCWs.

Finally, the structure of state medical licensing boards as well as hospital work culture contributed to the chronic emotional vulnerability present during the pandemic. State medical licensing boards often ask questions about mental health histories, both past and present, and physicians have cited a fear of negative consequences related to licensing as a barrier to seeking mental health treatment and care (Gold et al. 2016; Office of Health Policy 2022). Generally speaking, physicians are less likely to seek mental health treatment in states where the licensing application inquires about their mental health history (Dyrbye et al. 2017). This has contributed to a culture within hospitals — and within biomedicine as a whole — that places low priority on mental health and discourages HCWs from seeking mental health treatment.

The pandemic worsened this culture and prevented HCWs from seeking out help for their increased susceptibility to mental health issues. Kristen and Mia both used the language of trauma and PTSD to describe their emotional experiences, but they both said that they did not

share these personal feelings at work. Kristen felt like her supervisors and administrators simply wouldn't care at all and said, "Since when have they ever cared [about mental health]? They don't care! I don't think it's just at this hospital, I think it happens at a lot of other big hospitals." As for Mia, she feared that her abilities and performance as a HCW would be negatively evaluated if she expressed her worries and concerns about her mental health. When her supervisors asked about her feelings about the new workload, the state of the hospital, and the pandemic, Mia refused to answer them honestly. She instead bottled up her true feelings on the matter and kept quiet. "For me to be put on the spot with people who are above me, who all said that it [the work and their mental health] was fine, I could not say how I was truly feeling," she said.

Natalie, a clinical pharmacist, also expressed similar sentiments to Mia. Even though she experienced "crazy amounts of stress and grief" during the pandemic, she did not express these worries to any of her supervisors. Instead, she felt more comfortable talking about her concerns to her coworkers or those that worked below her because they did not have the institutional power to use it against her. She said,

> "I just can't tell my boss that I'm depressed, you know? What if he thinks I can't do my job? I could tell my work friend, but I can't tell my literal boss. It's not like I'm usually depressed, I'm pretty easy. The pandemic has just been so much, not just for me but for everyone."

And so, Natalie continued to work without ever telling her supervisors about her mental health struggles. The added pressures of absent workers made her feel like she couldn't take a day off, and eventually, she stopped talking about her mental health at all as the pandemic went on.

Issues such as these are core flaws within the American healthcare system that contributed to emotional vulnerability prior to the pandemic. The pandemic merely aggravated

these issues and as a result, HCWs were forced to shoulder even a greater emotional burden than they have before, leading to increased susceptibility to grief, trauma, and stress. Without addressing these factors, emotional vulnerability will continue to persist in a post-pandemic world.

Administrative Responses to Emotional Vulnerability

This unprecedented period of chronic vulnerability has not gone unnoticed. Among the HCWs I interviewed, almost all reported that hospital administration attempted to redress the situation by offering interventions and additional rewards. However, all of the HCWs that mentioned these interventions also added that they did not personally find them to be helpful.

Lauren and Anish mentioned that their hospitals tried to provide additional benefits such as catered food and hospital merchandise such as water bottles and sweatshirts during the pandemic. Anish laughed and said, "I guess it's nice to eat steak and lobster. Not sure how that's solving COVID, but I'll eat it if they give it to me." Lauren described these events and items as being "nice but surface-level." Both of them cracked multiple jokes about pizza parties being the hospital administration's "band-aid solution" to their emotional struggles and duress.

Some hospitals also provided mental health interventions such as free therapy sessions and wellness events, but many HCWs did not find them to be useful. Kristen in particular seemed upset about these interventions. According to her, all of the wellness events were scheduled during her work hours when she was treating patients. "How am I supposed to go to a wellness session if I have to intubate my patients at the same time?" she snorted. Because of the scheduling conflicts, Kristen said that none of her colleagues went to the wellness sessions. Kristen herself went to one therapy session but did not find it helpful. That therapy session only

made her realize that her mental state and workload were "a lot fucking worse than I thought it was." She did not return to any of the wellness events afterwards.

Liam and Jonathan mentioned that their hospitals and clinics also provided some mental health interventions but they personally did not use them. For Liam, it was a waste of his time, and he wished that the hospital provided them with more days off rather than mental health services during work hours. Jonathan did not use them because he didn't know about them until after the first COVID surge. He only found out after a department-wide email was sent out by administration several months after the first therapy sessions were offered. Even after he found out, Jonathan chose not to attend because he was too busy and because no one else in his department went.

I attempted to reach out to various hospital and clinic administration in order to learn more about the wellness interventions and rewards provided during the pandemic, but unfortunately, no one responded to my queries. The most information I could obtain was from the employment benefits page on the hospitals' websites, which included services such as health insurance, retirement and tax savings programs, and pet insurance. One hospital did provide a link to the number of wellness opportunities available for their employees, but like Kristen, Liam, and Jonathan said, most of these wellness opportunities appeared to be available during the typical 9 to 5 workday, which is when HCWs would normally work. Ultimately, these administrative attempts at rectifying the increased emotional vulnerability among their workers do not seem to have worked.

Conclusion

For many HCWs, helping others is a key aspect of their job. In the practice of healthcare, the compassion HCWs extend to their patients becomes more than just a performance; it

becomes something that they must embody for their patients. This kind of ethos serves to keep the HCW within the profession and to justify the power and authority that biomedical institutions assert over patient bodies. Although this emotional labor comes at the risk of overextending the emotional burdens of HCWs, the enactment of the medical gaze typically provides a foil for it. These countervailing professional demands exist in a certain kind of tension that HCWs learn to balance through their training and clinical experience.

However, the pandemic exposed HCWs to increased risks, both physically and emotionally. This prolonged state of exposure and the high-intensity workload ruptured the tension that HCWs typically maintained between the emotional and biomedical aspects of care and left them exposed on the frontlines of the pandemic. This was further exacerbated by pre-existing structural flaws in the healthcare system such as resource availability and distribution, the use of travel nurses to address staffing shortages, and the culture around mental health.

This period of vulnerability was unique in that it was a side effect of the pandemic fundamentally challenging the power of the medical system, and to some extent, its workers. Biomedical institutions are typically constructed as being bigger than life due to the authority society grants them over patient bodies. From birth to death, hospitals and other biomedical institutions manage and oversee bodies and their workings. These institutions hold the cure to biological problems that they locate in the body through the medical gaze, and HCWs serve as agents of the institutional agenda and will.

However, the pandemic pushed the limits of everything in society and fundamentally put on the line what is important to HCWs and their institution. COVID-19 demonstrated that we do need the medical system more than ever, but it also showed us the limitation of the medical

system's ability to respond to health issues. No one was beyond this virus, resulting in vulnerability across all levels of the hospital hierarchy. The pandemic made biomedical institutions face the limitation of their discipline and their ability to heal, creating an existential question for the people who have spent years training to be HCWs.

I point this out not to fault HCWs but rather, to point out how biomedical institutions are harming their workers through their expectations of medicalization and proper care. HCWs exist in a unique position where they are simultaneously given power over patient bodies while being surveilled and controlled by their institution. These interactions between authority and power within the positionality of the HCW creates more opportunity for emotional vulnerability to occur. In the next chapter, I discuss the ways in which power and authority entangle with linguistic socialization and gender performance to reveal socially sanctioned ways to express vulnerability in the workplace.

CHAPTER 3:

Entangling Power and Gender in the Language of Vulnerability

Charlotte, a pediatrics resident, finds the most support when she joins her colleagues in the locker room at the start of each work day. They gather here to drop off their backpacks, change into their scrubs, and don on their PPE. With each additional item they put on — mask, cap, gown, face shield, globes — they become obscured from view save for their eyes peeking over the edges of their masks. But Charlotte has gotten better at reading their expressions based on how their eyes crinkle when they smile or frown. These are her colleagues after all: the same nurses, residents, and technicians who have weathered the storm with her throughout the pandemic.

Here, they talk about how the last shift went, what they're looking forward to, what they think will happen during the day. One of them even jokes around by asking if the others think they're going to get a pediatric patient that day. "Not a chance," Charlotte tells him. They've only been treating adult patients for the past few months because the neighboring hospital cannot handle the number of patients coming to their doorstep. Now, they have to pick up the slack and treat adult patients at their children's hospital. It's stressful work, certainly, but Charlotte finds comfort in the fact that she will be enduring this with others.

"We went through a lot together," she said. "I don't know what I would've done if I didn't have them." And that remained the case for the rest of Charlotte's stories. For every incident or experience she described, it was always phrased as the plural form where "we" did this together or "we" experienced a lot of stress and grief during the pandemic. Charlotte never once used "I" unless she talked about what she did after her work day ended. Everything else pertaining to her work at the children's hospital was framed as a group experience.

This was common among many HCWs I interviewed, with many of them describing their work experiences as being a "group effort" or something that "we all did it together." However, there were a few instances that stood out to me compared to the rest. When asked about the pandemic, all James had to offer was just a small chuckle. He is a dentist who continued to work throughout the pandemic. "It wasn't that bad," he told me. "Stressful in terms of financial situation, I guess, but I just hung in there." Liam, another dentist, and Jonathan, an internist, had similar reactions where they talked only about their individual experiences during the pandemic and rarely talked about their colleagues.

Although this may seem like a slight, surface-level difference upon first glance, I believe that the language that HCWs used to describe their experience can potentially lend an insight into the societally sanctioned ways in which people express distress. For instance, this distinction of "we" vs "I" was divided by gender among my interlocutors. Every person that utilized "we" to describe their pandemic experience identified as female, and every person that used "I" identified as male. This was compounded by the fact that most of the men I interviewed occupied positions of power within the hospital or clinic.

The previous chapters have described the ways in which HCWs *experienced* emotional vulnerability and its consequences, but this chapter will delve more deeply into the way HCWs *described* their experiences. Both are examples in which increased emotional vulnerability disrupted the established tension between affective care and medicalization, but the latter draws more deeply upon the anthropology of language to describe the socially permissible ways in which people navigate vulnerability. It is important to note that this chapter relies more on observations of the language used by my interlocutors rather than complete answers and opinions

from them, but I feel as though it would be amiss of me to not offer potential explanations for this phenomena as part of my analysis on vulnerability.

In this chapter, I first locate my observations within the context of language socialization and gendered expectations in the workforce. I then posit that linguistic socialization and gender performance entangle together in the hospital labor hierarchy and influence the ways in which HCWs describe and express distress and relief. In particular, I argue that the language male vs female HCWs use to describe their struggles lend an insight into the societally sanctioned ways in which people express emotional vulnerability as well as their positions of power within the hospital.

Gendered Expectations & Language Socialization

The use of "we" vs "I" was gendered among my interlocutors with female HCWs describing their emotions during the pandemic as a collective, lived experience. Even though every HCW I interviewed worked in a team of some sort, whether it be in the primary care wards or the ICU, female HCWs tended to answer my questions with a description of the entire team's experience rather than just their own. Natalie, a clinical pharmacist, was one of the HCWs I had the longest conversations with, and she almost always described her memories of the pandemic through a group lens. Even when she used "I" to describe an experience of hers, she would always relate it back to her coworkers in some capacity. For instance, when she talked about how she felt pressured to work overtime during the pandemic, she also said, "But we all feel like that, you get it, right? They also work overtime, so they must be just as tired and stressed as me."

In contrast, Liam, a dentist, only talked about the experiences that directly impacted him. He identified his finances as the greatest impact the pandemic had on him. He initially did not work for the first few months of the lockdown because his clinic partners decided to reduce the

number of staff at the office, and in response to that, he said, “Not working was really stressful for me. Consider my income, if you’re not working for a few months, that’s like tens and tens of thousands of dollars that you lost, that you missed out on.” I asked if he was in a financially precarious position to which he said, “No, I would have been fine and I was fine. It’s just a loss, you know?” Even when asked about his coworkers and his relationship with them before, during, and after the pandemic, he framed it as a business transaction with his main priority being “a good, busy, consistent workflow between us.”

The use of “we” vs “I” was gendered among my interlocutors with female HCWs exclusively describing their emotions during the pandemic as a collective, lived experience. Moreover, I noticed that the male HCWs I interviewed tended to downplay their emotional experiences despite having similar stories to the female HCWs I interviewed: stories about patient deaths, fears about contagion, and worries about their own stress and burnout. Still, the male HCWs were more reluctant to share these experiences with me or describe their emotions in further detail. For example, Oliver is an internist whose experience I describe in Chapter 3. His story, according to him, was a simple, straight-forward experience that could be summed up in two sentences: “My last patient was dying, and I remember tripping on my way to find him. His family wasn’t picking up the phone, so I stayed with him and that’s how my shift ended.” When I asked him for more details about that anecdote, he initially only provided information about procedures, medical codes, and the kinds of medications that he typically prescribed for COVID-19 patients. It took more time and more conversing for him to finally divulge more details about the emotions he felt during that time. Oliver was one of the few male HCWs I interviewed that ever shared that level of emotional detail with me.

This was in stark contrast to female HCWs who extensively described their affective experiences during the pandemic. Natalie spent over 15 minutes detailing how she felt stressed, overworked, and under-appreciated during the pandemic. "We work so hard only for patients to ask us for ivermectin," she lamented. "And we have to work extra shifts to cover for people who are sick with COVID or are on maternity leave." She clearly outlined what her issues were in the workplace and how she felt about it, and she even went into detail about how she thought her coworkers were handling the stress. Similarly, Kristen and Mia, two internists, described their emotional experiences using the language of trauma and PTSD. Although they included details about medical codes and treatments like Oliver did, they also expanded into how they felt after interacting with patients and their families, how they felt supported or unsupported by various people in their lives, and how their pandemic experiences continued to impact their daily work. This was surprising for me, especially since I asked each and every one of them the same exact questions. If anything, I needed to prompt Oliver more in order to learn more about the details of his experiences.

These descriptions do not necessarily mean that the male HCWs I interviewed did not experience any emotional vulnerability at all nor does it mean that men are incapable of expressing their emotions. Rather, I believe that these observations lend an insight into how people are socialized into the field of medicine and how they acquire the language of the field.

Language is an essential communicative skill and process that connects daily lived experiences with the cultural representation of those experiences. Through language, reality is constituted and negotiated, and through language, experiences and interpretations of those experiences are legitimized (Denzin 1992; McLaren 1997; Urciuoli and LaDousa 2013). Language is also an ongoing practice that is built upon itself through interactions with other

people, also called language socialization. When broadly defined, language socialization refers to the process through which people acquire the knowledge and practices that enable them to participate effectively in the social life of a community (González 2008). Language is not simply acquired, but rather, socialized into people through the interactions they have with other people in the community (Garrett and Baquedano-López 2002). Socialization enables people to recognize, negotiate, and construct a wide variety of meaningful social interactions and contexts. This also allows them to expand their social horizons by giving them the tools to engage with other people in different circumstances, roles, and statuses.

Language socialization is an ongoing process that interacts with its speakers and the worlds that they occupy, whether those be cultural or professional. Much like the habitus, the proper language and customs required of the professional healthcare setting is acquired through a social process (Bourdieu 1990; Giddens 1979). Professional language socialization is a co-constructed, mimetic process that is guided by the preferences, orientations, and dispositions that are culturally specific to the workplace in nature, and the accomplishment of this process is considered an achievement within its speech community (Schegloff 1986). In a sense, the hospital workplace functions as a speech community, where all the HCWs share the same rules and norms for the use of a professional language. Not only do they have to engage in the same discursive practices that form their professional habitus, they must also speak in a way that is professionally required of them (Shankar and Cavanaugh 2012; Urciuoli and LaDousa 2013). After all, communication skills in the hospital workplace serves as a form of linguistic capital valued for its utility and ability to bring in more revenue for the hospital (Irvine 1989; Urciuoli and LaDousa 2013). The language used in the workplace also possesses an underlying dominant metamessage, which promotes utilitarian efficiency and work improvement (Collins 1995; Heath

1983; Peters 2012). Thus, workers are encouraged to adapt to the new language in the workplace as fast as possible, and the longer a worker remains in the workforce, the more adept they become at communicating professionally (Urciuoli 2008). Furthermore, those occupying higher ranks of the hospital labor hierarchy often possess more linguistic capital by virtue of the position that they hold (Urciuoli and LaDousa 2013). Their words matter more and have more impact due to the number of people occupying the positions beneath them.

This is further compounded by the intersection of gender with labor and hierarchies. Labor is not absent of gender; in fact, there is an "implicit masculinization of the macro-structural models" that comprise capitalist labor (Freeman 2001). When speaking of gender, I utilize it to describe the socially constructed differences between female and male, feminine and masculine, that are reproduced and performed in various activities, practices, and rituals. In terms of performance, I specifically draw upon Judith Butler's interpretation of gender performance where they describe gender as a learned performance that retroactively constructs one's social identity as masculine or feminine (Butler 1988).

Although women comprise about 70% of workers in the health and social sector of biomedicine, they are less likely to be employed full-time and experience an average gender wage gap of about 28% (Boniol et al. 2019). Although female representation in the health sector has been increasing over time, male HCWs dominate positions higher up on the hospital labor hierarchy (ex: physicians, dentists, pharmacists) across the globe (Boniol et al. 2019). Female HCWs are also impacted by discrimination from both their patients and their supervisors (Govender and Penn-Kekana 2008), which they attempt to redress through the way they perform and communicate with their patients, coworkers, and supervisors. Through this, gender

performance and language socialization entangle together in the hospital workplace, influencing how HCWs across the labor hierarchy speak to one another.

Authority & Gender in the Hospital

Given these connections between gender, language, and authority, there are several plausible explanations behind this phenomenon I saw among my interlocutors. First, the limited expressions of distress may have been due to an intersection between authority and gender. I realized that the only three interviewees who occupied higher-ranked positions in the hospital — attending physicians or dentists — were all men.

In patriarchal Western societies, cis men statistically are less likely than women to express their emotions (Boniol et al. 2019). They are less likely to obtain emotional support from a social network, choosing to rely on their romantic partner instead (Zakowski et al. 2003). Men are also often discouraged from showing or displaying emotion in excess and are told to "man up" or "act like a man" (Govender and Penn-Kekana 2008; Maharaj 1995) In essence, men are discouraged from performing acts that may reveal their emotional vulnerability, particularly in public or the workplace. This is a part of hegemonic masculinity, defined by Raewyn Connell as being the dominant notion of masculinity within the contemporary American context whereupon the "real man" is defined (Connell 1987). Although she specifies that hegemonic masculinity is built on the domination of women and the formation of an intermale hierarchy, I believe that emotional vulnerability is involved in the maintenance of the latter. Within this intermale hierarchy she describes, the expression of an emotion other than anger and the admittance of weakness lowers one's position and thus, one wishing to present as a “strong man” must perform to the standard masculinity demands of him (Jennings and Murphy 2000; Kupers 2005).

If this applies towards labor hierarchies as well, then men occupying higher-ranked positions in the hospital may have felt pressured to limit their expressions of emotional vulnerability and distress. After all, the pandemic created a crisis of professional competency for HCWs due to the lack of a specific cure or vaccine against the virus in the first surge. HCWs across the country had to deal with losing people at a rapid rate that they had never seen before, and they may have lost their confidence in their ability to treat patients as a result. Refusing to acknowledge their emotional vulnerability to other people such as their coworkers or supervisors may have been an attempt to regain a sense of control and authority over the situation. Their professional competency may have also been questioned by others in the hospital workplace had my male interlocutors expressed more vulnerability.

For instance, Anish, the nocturnist, seemed to care deeply about his competency in the workplace. Although Anish and I did not explicitly talk about his relationships with other HCWs, he emphasized how he had to oversee 300 beds and ensure that his performance was "on par" with other doctors in his field. "I'm proud of the work I do," he said. "I'm medically educated, trained to make the right decisions for them [my patients] and part of that means I gotta suck it up and go to work." Perhaps his hesitancy to talk directly about his emotions or his tendency to frame his work as an individualistic effort arises out of his desire to appear competent to both his patients and the hospital administration. His individualistic perspective may also arise out of the fact that he is the only nocturnist in charge for the night; he may not perceive other HCWs such as nurses and technicians to be part of his experience.

Liam and James also referenced competency when talking about their work as dentists. Liam prioritized his work over his affective feelings of distress when he said, "It doesn't matter how stressed I am. No one needs to know that to work harder or better." James echoed a similar

sentiment when he said, “I don’t need to tell others that I’m stressed. I just go to work and come home and repeat. Business is business.” Even when I asked them to elaborate more on their emotional feelings and what exactly they meant by stress, they related it back to how it impacted their work performance and finances. It seems as though they still experienced the same kind of pandemic-induced emotional vulnerability that other HCWs described. However, the extent to which they were willing to discuss it was what set HCWs like Liam, James, and Anish apart. Perhaps they viewed this period of emotional vulnerability — or as they termed it, “stress” — as a threat to their competency and by extent, their authority in the workplace.

Aside from the entanglement of gender, language, and labor, this phenomenon may be attributable to my own positionality. As a young, female-presenting college student, my interlocutors may have elected to remove certain details from their responses during our conversations. They may have felt uncomfortable sharing their moments of emotional vulnerability due to our age gap, our different professional level, or our difference in gender. Perhaps they wanted to establish their authority by emphasizing their prioritization of competency and efficiency. Perhaps they would have felt more comfortable being emotionally vulnerable with me had I presented as a man. It is difficult to tell, but these are all certainly possibilities.

Another possible interpretation of this phenomenon may have more to do with the number of opportunities available to express emotional vulnerability. Generally speaking, it seemed as though the lower-ranked and/or female HCWs had more opportunities to express these feelings due to the stronger sense of teamwork they shared with their coworkers. This sense of camaraderie may have contributed towards their description of the pandemic as a collective

emotionally vulnerable experience, and it could explain this dichotomy between "we" vs "I" to characterize the pandemic.

Research on HCWs demonstrates that lower-ranked workers such as nurses and technicians frequently worry about problematic power dynamics between themselves and their supervisors (Delva, Jamieson, and Lemieux 2008; Kvarnström 2008; Zwarenstein, Goldman, and Reeves 2009). Physicians are perceived to hold more power in interprofessional teams due to their higher level of access and control over the kind of care the patient receives. As a result, lower-ranked HCWs tend to work together in order to adjust care according to the physician's demands (Delva et al. 2008). Nursing is also treated more as a "caring" profession compared to physicians, and as a result, this notion of empathy and care within the field may contribute to more collaboration and group work compared to physicians (David 2000). Female HCWs also generally report experiencing more camaraderie among their coworkers compared to male HCWs (David 2000; Kvarnström 2008).

Samantha, an ICU nurse, felt more affinity with the staff nurses employed in the ICU compared to the physicians she worked with. "They [the attending physicians] just tell you what to do," she said. "The ones who actually do it is us. It's always been like that though, not something from COVID." Even though she specified that this was a consistent feature of her workplace rather than something arising out of the pandemic, this connection between Samantha and her fellow nurses seemed like a significant aspect of her pandemic experience. It was this sense of fellowship that allowed her to feel more comfortable talking about her emotional stressors with other nurses in her unit, thereby allowing her more opportunities to voice her concerns and her feelings. She, by virtue of her training as a nurse and by her occupation as a lower-ranked HCW, viewed the pandemic as more of a collective emotional experience.

Charlotte, the pediatrics resident, also felt a greater affinity with her coworkers during the pandemic. “It brought us together,” she said. “We all went through something horrible together, and we’re stronger as a unit because of it.” Notably, she only mentioned other nurses, residents, and technicians when I asked her who she was referring to when she said “we.” She did not mention any of her attending physicians or the hospital administration. Much like Samantha, she attributed her work during the pandemic as being the product of her unit’s collective efforts. Kristen echoed a similar sentiment when she said, “I had a good time with my other residents in that we suffered together and bonded together. It really brought us closer together. Not really for my attendings though. They were just… There.”

For both Charlotte and Kristen, the emotional vulnerability they experienced and described to me was something that was shared by the entire group. Like Samantha, they tended to share more vulnerable moments with their coworkers by virtue of their close ties with them and frequent work shifts together. Compared to the higher-ranked male HCWs I interviewed, it seemed like these women had more opportunities to discuss emotional vulnerability specifically with their fellow coworkers.

It is also plausible that female HCWs are culturally allowed to express more moments of emotional vulnerability than male HCWs, especially along the lower rungs of the hospital labor hierarchy. Charlotte in particular clarified that she only talked about her emotional vulnerability with people that were “on the same level” as her, which tended to be women. It is difficult to entangle whether or not this is something that is socialized within lower-ranked HCWs or if this is a specifically female phenomenon on the hospital labor hierarchy. Unfortunately, I did not interview enough male HCWs to fully determine this. However, in all of these possibilities, the

intersection between authority, gender, and labor can reveal more about the socially acceptable ways to express vulnerability and distress, particularly within the realm of biomedicine.

Conclusion

As part of their professional habitus, HCWs are socialized to speak in a specifically biomedical way within the workplace. This is also shaped by the gender performance that they are expected to give as well as their position on the hospital labor hierarchy. As such, the intersection between these three factors shape the ways in which HCWs communicate their distress and determine socially sanctioned ways of expressing emotional vulnerability. Although these interpretations are more speculative than empirical, they still lend an insight into the available ways in which HCWs describe their vulnerability in the face of the pandemic.

CONCLUSION

In this thesis, I describe the ways in which the pandemic has affected and disrupted the ways HCWs work in biomedicine. By reflecting on the wealth of literature on healthcare and vulnerability, I discovered that the pandemic instigated a heightened period of chronic emotional vulnerability that significantly impacted the way HCWs perceive and treat their patients. HCWs have collectively witnessed an unprecedented event and dealt with the fallout in ways that many of us have difficulty grasping. In a way, HCWs have been living in a landscape of fear shaped by the spread of a new virus, the increasing death tolls, and the lack of resources and support from their institution. In response, HCWs have had little choice other than to intensify their work and cope with the increased susceptibility to grief and trauma.

Consequences of the Medical Gaze

Throughout my conversations with my interlocutors, it became more and more evident that the medical gaze significantly influenced the way they perceived their work and emotional experiences. Many of them described their emotional vulnerability as a "before" and "after" the pandemic, but the fact remains that they deployed the medical gaze before, during, and after the pandemic. The medical gaze affects people who use it, not just the people it perceives. By its very nature, the medical gaze dehumanizes the people it scrutinizes while forcing the person deploying the gaze to reconfigure the way they view and understand people. I believe that this period of emotional vulnerability was caused, if not exacerbated, by the demands the medical gaze made of HCWs.

Biomedical institutions directly profit off of the medical gaze, and their reluctance to address HCWs' concerns during the pandemic demonstrates that these institutions are willing to

sacrifice the ethos of proper care in order to achieve greater productivity and profitability. Staffing and resource shortages also illustrate how hospitals consistently prioritize their revenue over the well-being of their patients and their workers. Thus, the resulting burnout, stress, and trauma is a consequence of the medical gaze rather than a consequence of the pandemic. Current literature also supports this; there are numerous papers on burnout and stress among HCWs published prior to the pandemic.

If anything, the pandemic served as a crucible for the conflict between medicalization and affective care to come to a head. The pandemic challenged the biomedical institution's ability to cure biological problems and forced it to face its limitations and flaws, resulting in existential questions for the very workers that the institution hires. Most works on medicalization focus on the consequences for the patients and how their care is negatively impacted by this dehumanizing, probing gaze. However, I argue that HCWs themselves are at stake as well. Although they exist in positions of power over patients, they too are surveilled and subjected to the biomedical institution itself. They are not exempted from the consequences of the medical gaze. And so, they were forced into this state of vulnerability while doing an impossible task: treating pandemic patients while actively being hindered by the medical gaze.

Possibilities After the Pandemic

If we do not address the core issue of the medical gaze, then the resulting problems of stress, trauma, and vulnerability will continue long after the pandemic ends. This issue will continue to fester within biomedical institutions and negatively impact both HCWs and patients. Given that the effects of the pandemic are still rippling across society, it is difficult to precisely assess how these consequences will manifest. However, there are several possibilities in how this could unfold.

First, this level of increased emotional vulnerability may lead to more HCWs exiting the field and changing careers. Already we are seeing a burgeoning number of studies on the decreasing number of HCWs and the number of HCWs changing careers to something less draining and more profitable. Many staff nurses are transitioning to travel nursing due to the increased pay, and many physicians are transitioning out of primary care to less grueling departments. Some physicians even report transitioning to other careers that are less emotionally taxing such as industry consulting or medical research. This decrease would further exacerbate the existing staffing shortage and aggravate the stressors experienced by HCWs.

Another possibility is decreased quality of care due to increased emotional vulnerability and subsequent acceleration of the medical gaze. HCWs may be adversely affected by their increased susceptibility to emotional stress and grief, and it could leave them psychologically exhausted. That exhaustion could result in psychological distress and poor judgements or mistakes made in the workplace. Although several of my interlocutors expressed that their intensified medicalization of their patients made them more efficient workers, patients may experience the resulting care as being more impersonal or an offense to their dignity and personhood. The dehumanization of patients involved in the medicalization of their bodies may also adversely affect communication between HCW and patient, which may impact the exchange of critical medical information.

I begin to wonder if this period of vulnerability could have been mitigated in any other way. Although hospital administration attempted to redress the situation by offering mental health interventions and wellness events, many of the HCWs I interviewed said that they were not helpful at all. I propose that rather than individual actions done by various administrative staff, overarching policy changes in how hospitals are managed and staffed would be a better

answer to the problem faced by HCWs during and after the pandemic. As we begin to imagine a "new normal" post-pandemic, we must critically examine the ways in which our healthcare system is structured and managed and how the medical gaze is reinforced within it.

The pandemic has demonstrated that there is a dire need to invest in public health infrastructure and coordinate public health efforts. The reliance on a capitalist model of supply and demand resulted in the shortage of critical medical supplies such as PPE and ventilators, putting both HCWs and patients at risk of infection and death. Hospitals with an excess of certain resources could have distributed supplies to other hospitals in need, and hospitals overrun with patients could have directed some patients towards other hospitals with empty beds. Instead, the American healthcare system remains a service industry where profits and revenue are prioritized above coordination and centralization. Germany, for example, has a robust public healthcare system and was able to withstand the disruption of the supply chain (Hanson et al. 2021; Köppen, Hartl, and Maier 2021; Kreitlow et al. 2021). Because of this resilience and coordination of efforts, they were also able to accept sick patients from France, Spain, and Italy during the pandemic.

Staffing shortages arising out of institutional desires to maintain revenue also contributed to increased emotional vulnerability, decreased staff morale, and heightened medicalization of patients. Many of the HCWs I interviewed expressed frustration with being underpaid and unappreciated for the work that they were doing and how they were encouraged to work overtime, often without pay since their jobs were salary-based rather than hour-based. Instead of suspending certain HCWs and overworking current HCWs, hospitals could hire additional staff in order to support patient care activities. Hospitals could also increase wages, especially for

HCWs lower down on the hospital hierarchy who are more likely to come into contact with infected patients.

Aside from hiring more staff, medical institutions can also increase the number of HCWs being trained. This can occur through several avenues. First, the creation and expansion of additional clinical training opportunities can help HCWs in training such as medical students, nursing students, and technicians. For example, graduating medical students participate in an algorithmic program called the National Resident Matching Program (commonly called "the Match"). However, the Match has limited residency opportunities and many medical students do not end up matching to a residency, which is required to obtain a medical license and work as a physician. If there were more residency opportunities, then there would be more future HCWs available to fill in the employment gaps. Medical institutions could also decrease the financial barriers present when obtaining a medical education and license.

In regards to my own research, I also would have liked to further examine the ways in which different factors such as race and socioeconomic status influenced the extent to which HCWs experienced vulnerability and deployed the medical gaze. Due to the disproportionate number of white people staffed at my research sites, I expected most of my interlocutors to be white as well. However, most of them were Asian-American, and I am particularly interested in how their identity as Asian-Americans affected the way they perceived their work and their patients. During the pandemic, former President Donald Trump blamed China for the origin and spread of COVID-19, calling it the “Chinese Virus.” This amplified blame against Asian-Americans and accompanied a rise of anti-Asian hate crimes and sentiments across the nation (Lee 2021). How has the vilification and scapegoating of Asian-Americans affected Asian HCWs working on the frontlines of the pandemic? Would this affect the way they experienced

emotional vulnerability? How would this increased xenophobia and Sinophobia affect the way HCWs medicalized Asian patients while under emotional duress?

I am also interested in exploring how the hospital labor hierarchy continues to perpetuate inequities across the hospital. Because most of my interlocutors occupied the lower rungs of the hospital hierarchy, much of my data is drawn from these experiences. I would be interested in interviewing hospital administration to understand how and why institutional policies from the pandemic were constructed and how their experiences differ from HCWs on the frontlines.

As I conclude my thesis, I only think about my sister and the fear and grief she must have sustained during those long years. She intubated countless patients who couldn't breathe, watched as people refused to get the vaccine and later ended up in the ICU, and sobbed at the end of her shifts from the sheer stress of it all. She was just one out of many HCWs who experienced this level of emotional vulnerability, and yet, she continued to work day after day, refusing to stop. I cannot fathom the level of resilience that my sister and other HCWs displayed in spite of their increased vulnerability. I hope that this thesis can give light to my sister's experiences as well as those of other HCWs who worked tirelessly on the frontlines.

APPENDIX

Name	Occupation	Age
Liam	Dentist	27
Samantha	Nurse	48
James	Dentist	35
Charlotte	Pediatrics	29
Anish	Nocturnal Medicine	31
Lauren	Physical Therapist	32
Kristen	Internal Medicine	32
Amelia	Hygienist	43
Jonathan	Internal Medicine	35
Oliver	Internal Medicine	29
Natalie	Hematology & Oncology Pharmacist	27
Mia	Internal Medicine	31

Table 1. A list of my interlocutors along with their occupation and age.

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