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Crisis Support Through Policies for Medical Professionals in 2020 and 2021 During the COVID-19 Pandemic

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Abstract

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by

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MPA, University of Phoenix, 2018

BACFCS, University of Illinois at Springfield, 1997

Dissertation Submitted in Partial Fulfilment

of the Requirements for the Degree of

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Abstract

The rapid spread of the coronavirus (COVID-19) left many countries unprepared for a virus of its magnitude, particularly medical professionals and their practices. Current public health policies in Illinois cities must address the essential facility-based resources medical professionals use to ensure proper medical services during a pandemic. This basic qualitative research aimed to bridge the gap between policies addressing an urgent problem and poor protections that support medical professionals through a health crisis, such as the COVID-19 pandemic. Kingdon's multiple streams framework provided the conceptual framework for the study. The research question addressed policies that would bring about changes to improve medical facilities and support during a pandemic. The participant sample included small Illinois medical facilities that lacked adequate personal protective equipment, life-saving medical devices, and government support assistance during the COVID-19 pandemic. The data were collected by surveying 10 medical professionals and understanding their real-world experiences and opinions. Findings from the thematic analysis indicated that medical professionals did not receive appropriate crisis support under current policies. Thus, supported by Kingdon's multiple streams framework, it is recommended that a medical task force with supportive guidance be provided through policy for positive social change.

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Dedication

I want to dedicate this dissertation to my children, family, and community in Decatur, Illinois, and abroad. I believe in the mission of social change, and Walden University has helped prepare me to become an agent of change. Thank you, and let us make a difference that can bring social changes to our nation and the world.

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"If you believe in yourself, anything can be possible and not out of reach."

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Chapter 1: Introduction to the Study

The health crisis caused by the COVID-19 pandemic revealed various facets in which public policy implementation plays a role in the effectiveness of medical services. Communities depend on effective medical care, and the pandemic severely impacted public services, residents (considered nonessential workers), frontline workers, and society. Technological advances created convenience during the COVID-19 pandemic, the recourse being telehealth, which seemed the most appropriate option (Lohmeyer, 2021; Menifield & Clark, 2020). However, those categorized as being in a vulnerable population (i.e., with a high-risk health condition and low income) may not have access to benefit from telehealth services (Lohmeyer, 2021; Menifield & Clark, 2020). Moreover, local governmental entities were divided on appropriate societal restrictions and effective strategic planning (Ashcraft et al., 2020; Chmielewski, 2020). A Macon County, Illinois, government division exhibited the need for more information on how implementing new public health ordinances would best serve medical practices. The current study examined policy shortfalls for medical professionals when they must modify operations for their safety and duties during the COVID-19 pandemic. I attempted to develop an understanding of whether adequate public health policies are crucial to achieving success when navigating a global health crisis. In Chapter 1, I present background information relevant to the problem, purpose, significance of the study, nature of the study, conceptual framework, operationalized definitions of the terms used in this study, general assumptions, limitations, and challenges.

Background

In this study on public health policy, I focused on the policies concerning medical equipment, such as personal protective equipment (PPE) and medical services, during the COVID-19 health crisis from 2020 to 2021. I aimed to bridge the gap in the literature regarding potential policy change and actual implementation of a policy (see Jones et al., 2017; Levin et al., 2020; Ramey & Randall, 2021). Mallidou et al. (2020) explained that health policy is one of many dimensional factors developed using evidence-based lived experience and professional opinion. However, public health policies also attempt to bring extensive action to issues previously identified (Columbia University Irving Medical Center, 2021).

According to Balz (2020), the U.S. federal government has tried to improve medical services by updating health policy, but it has yet to offer immediate relief. Furthermore, for a policy, mandate, or ordinance to be considered, policymakers must have supporting information expressing urgency for enactment (Ashcraft et al., 2020; John, 2018; Menifield & Clark, 2020). Therefore, actionable findings from trusted and verifiable sources are necessary for policymakers and elected officials to consider enacting policies as necessary (Dodson et al., 2015). Public health issues that sometimes substantially impact small medical practices take time to be addressed, and a plan of action must be conducted to understand better how to combat crises such as the COVID-19 pandemic through policy. The data and analysis used to fill the gap may initiate positive social change, including publicizing valuable information for policymakers on the importance of actionable policy for medical professionals, increasing public health

advocacy, and successfully addressing a core socioeconomic issue of counties in Illinois. The Heartland Alliance (n.d.) reported that socioeconomic issues in most Illinois counties are on the poverty watch or warning list. That issue may be impacted by the increased unemployment rates, with illnesses also playing a significant role (Divounguy & Hill, 2021).

Problem Statement

A problem existed with medium-size Illinois cities' public health care policies between 2020 and 2021. The problem concerned policies addressing the necessary facility-based resources that medical professionals need to ensure proper medical services, medical equipment support, and assistance during a pandemic**.** The approach to finding data for the resources-based problem in the current study involved surveying medical staff in a city with a population ranging from 70,000 to 90,000. Furthermore, this study addressed a gap in the literature concerning urgent public health issues requiring emergency medical mandates and directive policy measures for the future to ensure medical professionals' safety and health. I researched relevant information to understand what public health policies are currently adequate in providing crisis support for medical professionals so they may maintain acceptable health practices. Although recent updates to Illinois compiled statute Civil Immunities (745 ILCS 70/) Health Care Right of Conscience Act, Illinois General Assembly (n.d.-a) outlined liabilities and violations related to COVID-19 in general terms, there were no directives on services, support, and assistance for medical professionals currently in Illinois policies. Although no specific directive was active, actionable findings are needed to pass new and effective policies.

The supporting literature from trusted and verifiable sources helped me identify the gap and increased the urgency for policy enactment (see Ashcraft et al., 2020; John, 2018; Menifield & Clark, 2020). The problem impacted medical professionals, their facilities, and the low-income and under-resourced communities they serve. For example, many Illinois medical facilities could not accept new patients seeking health care during the COVID-19 pandemic (Illinois Department of Public Health, 2021). The gap in the literature justified the need for an increased understanding of what issues determine actionable findings needed and whether all medical professionals should be considered verifiable resources for an essential policy to be implemented during a pandemic crisis.

The study contributed to the body of knowledge by exploring the unmet needs of medical professionals in a medical facility in a small Illinois city. The knowledge gained from this study may assist in influencing public health policy tailored toward medical professionals in small cities in the event of a future pandemic. Furthermore, this study may contribute to positive social change by increasing awareness about the vital role that small city medical organizations play in providing medical care and related policy implications. This valuable information may also increase medical professionals' advocacy on public health issues and, in turn, increase awareness of the core socioeconomic issues impacting low-income populations during pandemics.

Purpose of the Study

This basic qualitative inquiry aimed to explore and seek solutions to policy shortfalls regarding healthcare professionals and their operations when providing services, support, and assistance to patients in small health care facilities. Obtaining

policy information from published government data on how local governments apply policies (mandates or ordinances) toward medical professionals and their facilities during an epidemic or pandemic may bring clarity to identifying and solving interruptions in health care crisis support. To support the examination of this phenomenon, I surveyed 15 medical professionals to capture their perspectives on working through modified operations from 2020 to 2021 during the COVID-19 pandemic. I sought to reveal where support issues were weakest and how enacted policies could increase effectiveness.

Research Question

The primary research question addressed how successful implementation of short-term policy planning in public health could be helpful to small or privately owned medical facilities. Gaining an overview of current databases and reliable resources is of the highest importance for public health policies for medical professionals. The research question was the following: How do Illinois medical professionals describe policy changes that would improve their medical facilities and the support they received during the COVID-19 pandemic?

Conceptual Framework

Kingdon's multiple stream framework (MSF; Giese, 2020) was the conceptual framework for the study. Literature reviews, semistructured questionnaires, and accredited web-based research helped me complete this research. A key aspect of public health policies is the timing of accurately communicating information to decision makers so that there is commitment and collaboration to distribute needed resources effectively (Raus et al., 2020). Although regulatory barriers can delay the implementation of

policies, Giese (2020) explored the use of Kingdon's MSF and how the COVID-19 virus afforded a potential window of opportunity in support of telehealth policy changes and the improvement of medical facilities for Illinois medical professionals.

The MSF was developed by Kingdon in 1984 to demonstrate that policies may have different streams (problem stream, policy stream, and political stream) that function independently (Weible & Sabatier, 2018). There are windows of opportunity (timing of an issue/problem and level of urgency) that initiate interaction between streams. Additionally, the framework views problems as social constructs that are shared experiences of individuals who agree that a concept exists rather than objective actuality (Weible & Sabatier, 2018). The MSF allowed for a basic qualitative approach and was appropriate for this study based on the complexity that may arise during the research. The literature and participants' perceptions provided the study's rationale. I chose the MSF as an appropriate framework for this qualitative inquiry to enhance understanding, address the research problem, and answer the research question. According to Patton (2015), there is only sometimes a correct approach for a qualitative inquiry. The preferred approach is choosing and knowing what the qualitative strategy offers regarding the topic of interest. Also, according to Caffrey (2023), the conceptual framework establishes why the study is relevant and appropriately identifies if biases may exist for the researcher. The MSF was chosen to review existing causes, the context from the semistructured questionnaires, and the literature reviews to understand the research problem better.

Nature of the Study

The basic qualitative approach with saturation or redundancy sampling was used to obtain in-depth knowledge on the lack of existing information about the research problem. Although many different methods could have been applied to this research, the generic design was chosen. The basic or generic qualitative design is most common in qualitative studies and influences the analysis (Patton, 2015). A "generic methodology explores an experience, such as a person's belief or attitude" about a phenomenon (Willgens et al., 2016, p. 2386). I gained insight into how the work lives of the selected participants were influenced by the pandemic based on how each individual described their experiences.

Furthermore, according to Merriam and Tisdell (2016), this research method assists the researcher in understanding the meaning of a phenomenon without the need to define parameters, such as the focus on the data or the interpretation of a participant's lived experience. Instead, the researcher can draw in-depth information from the perspective of individuals to answer the research question and explore the research problem. Much can be gained from this type of study if the critical elements of the thematic analysis are consistent with this approach.

While testing different qualitative data analysis (QDA) software programs, I was concerned that all the data examined with this type of research might be challenging. Because only a small amount of data was processed for this study, a practical approach using NVivo software support was used. The data from 15 participants were collected using semistructured questionnaires, depending on the availability of health care facilities

and their employees. The questions were created to maximize the data obtained from each participant and fully explore the elements of the research problem. Further, the data collected were analyzed for commonalities, patterns, and themes in responses, which may identify why gaps in medical services, support, and assistance exist.

Definitions

The terms defined in this section are provided to clarify each word's intended meaning and use in this study. A customized definition of terms was needed to ensure a complete understanding of this study's dynamics, concepts, and ideas.

Coronavirus (COVID-19): The virus is named for the appearance of its outer layers, which resemble a crown; hence, "corona" means "crown." The virus emerged from the SARS-CoV-2 or Severe Acute Respiratory Syndrome Coronavirus 2 disease, which causes an individual to experience a respiratory illness (Centers for Disease Control and Prevention [CDC], 2022a; Johns Hopkins Medicine, 2022; Mayo Clinic, n.d.).

Didactic: A teaching method that follows a consistent scientific approach or educational style to engage the student's mind; intended to convey instruction and information and serve another purpose, such as pleasure and entertainment (IGI Global, n.d.-a; Merriam-Webster, n.d.-a).

Epidemic: A rise of disease that exceeds an expected level for the population in a geographical area; a disease that causes an abnormal amount of a population to be affected (CDC, 2012; Merriam-Webster, n.d.-b).

Hawthorne effect: The participants' behavior is altered due to being aware that they are being observed (American Psychological Association, 2023a).

Health policy or public health policy: Actions are taken by governments—national, state, and local—to advance the public's health. Public health policy is determined by consultation, negotiation, and research, which leads to a plan of action that sets out a vision of identified public health goals (IGI Global, n.d.-b; Martin, 2008).

Healthcare professional(s) or medical professional(s): Healthcare professionals' study, diagnose, treat, and prevent human illness, injury, and other physical and mental impairments of their populations. Medical professionals include doctors, nurses, hospice workers, emergency medical technicians, and other trained caregivers (World Health Organization, 2013; RAND Corporation, 2022).

Influenza (flu) is an acute virus caused by a collection of single or double-stranded complex organisms, also known as ribonucleic acid (RNA viruses). The influenza virus has three classification types known to affect humans: Type A (cause for epidemics, moderate to severe symptoms), Type B (concentrated outbreaks, less severe and "may occur in seasonal epidemics but not pandemics"), and Type C (causes mild illness, "does not occur in epidemics and pandemics"). Type D is not known to cause illness in humans (Britannica, 2022; Merriam-Webster, n.d.-c).

Mandate: An authoritative command to officially require a policy as mandatory (Merriam-Webster, n.d.-d).

Ordinance: A law made by a city, county, or local government to maintain order (Cambridge Dictionary, n.d.-a).

Pandemic: A sudden spread of an infectious disease that affects multiple countries or continents and large groups of people in those areas for an extended period (Cambridge Dictionary, n.d.-a; Merriam-Webster, n.d.-e).

Policy: A collection of ideas or plans that have been officially agreed upon to address specific issues, which are decided upon by a government entity or group of elected officials (Cambridge Dictionary, n.d.-c.; Collins Dictionary, n.d.).

Public Readiness and Emergency Preparedness Act (PREP Act): A declaration to provide liability immunity to healthcare professionals and entities (referred to as covered persons) against claims that result in harm or damages caused by a manufacturer, distributor, administration, or the use of medical countermeasures (referred to as covered countermeasures). The only exception is if the claims involve willful misconduct, as defined in the PREP Act. Additionally, the declaration may be revised if circumstances justify a change (Azar, 2020).

Seroprevalence: The frequency of individuals in a population who have a particular element and especially antibodies to an infectious agent in their blood serum (Merriam-Webster, n.d.-f; CDC, 2020b).

Telehealth or telemedicine: Enables video or phone appointments between patients and their healthcare practitioner (Hasselfeld, n.d.).

Triangulation: Using multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena (Patton, 2015). Triangulation has also been viewed as a qualitative research strategy to test validity and reliability through converging information from different sources. Denzin (1978, as cited in Carter et al.,

2014) and Patton (1999, as cited in Carter et al., 2014) identified four types of triangulation: (a) method triangulation, (b) investigator triangulation, (c) theory triangulation, and (d) data source triangulation. These four types of triangulation are usually followed by a discussion of using focus groups and in-depth individual interviews as an example of data source triangulation in qualitative inquiry (Denzin, 1978; Patton, 1999, as cited in Carter et al., 2014).

Variant (viral infections): The genetic code of a virus when it undergoes genetic changes, producing one or more mutations that make it different from a similar but known virus (CDC, 2022b).

Assumptions

Based on preliminary mock interviews with various healthcare professionals, I made assumptions for this study. The first assumption was that I expected the participants to be more comfortable because they were aware of the scope of the study. Next, based on the expectation of participant comfort, I assumed the participants would be completely open and honest when responding to the questions. Following this assumption was that the participants would have familiarity with resources and have some knowledge of how a policy may or may not affect their daily operations. The final assumption was that the participants' availability would allow me to complete the data collection process via interviews within an appropriate time frame.

Scope and Delimitations

The scope of the study included a group of 15 healthcare professionals from a medical facility in a small town in Illinois. The facilities were assumed to have endured

modified operations during COVID-19 in Illinois. Large hospitals or similar-sized facilities were not included in the study due to the scope of the research. Further, other data sources, such as government websites documenting policies on public health crises and credible sources of information on Illinois medical practices, were used to support significant findings.

Limitations

Extensive preexisting research revealed complications for good pandemic-related policies, such as policymakers' perceptions of obtaining information and how medical professionals perceive policy. These barriers could have made finding clear strategic communication approaches challenging to present credible evidence (see Ashcraft et al., 2020). Although presenting a phenomenon for potential policy change posed a challenge, limitations could have been revealed through the need for more viable and available data. The greatest challenge was using data from recruiting participants. Although there was minimal risk from data collection through coercion, I confirmed that participants were not worried about irreversible damage to their reputations. Although anonymity was held to the highest standard, informed consent may not have elicited full confidence from the participants. Validating data did not prove difficult when the participants surveyed needed to understand the potential value of the research (Health Knowledge, n.d.). The validation factor and the inability to generalize data did not require further analysis as initially anticipated. Ensuring the sources' reliability and validity was essential to present the research with the expected quality.

Significance of the Study

The significance of this study was understanding how policy impacts resources during a health crisis (pandemic or epidemic); medical professionals need assurance that verifiable resources are used to inform policymakers and elected officials in considering a health policy essential to the problem being experienced. The contribution of this study to public health policy focused on medical facilities in small Illinois cities, impacting healthcare professionals to bridge any discovered gaps in the same. Many studies focused on the mental health and support offered by comparing outcomes of a healthcare professional's lived experiences and the patients they serve from well-established medical policies (see Ashcraft et al., 2020; Chmielewski, 2020; Jones et al., 2017; Levin et al., 2020; Menifield & Clark, 2020; Napur, 2021; Ramey & Randall, 2021). However, no studies have focused on the perspectives of care healthcare professionals regarding how policy and mandates have or have not modified operations and positively influenced public health and medical care during a pandemic. More must be understood about why urgent medical equipment issues sometimes take time to address through policy. The implications for positive social change include publicizing valuable information for policymakers on the importance of short-term policy planning, increasing public health advocacy, and successfully addressing the core socioeconomic issues.

Summary and Transition

Successfully implementing any policy can depend on appropriately followed directives, processes, and administration. However, the study targeted a problem within current public health policies and crisis support during 2020 and 2021. Current policies

do not address the necessary facility-based resources medical professionals need to ensure proper medical services, medical equipment support, and assistance during a pandemic. COVID-19, much like the 1968 influenza pandemic, brought about significant pressure on healthcare professionals in small medical facilities to modify their operations. Consequently, these modifications caused most small medical facilities to decline and not admit new patients. The facilities also exhibited an increase in socioeconomic issues within low-income populations. This basic qualitative inquiry aimed to explore and seek possible solutions to policy shortfalls regarding healthcare professionals and the modified operations they undergo. I collected data using policy information from various credible sources, such as published government data, mainly focusing on the experiences of medical professionals during the COVID-19 pandemic through interviews.

Additionally, to ground the study, a conceptual framework was used to better understand the complexities of the research problem without the need to define parameters, such as focusing on the interpretation of a participant's lived experience. Instead, in-depth information was drawn from the perspective of each participant to understand to what degree crisis support is needed. Chapter 1 covered the nature of the study, assumptions made during the initial research, the scope and delimitations, potential limitations, and the study's significance. Chapter 2 addresses how the literature reviewed was substantiated by the conceptual framework throughout the literature research strategy.

Chapter 2: Literature Review

Chapter 2 includes a review of the resources and information from the current literature that addressed the research problem, purpose, and research question in this study. The literature highlights previous pandemic crises, the historical adaptation of public health policies, and the challenges medical professionals encounter during a pandemic. The literature also described beneficial elements essential to providing relief through the Coronavirus Aid, Relief, and Economic Security Act (2020) and the Coronavirus Response and Consolidated Appropriations Act (2021; U.S. Department of the Treasury, n.d.).

I sought solutions to policy shortfalls in allocating resources to medical facilities (e.g., PPE) and other resources for healthcare professionals. I explored how the level of crisis support impacted medical facilities' ability to provide services, support, and assistance to patients in Illinois. Kingdon's MSF was used as a framework and conceptual theory to assist this qualitative study. The literature review involved analyzing various studies, references, and informational sources that focused on crisis support for medical professionals. I also analyzed extensive preexisting research that revealed the existence of known barriers, the mitigation of urgent health issues, the effects of policies being implemented with urgency, and historical aspects of crisis support through policies. According to Hayes (2014), public policies are implemented to resolve issues that threaten public safety or serve the general good. However, policymaking can sometimes be tough as it may affect lives and may not be understood by those adhering to or issuing policy.

Further, preexisting research revealed barriers to successful policy implementation (Ashcraft et al., 2020). Examples included the perception of urgency because of how policymakers obtain information about a crisis and the disparities experienced by medical professionals in small Illinois-based health care facilities (Ashcraft et al., 2020; Andraska et al., 2021). For example, according to Ashcraft et al. (2020), policymakers perceive the level of urgency in a situation differently and only from a few trusted sources, which adds another challenge to communicating a need for a broad policy while presenting credible evidence. The literature review focused on public health, health care policy, and medical resources provided to small towns in localities.

The most important literature to this study involved health care policy during a pandemic, the perspectives of medical professionals, and perceived motivators on how policy meets the needs of patients during a crisis. According to Levin et al. (2020), complete information can mitigate urgent issues when policy implementation is critical. For example, seroprevalence testing, such as with COVID-19, is a medical method used by the CDC to discover how many people may have life-saving antibodies to fight off the COVID-19 virus. However, information from seroprevalence testing needs to be completed during policy creation and implementation so that further study can occur (Levin et al., 2020). The following sections cover other literary searches on public health policies with similar results and the most current information on how medical professionals risk their safety while attempting to acquire needed resources (e.g., PPE) under the direction of a governmental mandate.

Literature Research Strategy

The literature searches included full-text journal articles from databases found at the Walden University Library. The databases that provided a foundation for this literature review consisted of journals and articles, dissertations and theses, and databases such as Thoreau, EBSCOHost, and ProQuest. Other resources used to explore the literature included the Illinois Department of Public Health, the CDC, the Center for Research Quality, the World Health Organization, and the Food and Drug Administration (FDA). Additional searches included information from scholarly resources such as Google Scholar and academic literature documenting policies on previous and present global public health crises.

To enhance the focus of the literature review, the following keywords were used in searching the databases using organizational and topical searches: *public health policy*, *qualitative policy studies*, *COVID-19*, *pandemic prevention*, *supportive policy*, *policy strategies*, *theory of policy*, *adopting mandates in public health*, *medical resources*, *public health obligations*, and *other keywords* (i.e., *social constructs*). The literature review search also considered information on policy planning and complications, the effectiveness of policy strategy, and health policy mandates that indicate an adverse influence on medical professionals. Furthermore, the conceptual framework guides where opportunities are created for health policy and medical professionals while outlining where an opportunity to implement potentially beneficial policies is found.

Conceptual Framework

Literature reviews, participant questionnaires, and web-based research informed the linkages between the selected methodology, research question, and research problem. The key attributes of public health policies are specified in the timing and accuracy of communicating information to decision makers; these aspects establish commitment and collaboration to distribute needed resources effectively (Raus et al., 2020). Although regulatory barriers can delay the implementation of some public policies, Giese (2020) explored the use of Kingdon's MSF and how the COVID-19 virus allowed supporting telehealth policy change.

MSF was developed by Kingdon in 1984 to demonstrate that policy processes have different streams (i.e., problem stream, policy stream, and political stream) and that their functionalities are independent (Weible & Sabatier, 2018). As such, windows of opportunity (timing of an issue/problem and level of urgency) initiate interaction between the independent streams. Additionally, the framework views problems as social constructs explained through the shared experiences of individuals who agree that a concept exists (Weible & Sabatier, 2018). The MSF conceptual framework allowed for a basic qualitative approach and was appropriate for this study based on the complexity that may arise. The literature and participants' perspectives provided a rationale for the study. According to Patton (2015), there is no right approach; choosing a design is more about preference and knowing what each qualitative strategy offers regarding the chosen topic of interest and methodology. Also, according to Caffrey (2023), the conceptual framework establishes why the study is relevant and identifies whether biases may exist

for the researcher. The MSF provided the parameters, guidance, and foundation consistent with the current study. A conceptual framework was chosen to review existing causes, appropriately analyze the context from questionnaires, and gain an understanding of the research problem through literature reviews.

According to Chmielewski (2020), a conceptual framework is a system of concepts, assumptions, expectations, and beliefs in which images or suggestions link broad and abstract ideas—understanding the research problem through concepts from the literature linked prior research to new real-world experiences or events. In addition, to identify why a problem exists, MSF, as explained by Giese (2020), describes how opportunities are only open when multiple streams partner to address a vital issue. Medical professionals should strive to understand when there is an opportunity to influence change and find innovative solutions. Using MSF as the conceptual framework for this study may help clarify the role medical professionals play in influencing crisis support awareness and related policies. Further, medical professionals may advocate for a new or updated policy and reveal an opportunity for better expectations in the future.

Key Concepts

Key concepts in this study included various medical professions and providers of crisis support through federal regulations. This section also focuses on healthcare professionals adhering to regulations and the historical factors related to pandemics, policies, and mandates over time. Finally, this section explores challenges that medical professionals encounter and beneficial elements that have historically been derived from the same.

Medical Regulations

Healthcare providers encountered many challenges during the COVID-19 pandemic in the United States, including medical device shortages. According to the U.S. FDA (2022a), removing a medical device from a maintained list is appropriate if the demand for medical equipment is higher than the available supply for an extended time. In addition, the FDA also regulates emergency use authorization (U.S. FDA, 2022b). Issuing an emergency use authorization means the FDA authorizes using a pharmaceutical manufacturer's unapproved medical product because "there are no adequate, approved, and available alternatives" (U.S. FDA, 2022b, para 9) to combat a virus during active pandemics.

Other regulations followed by medical professionals are local and state public health policies. However, although these policies rarely vary and impose certain restrictions due to COVID-19, the PREP Act declaration provided medical professionals with liability immunity (Azar, 2020). As a result, it is impossible to sue a physician for malpractice unless evidence of malicious intent can be proven.

According to Maree et al. (2021), public health policies should also be integrated to fit the complexities of patient health care, eliminating the need for the PREP Act to be declared when public safety is heightened. Although the PREP Act moderates a medical professional's legal responsibility, it also creates potential opposition between medical professionals who follow the Hippocratic Oath and those who may not (Azar, 2020). Although legal responsibility is a challenging factor that arises from the PREP Act, some challenges are outside the healthcare professional's control (Azar, 2020).

Historical Pandemic and Epidemic Elements

Pandemics and epidemics have taken the lives of millions of people over the centuries. Pandemics are the global spread of infectious diseases. In contrast, epidemics are the rapid spread of an infectious disease within a specific region or country (CDC, 2012). Infectious diseases are not a new problem; they have caused suffering beyond measure for centuries (CDC, 1999). Although much can be learned about the causes, symptoms, and medications that can combat the viruses, a lack of comprehensive assessments has left future populations vulnerable to variant viral infections (Daou et al., 2020). According to Piret and Boivin (2021), pandemics date beyond the 19th century, and implementation measures were taken according to the level of the infectious threat. Historically, each pandemic was unique; over time, most were found to be variants of prior known viruses and still caused fatalities worldwide (Piret & Boivin, 2021).

The influenza virus has been the most frequently occurring pandemic throughout history. According to Piret and Boivin (2021), a virus was described best during the four years that the Russian Flu existed between 1889 and 1893. Although the virus was well documented, there was no definite micro-organism or sources named where the virus may have originated. However, Piret and Boivin (2021) noted that the same year of the first occurrence could not be accurately determined but that annual influenza epidemics are still around because of ongoing mutations. The last influenza pandemic, the swine flu, occurred from 2009 to 2010 and was quickly combatted by vaccination (Piret & Boivin, 2021). As a result, these potentially deadly pandemic-causing viruses were managed

enough to be considered epidemics. Vaccinations also lessened the high potential for a deadly pandemic, so vulnerable populations were urged to vaccinate.

Like the influenza virus, coronavirus can infect animals and humans and varies in name depending on the strand. RNA viruses are usually described as infectious because they do not contain DNA. RNA viruses are single-celled organisms that cause illnesses such as SARS, which is in the Coronavirus category (Piret & Boivin, 2021). Additionally, according to Piret and Boivin (2021), one of the variants (MERS-CoV) started in 2015 with sources that could be confirmed, and the other variant (COVID-19) started in 2019 with no confirmed source. These two Coronavirus variants are ongoing and present many challenges for healthcare professionals and policymakers alike (Piret & Boivin, 2021).

Mandates Over Time

Each country, state, and city differ in handling pandemic crises. For example, according to the Illinois Department of Public Health (2014), the State of Illinois acknowledges that the federal government will assume primary responsibility for key elements of any public health emergency. Although this plan was based on the influenza pandemic response plan, it is similar to the current plan in place today. However, each plan is measured based on the severity of an outbreak in a specific area. Therefore, medical professionals follow the same hierarchy of authority that their state regulates and the response plan devises.

Before the pandemic, medical professionals faced various daily hazards threatening their safety, such as diseases and chemical hazards, while treating patients

(CDC, n.d.). However, in the late 1800s, doctors and nurses had little training, and virtually anyone could practice medicine. According to Sandvick (2009), only a few states required registration with the local authorities for a physician (medical professional) to practice medicine, but that requirement drastically changed between 1870 and 1900. For example, the change was recognizable in the 1880s when the examination board was created (Sandvick, 2009). Approximately 13 states still need to enforce a registration law or begin supporting laws and statutes to make an examination mandatory to practice medicine legally (Hamowy, 2014). In that era, it was believed that impoverished conditions or low morals caused disease; therefore, no mandates were enacted to slow the spread of a virus (Breslaw, 2012.). To be more precise, the political climate played a significant role in vilifying science in medicine because viable cures were not present. Science was not applied to medicine, so believing that germs were the root cause of infectious disease was implausible (Breslaw, 2012.). However, when these infectious outbreaks were happening, some state and local municipalities turned over the authority of quarantine requirements to the federal government (CDC, 2020b). These events shaped how mandates are handled today and why control plays a significant role in an individual state's reaction to enacting mandates concerning infectious diseases.

Illinois followed the COVID-19 federal public health emergency, which declared COVID-19 a national issue, by enforcing mandates that enacted required vaccinations and protective face wear (Illinois, 2021). This executive order conveyed concern about protecting the safety of frontline workers (i.e., healthcare professionals), and many other states followed suit. However, shortly after Wyoming's governor signed the executive

order declaring a public health emergency and mandates were enforced, the Wyoming House of Representatives claimed that the federal order removed an individual's civil right to choose (Wyoming, 2021). Although Wyoming is no different from any other state within the United States to enact such a declaration, it differs from Illinois' adaptation to the pandemic. Each state's representatives try to maintain balance and fairness among citizens in their jurisdictions while maintaining consistent and well-established mandates, but this has always been challenging (Zick, 2005, p. 336). Thus, the reason that mandates undoubtedly vary from state to state and ultimately differ for medical professionals in their efforts to operate effectively.

Finally, in the present, under pandemic conditions, each state may or may not take direction in implementing Federal regulations. For example, Illinois fully accepted federally enacted mandates, such as vaccination. In contrast, Wyoming rejected the vaccination requirement by passing State House Bill 1002 (HB1002), which declared their state "a sovereign state," and a federal mandate cannot be enforced on its citizens due to it being unconstitutional (Wyoming, 2021). According to Zick (2005), a declaration of this sort would express that the federal government is expected to recognize and respect the states' control and sovereignty in some circumstances.

Resource Challenges

Kooli (2021) states that medical professionals' challenges extend beyond being short-staffed and meeting patient needs when resources are scarce during the COVID-19 pandemic. Hospitals and medical facilities experienced financial strain because of increased costs, lack of full reimbursement, and a massive loss in patient attendance

(American Hospital Association, (AHA), 2020a). Due to these circumstances, tough choices were made concerning funding for staff to stay on duty. Additionally, according to the American Hospital Association (2020a & b), the massive fluctuation in patient attendance can partially be attributed to employment termination and health coverage loss. In contrast, according to Czeisler et al. (2020), patients were highly concerned about their vulnerability to COVID-19. They did not see where the risks outweighed caring for themselves with a pre-existing condition. Obstacles like this exist because long-time patients now avoid or delay care for preventable and treatable health conditions unrelated to COVID-19 (Czeisler et al., 2020). Furthermore, these difficulties lead to various ethical dilemmas in decision-making for medical professionals, raising their concerns regarding patient care (Czeisler et al., 2020). Reasonable distribution of scarce medical equipment is not within the control of all healthcare professionals; however, decisions to request scarce resources are within healthcare professionals' control (Emanuel et al., 2020). Medical treatment resources are backlogged due to the COVID-19 pandemic, and healthcare professionals can request resources, although resources would not be received when needed. Additionally, current and potential patients' perceptions of the medical services also challenge medical professionals.

The dilemmas created include possible patient refusal of services, medical personnel accountability issues, loss of trustworthiness of healthcare professionals, and unequal treatment of patients (Czeisler et al., 2020). Although these dilemmas transpire frequently, healthcare professionals are covered under specified protections and, therefore, not liable or officially blamed for poor care (Kooli, 2021). These circumstances

are compounded when a decision is made, such as decisions that concern costs that ultimately impact a patient's life due to insufficient distribution of life-saving medical equipment (Huang et al., 2021; Kooli, 2021; Maree et al., 2021). Consequently, the decisions made by medical professionals, no matter how disagreeable or undesirable the outcome, must also come with an understanding that outcomes are exacerbated when a pandemic-level crisis threatens public safety.

Beneficial Elements

The literature revealed that past public health policy, policy theories, and the adaptation of various policies concerning pandemics in public health are beneficial in implementing an emergency policy that can be utilized to create a basis for a public health policy standard (Hick et al., 2004; John, 2018; Jones et al., 2017). As John (2018) has stated, public policy theories have the potential to influence change. Although complexities in policymaking decisions impact the smooth implementation of policy, the potential for creating public goods is excellent (John, 2018).

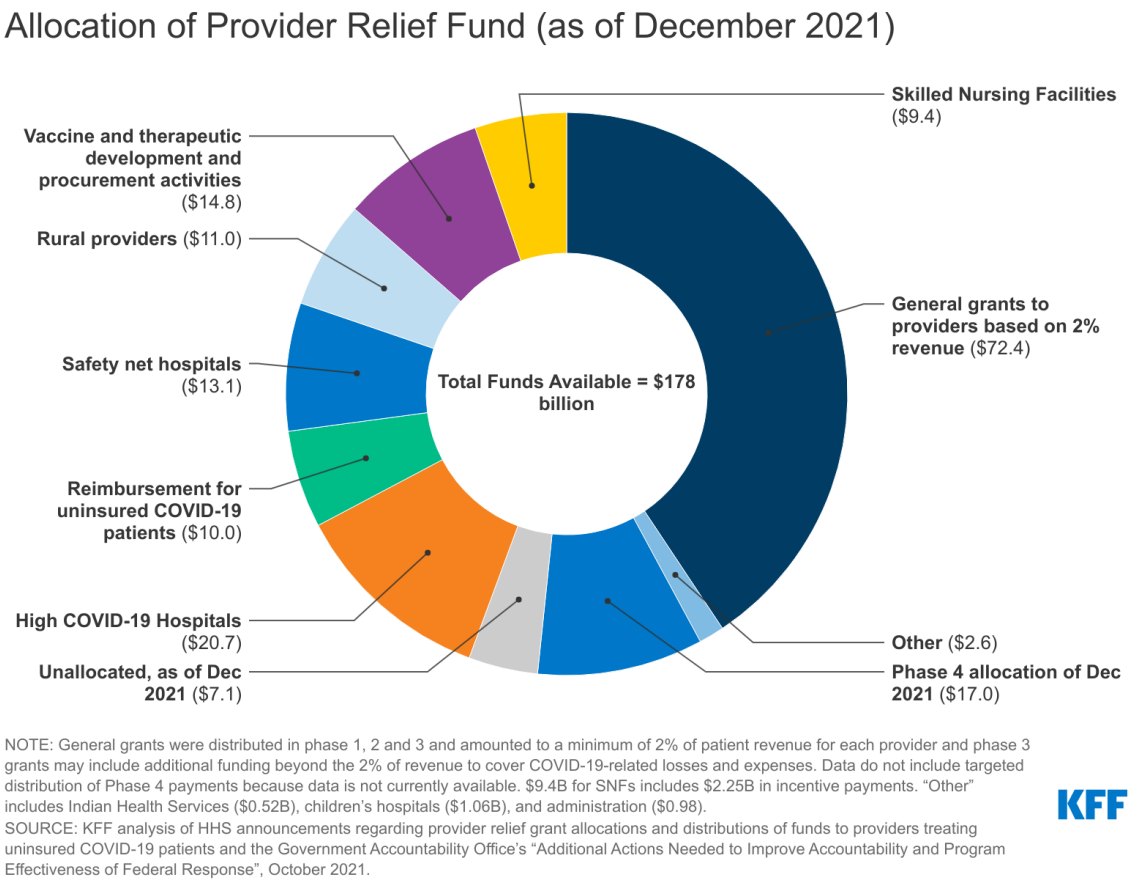
Medical professionals must look past traditional operations to achieve safe and satisfactory conditions for themselves and their patients (John, 2018). For example, when MSF is appropriately applied, brief windows of opportunity are open to allow for policy change, such as the opportunity to implement a telehealth policy due to the COVID-19 pandemic (Giese, 2020). Thus, medical professionals may benefit from investing in an internal advocate identified as a policy entrepreneur (PE). According to Christopoulos, King, and Roberts; Kingdon; and Mintrom and Norman (as cited in Arnold, 2021), "Policy entrepreneurs encourage substantive policy change, and according to Mintrom

(1997, as cited in Arnold, 2021), often introducing new or creatively recombined ideas into the policy process" (p. 969). Additionally, according to Gregg et al. (2018), MSF can be beneficial if a medical facility has a policy entrepreneur (PE) to actively seek a connection between a problem and a policy while networking through political streams to find a window of opportunity. Opportunities such as adaptable mandates like telehealth policy (or telemedicine) strengthened the efforts to control the spread of the COVID-19 virus (Gregg et al., 2018).

In addition to control efforts, the federal government enacted policies to provide relief to medical organizations and professionals. For example, two Acts were passed in 2020/2021, named the CARES Act (2020) and the Coronavirus Response and Consolidated Appropriations Act (2021) (US Department of the Treasury, n.d.). These acts aimed to help with medical facilities' financial losses due to reduced patient care. For instance, according to the American Hospital Association (2020b), hospitals and health care systems lost an estimated $120.5 billion from July to December 2020. However, as shown in Figure 1 (Ochieng et al., 2022), the $178.0 billion in relief funds were distributed to hospitals and other healthcare providers to compensate for the financial losses caused by the pandemic.

Figure 1

Relief Funds Provided to Medical Professionals and Organizations



Note. The fund allocation figure pictured above displays where the US Department of Health & Human Services (HHS) distributed funds by the end of 2021. Most of the total funding went toward general grants based on operating expenses or a minimum 2% loss in annual revenue because of the pandemic. According to Ochieng et al. (2022), the objective of HHS was to first support smaller providers with disbursements since their facilities operate on a narrow margin and serve communities with higher needs. From Funding for healthcare providers during the pandemic: An update, by Ochieng et al., 2022. (https://www.kff.org/coronavirus-COVID-19/issue-brief/funding-for-health-care-providers-during-the-pandemic-an-update/).

Policies and Acts like these benefit the health concerns of medical professionals and their patients by supporting the development and distribution of vaccines, expenses related to PPE, uninsured patients, facilities, and staffing (Ochieng et al., 2022). Although these policies and Acts are beneficial, each policy's provisions vary by state. For example, the provisional standard of telehealth policy is to be consistent "with all federal and State privacy, security and confidentiality laws, rules, or regulations" (Illinois General Assembly, n.d.b, para. 14). Hence, being consistent with State rules or regulations is why 47 states, including Illinois, have inconvenient stipulations in place. The stipulations limit patient access to telehealth with an out-of-state healthcare specialist because they do not have licensure within that state (Pioneer Institute, 2022). Another example can be found in Illinois State Bill 1811 (SB1811), which reiterates that specific stipulations are necessary to protect "public health, welfare, and safety" (Illinois General Assembly, n.d.c, para. 7). Some policies may limit social interaction but are necessary when a state of emergency is in place.

Policies on Social Interaction

Chmielewski (2020) expresses that the global lockdown initiated by the COVID-19 pandemic presented an unprecedented phase in societies where fear and distrust of the environment outweighed the need or want of any social interaction. Confinement policies reached a point where individuals began to self-restrict their movements without further enforcement of mandates or policy declarations (Czeisler et al., 2020). Those in vulnerable health positions settled on the best resolve to preserve their health in light of COVID-19, which is to delay treatment for as long as possible, especially if the social

interaction perception was too high for their comfort (Czeisler et al., 2020). Furthermore, Chmielewski (2020) suggests many different perceptions of what it means to interact socially. A few theories have insinuated that never meeting in person would soon be the definition of social interaction and may benefit existing in the continuance of social distancing without government enforcement.

Policies on Crises Planning

According to Cerna (2013), a policy is formed to affect the future direction of society, and the successful implementation depends upon whether directives are appropriately followed (p. 17). In public health, crisis planning or proactive preventative measures taken to reduce viral infections are complex when policies need to reflect the health and safety of medical professionals and the communities they serve. According to Lui and Geva-May (2021), the pandemic created complexities in policy response but is now adding value to the gain of extensive literature nationally and internationally. The current studies encourage future policy responses to be implemented with more knowledge than before (p. 133). Additionally, according to Menifield and Clark (2020), crisis planning, generally speaking, should be adjusted to learn from past pandemics and what did or did not work to prevent the further spread of the viruses. Similar literature agrees that the neglect of proactive planning has caused economic instability and uncertainty when generalized policies are applied to similar but nuanced situations. Thus, it forces medical professionals to make decisions that do not optimize resources, potentially leading to devastating outcomes, like losing an individual life or many lives (Menifield & Clark, 2020; Nupur, 2021; Petrovic, 2020). As such, Vindrola-Padros et al.

(2020) suggest that current evidence-based data should be used in a rapid research design that presents all pertinent information during the height of a pandemic to assist in making necessary modifications to the public policies and its administration.

Other suggestions to improve the efforts of proactive planning include focusing on promoting problem-solving policies, learning how the government prioritizes each step of policy implementation, and creating more virtual didactic programs. Suggestions allow initiatives for medical trainee education to support the quality of patient care (Ramey & Randall, 2021; Reed et al., 2020). Such efforts and the correctly applied framework afford an opportunity that would only be realized if medical professionals provided comprehensive information on urgent issues. However, effectively conveying that information is critical in promoting change to an established policy or creating an additional policy.

Summary and Conclusion

The literature reviewed in this research found issues with the need for more comprehensive information on the policy concerning crisis support. In addition, how effective communication is passed to policymakers and promptness in responding to past pandemics. According to the literature, many issues were relevant to the phenomenon. Ideally, the policymaking process is well-informed regarding mitigating urgent public health issues. However, enacted mandates or policies can only be as effective as the data on urgent issues. The literature confirmed that public policy provides a motivation to promote positive social change and enables courses of action under specific circumstances. Hence, concluding lessons were learned by modifying techniques and

solidifying appropriate procedures. Many studies have been conducted over the last few years surrounding the COVID-19 pandemic. Those studies communicate the importance of conducting further research to obtain reasonable results, such as policies and their success. Inclusively, the literature reviewed expresses issues over appropriate crisis support and effectively communicating or addressing the much-needed resources for medical professionals. In addition to these concerns, the literature also offers suggested solutions to begin addressing the issues from a public policy perspective.

In conclusion, through the literature, it is noticeable that there are several matters medical professionals must be aware of that alter daily operations when public health and safety are of heightened concern. Although medical professionals understand that public health policies are designed to assist in solving current and potential future issues, pandemic-level emergencies take time to predict or anticipate. Sometimes, health care facilities may need more medical services for their patients, temporarily closing due to being short-staffed or permanently closing a specific location. Closings alter how small facilities of healthcare professionals operate and successfully carry out patient care. In the future, determining a standard is essential in establishing policies that offer more significant crisis support for medical professionals.

In Chapter 3, I will address the research methodology for this qualitative inquiry to determine if a significant understanding can be established. I will discuss the research design and rationale, the role of the researcher, participant selection, the interview guide, and procedures for data collection. Then, the data analysis plan and its trustworthiness for this study will be explained.

Chapter 3: Research Method

The research method presented in this chapter outlines the design, rationale, and functions used to explore the research problem and question. In addition, participant selection, data collection procedures, data analysis plan, and trustworthiness issues are described. I aimed to uncover the perspectives of medical professionals during the COVID-19 crisis of 2020–2021 to determine whether the policies in place at the time provided appropriate support and proper facilities.

The circumstances surrounding the COVID-19 pandemic caused a phenomenon in which public health policy and medical professionals were required to evolve along with rapid changes (Menifield & Clark, 2020). However, there is a lack of information covering medical professionals' perspectives, and substantial support is needed while also trying to adhere to current public health policies (Koontalay et al., 2021). Therefore, a basic qualitative inquiry with purposive sampling was needed to obtain in-depth knowledge and address the gap in the literature and the research problem.

Chapter 3 presents detailed information on the research method and rationale for the study. I applied a basic qualitative design and thematic analysis approach and sought solutions to policy shortfalls addressing facilities (i.e., PPE) for healthcare professionals; I also presented a rationale for the design, data collection process, data analysis, participant selection, and evaluation method.

Research Design and Rationale

Although this study could have applied many different methods, the basic qualitative design and Kingdon's MSF were chosen to obtain participants' reactions to

changes experienced during 2020-2021. The justification for choosing this qualitative approach in combination with MSF was that both provided flexibility and multiple ways to gather necessary data, enabling effective analysis (see Weible & Sabatier, 2018). Accordingly, the qualitative approach and MSF allowed insight to be gained in formulating a possible solution to the research problem; this approach was relevant because there are different stages to policy cycles in government, and MSF can be applied to find an opportunity (Weible & Sabatier, 2018). MSF was appropriate for the current study, which sought to contribute to the body of knowledge on how crisis support can be better addressed in public health policies. The following research question aligned with the research problem and two of the MSF streams of problem and policy: How do professionals in medical practice describe policy change and the support regarding personal protection equipment (PPE) received during the COVID-19 pandemic? The research question supported the research problem, which hoped to reveal an opportunity to encourage change in health care crisis supporting policy for medical professionals (see Weible & Sabatier, 2018).

Additionally, according to Patton (2015), the basic qualitative inquiry includes qualitative methods, in-depth interviews, fieldwork observations, and document analysis to answer straightforward questions. Furthermore, according to Merriam and Tisdell (2016), a qualitative research method assists the researcher in understanding the meaning of a phenomenon without the need to define parameters such as focusing on the data or interpreting a lived experience. This focus further leads to in-depth information being drawn from the perspective of individuals, providing a further explanation of a research

question or the topic of interest. Therefore, much can be gained from a study of the critical elements of thematic analysis consistent with a qualitative approach (Patton, 2015).

Role of the Researcher

Complete awareness of biases and lowering those biases is essential in qualitative research to maintain integrity in an analysis of the data (Sullivan & Sargeant, 2011). My primary role was an overt observer, for which the participants greatly minimized ethical issues such as the Hawthorne effect because they were fully informed of the research details and could ask as many questions as necessary to decide to participate. However, according to Sutton and Austin (2015), the researcher's primary responsibility is to protect participants and their data by enriching the study through relevant literature and participant interviews. I conducted the study under strict guidelines and was unbiased. In addition, no personal relationships existed. Although there is a physician–patient relationship at this facility, and this relationship can be considered an exclusionary factory, these individuals were not asked to participate in the study if they felt it would bias their responses.

My researcher biases were managed because no formal or informal relationships existed where power was held over the participant. Also, no relationships were formed during or after the study, compromising the facility's ethical standards. According to Giorgini et al. (2015), preconceived notions of the data are lessened when organizational ethics are used as a guideline. Therefore, I decided to set firm ethical guidelines that would exhaust alternatives that could undermine the reliability and validity of the data.

My role as the researcher was to clarify that participation in this study was voluntary and anonymous. As the researcher, I acknowledged and understood that the nature of the study must be disclosed in the informed consent document before obtaining a signature. Furthermore, I ensured that participants understood they would not receive any incentives or rewards for voluntary participation. Although incentives or rewards can be considered appropriate, the participant's input conveyed by the researcher can be perceived as having been under an undue influential bias (U.S. FDA, 2018). Hence, I ensured appropriate questions were asked of the selected participants, analyzed the data unbiasedly, and identified any trustworthiness issues. In addition, I maintained full disclosure of the research objectives and allowed participants to ask preliminary questions to understand those objectives (see Palmer, 2015). I also reminded participants of their right to opt-out during the data collection phase (semistructured questionnaires). I acknowledged that exercising the option to withdraw would not be met with resistance, even if that action unsuccessfully obtained data saturation.

Quality, validity, and reliability are essential in developing knowledge of crisis support for medical professionals with credible evidence (Swisher, 2019). I identified objectives that would assist me in adhering to my role as the researcher, allowing easier management of my biases throughout the data collection process. For example, deviation from any steps recommended by the Institutional Review Board (IRB) to enhance my role as a researcher was not an option. My goal was to accurately convey the valuable information obtained from each participant's unique perspective to understand better what would improve medical facilities and the support they receive during a pandemic.

Methodology

Although a basic (generic) qualitative design was used in the current study, many studies focused on a phenomenological approach to explore how people interpret health care (Isaacs, 2014). However, the purpose of a basic approach is to obtain adequate descriptions that hold significance to the study from the participants' perceptions of a phenomenon (Patton, 2015). I aimed to gather real-world perspectives from participants on how they interpreted the lack of crisis support throughout the COVID-19 pandemic during 2020–2021.

The experiences shared by each participant are a vital part of the basic approach used for thematic analysis. The IRB approval number 08-03-23-1057848, which expired on August 2, 2024, allowed me to discover the truth and gain knowledge from the participants through their descriptive experiences of the COVID-19 pandemic (see Patton, 2015). Generally, a basic approach is suitable for contributing to the body of knowledge relevant to the participants' expertise (Patton, 2015). The basic approach was selected to determine the perspectives of the small group of participants to emphasize a particular problem: what type of crisis support was experienced at the time of the phenomenon, not how the healthcare workers felt emotionally based on the experience (see Nelson, 2011).

Each participant was asked seven identical questions (see Appendix A). The responses were analyzed using a basic method to explore participants' perceived experience during the modified policy changes from the COVID-19 pandemic impacting daily operations without appropriate crisis support. The responses to the questions were

the primary data. The data were analyzed to understand the outcomes detailing the comprehensive accounts of the various healthcare professionals' experiences throughout the COVID-19 pandemic of 2020–2021. Additionally, the following objectives guided the data analysis: (a) bracketing subjectivity or setting aside prejudgments (biases) that may exist, (b) reviewing data from the semi-structured questionnaire and following up if necessary, and (c) identifying irrelevant or repetitive data that need to be eliminated (see Patton, 2015).

Finally, purposeful sampling allowed for viable information as participants were selected because they possessed the characteristics or were a viable representation of the population due to their credentials, which could also be subcategorized as homogeneous sampling (see Patton, 2015). This purposeful sampling for the data analysis allowed for themes to emerge from the participants' questionnaires (see Robinson, 2014). I incorporated thematic analysis to organize the information into meaningful data through this sampling method.

Participant Selection Logic

The 15 participants were selected using purposeful sampling. Participants were provided informed consent forms for review and approval. The criteria for participation included individuals interested in the study topic and willing to share their experience while providing health care in Illinois during the COVID-19 pandemic of 2020–2021. The selected participants were not unfamiliar persons (those under a random selection process) or individuals purposefully recruited from protected populations such as children or individuals with disabilities. These willing and voluntary participants were selected

based on the controlled environment and confidentiality standard the selected medical facility held. I maintained anonymity and confidentiality through the survey questionnaires and beyond.

Inclusion criteria are applied to assess the critical aspects needed to identify the target population for a study (Patino & Ferreira, 2018). The sample for inclusion in the current study met the following criteria: (a) healthcare worker or professional, (b) minimum of 1-year of experience in a small health care facility through the years 2020–2021 during the COVID-19 pandemic crisis, and (c) willingness to provide in-depth information concerning the impact on daily operations. A sample size of 15 was needed to achieve data saturation from those selected; however, if data saturation had not been achieved at 15 participants, more would have been used until saturation was achieved. Each participant was formally contacted or invited by email or phone with the request to participate. Upon consent, each participant was given a choice in participation style and comfort. They could receive an electronic version of the written questionnaire via email or participate on location with the written questionnaire delivered to the facility for increased privacy. A small, undisclosed Illinois medical facility where a professional relationship with a few staff members had already been established was chosen. The participants from the undisclosed medical facility who promptly responded to the invitation were chosen. These individuals were considered for inclusion first because a conclusion date was a deciding factor, set a week before data analysis began.

The data collection methods conventionally used for qualitative research include interviewing, open-ended surveying, and questionnaires. I used the questionnaire method

and gathered enough data from the reviewed literature to analyze the qualifying participants' perceptions. I examined crisis resource support available to localized health care facilities. The purposeful sampling method assisted in recruiting participants by allowing me to connect with one participant with whom I had a positive rapport and who fit the selection criteria. Expanding the pool of voluntary participants in various health care facility positions also fits the inclusion criteria. The positive rapport minimized potential risks associated with unwillingness to participate during the study or concern for unintended disclosure of confidential information.

Instrumentation

A preliminary semistructured interview guide influenced the questionnaires tailored to elicit valid and confirmable data regarding the participants' perspectives. This approach allowed for open-ended qualitative data to be collected without me influencing the outcome (see Cohen & Crabtree, 2006). Data triangulation ensured the validity and credibility of the information provided during the data collection. According to the Joint United Nations Programme on HIV/AIDS (n.d.), data triangulation's primary advantage is that existing data can be used for review and analysis. The relevant data ensures that merging and differentiating data are not unnoticed because more than one study has been reviewed. In the current study, drawing from different sources, such as medical doctors and certified nurse assistants, increased the validity of the data. Other aspects that were applied to the instrumentation of data resources were notes and summaries developed from the questionnaires. The results were used to extract a more in-depth meaning from the coding process. The combination of the data collected was applied to the procedures

outlined in the data collection process, along with any annotations deemed necessary to analyze the data.

Procedures for Data Collection

The data collected from the questionnaires with participants was only concluded once data saturation was achieved from those who implied consent by completing the questionnaire. With the final number of participants and the ability to minimize scheduling conflicts, the data collection process was expected to last approximately 1-2 months or until data saturation was achieved after a minimum of 15 participants' data were collected. The semistructured questionnaires and attached implied consent letter informed volunteers of the purpose and procedures of the study. The consent form and questionnaires were hand-delivered to the approved medical partner and distributed to participants who responded to opt-in to the study. No participants expressed a significant privacy concern; therefore, it was unnecessary to provide informed consent via email with an explicit expression that signatures must be provided through DocuSign or other official electronic signature verification software.

Once questionnaires were completed, the data was recorded and input into the NVivo qualitative data analysis (QDA) software to ensure the accuracy of the data analysis. All participants were informed that they could withdraw from participation during the study and were not required to respond to all questions, as some did not apply to their positions. The ethical procedures followed kept all personally identifying information and answers to the questions confidential and did not share them with any person or group that did not authorize this study (maintaining anonymity). Participation

was voluntary, and refusing questions or completely withdrawing from participating was acceptable. In the end, the data collected was summarized, and no individual participating in the study was personally identified in the summarized results. Some responses were quoted, but no individual was identified as the source of the quote. The questionnaire was assigned a random alpha-numeric identifier to identify the responses as unique for the researcher's purpose and not attached to the identity of the participants who provided answers. The questionnaires provided were also given a variety of orders. For example, questionnaire AA001 may be selected from any participant, BB020 by another, and so on, randomly selected by whichever participant pulls from the pile of questionnaires without prior knowledge of the questionnaire assigned number.

To secure confidentiality and anonymity, I did not disclose to the participants how the alpha-numeric identifier was used. The participants were not being deceived but instead protected from disclosing their identifiers to one another, resulting in the threat to their anonymity. Furthermore, each completed questionnaire collected during the data analysis was reassigned a one-to-two-digit number (i.e., 1 through 15) randomly pulled from the pile as each was analyzed through the NVivo software application.

Data Analysis Plan

This basic qualitative inquiry study aimed to understand, from the perspective of medical professionals, how the lack of facilities (i.e., PPE) modified operations during crises due to possible policy needs. The purpose was based on the research question: How do Illinois medical professionals describe policy changes that would improve their medical facilities and the support they received during the COVID-19 pandemic? The

expectation was to utilize thematic analysis software to identify patterns in the data, revealing themes that evolve into more in-depth meanings from the information gathered. The thematic analysis allowed reflection on the trustworthiness of the data to make possible meaning of the data through a step-by-step process (American Psychological Association, 2023). Accordingly, in this study, I was able to familiarize myself with the data, create a code system that defined what each code means, and then identify, analyze, and appropriately interpret the data. As a result, valuable information was learned from the data to provide policymakers and others with an invested interest with a better understanding of what factors are of importance in policies or mandates related to medical professionals with small practices (i.e., a few doctors in a small to mid-sized building caring for multiple patients).

This software coded and categorized the information from the semistructured questionnaires relevant to the study. For example, the data was organized by any patterns or themes that emerged through the qualitative data analysis (QDA) software, making analyzing the data from each questionnaire less time-consuming. According to Saldana (2016), manually coding small amounts of data in a qualitative study is reasonable. However, the primary reason for using QDA is to assist in processing a significant amount of data relevant to the study. According to St. John and Johnson (2000), QDA holds significance because it offers flexibility and convenience and saves time.

Issues of Trustworthiness

Credibility, Transferability, Dependability, and Confirmability are the four components that define trustworthiness in a qualitative study (Stahl & King, 2020).

Therefore, each component is defined, explaining where proposed issues could arise and what was done to alleviate issues of trustworthiness.

Credibility

Credibility means providing accurate data to produce plausible findings in the research that are a fair representation of the data collected (Stenfors et al., 2020). Checking the accuracy of post-transcription data with the participants verifies how credible and confirmable the researcher's recorded information is from the participant's input (data). Although this increases the validity of the data and interpretations found within the patterns or themes determined through the questionnaires, the data also had to be transferable to similar organizations and from a reliable source. However, this study is meant to focus on the perspective of medical professionals in private practice settings to further studies on the crisis support received. Therefore, I established and completed follow-up consultations with the participants by providing them with a copy of their merged questionnaire answers to ensure certainty of the facts from the initial data received.

Transferability

Transferability refers to the described context of the research, how it was performed, and whether those findings are transferable to other settings, groups, or contexts (Stenfors et al., 2020). Transferability allowed the research results to be applied in situations similar to the current study. With transferability, the data gathered from the study would have posed a general issue with trustworthiness due to the duration and possible unique qualities obtained from the specific organization. According to Ravitch

and Carl (2021), these standards should be approached thoroughly but should also "…align with the research questions, goals, and contexts…" (p. 168). I improved the validity of the research by allowing the data collection process to be transparent in revealing the purpose of my study and possible outcomes to the participants to sustain the data collected. Validating research in this manner is commonly used in qualitative research with data source tables; they provide transparency and increase trustworthiness (Cloutier & Ravasi, 2021). For example, the research notes and the data analyzed from the questionnaires confirmed or disproved whether common themes emerged; saturation was achieved, and the data itself did not need to be reviewed. Prejudgments were reviewed before concluding whether themes appropriately represented the data to interpret meanings.

Dependability

Dependability refers to the extent to which research can be duplicated under like circumstances (Stenfors et al., 2020). Dependability is a factor that demonstrates that enough adequate information has been provided to such an extent that another researcher could follow the exact procedure, although reaching different conclusions (Stenfors et al., 2020). In this study, the research findings reflected stability drawn from credible data.

Confirmability

Confirmability establishes a clear connection between the data and results (Stenfors et al., 2020). Confirmability was established through conducting unofficial follow-up consultations with the participants, which also aligns with how credibility is corroborated. The goal was to demonstrate possible connections needed to transition into

data tables or be illustrated in a figure to support and summarize the explanation of my strategy (Stenfors et al., 2020). To conclude, triangulation was used throughout the various instrument types to increase the trustworthiness of this research. Using a strategy of thoroughness and balance created a way to sustain data saturation. Therefore, I stayed neutral throughout the study, ensuring quality, trustworthiness, confirmability, and credibility for this basic qualitative research using different techniques and methods, increasing genuine consistency.

Ethical Procedures

My research examined the experience of medical professionals in small health care facilities; I ensured that ethical procedures were followed throughout the research process. Ensuring ethics means devising or adapting principles that guide adherence to a specific academic code of conduct (Taquette & Borges, 2022). Thus, to allow the ethical procedures to go smoothly, an initial signed agreement between the IRB and me for the small medical facility partner was obtained to access the rest of the staff willing and available to participate voluntarily. After that step, each volunteer participating in the research received a questionnaire (which, upon completion, implied consent), an explanation, and the option to opt out. This ethical procedure stayed consistent with ethical research procedures and is integral to maintaining confidentiality and anonymity. Additionally, according to Taquette and Borges (2022), qualitative research is a complex activity because the study is conducted with individuals, not on them, and thus requires the researcher to be fully responsible for ethical integrity. However, the Walden

University IRB ultimately decides if the study complies with ethical standards before approval of participant recruitment or data collection.

Summary

Essential points were covered in Chapter 3 about the research methodology and design, the role of the researcher, and the data collection processes used. Each point outlined in Chapter 3 conveys the actions and procedures necessary to obtain data. All participants are from a selected Illinois local health care facility partner. Each selected participant has a shared lived experience with the phenomena under study. The sample size was determined by data saturation with a minimal sample size of 15 defined and the participants meeting the inclusion criteria. I used semistructured questionnaires to obtain an in-depth understanding of the participants' perspectives and then conducted follow-ups to maintain the accuracy of the data collected. Finally, these actions demonstrated how trustworthiness is vital in the ethical procedures observed. In Chapter 4, I present the research results from the research method of this basic qualitative study.

Chapter 4: Results

This research aimed to explore and seek solutions to the research problem. The study addressed small medical facilities in Illinois and the medical professionals' perceptions of their experiences during the COVID-19 pandemic crisis in 2020–2021. Following an extensive review of the literature surrounding this study, I identified a gap associated with medical professionals' perspectives. The following research question guided the study: How do Illinois medical professionals describe policy changes that would improve their medical facilities and the support they received during the COVID-19 pandemic? In medium-size Illinois cities' public health care policies between 2020 and 2021, there was a lack of health care-related policies that directly addressed necessary facility-based resources and equipment. The information shared by the participants presented key insights based on a lack of resources, such as medical equipment, services, and assistance, that medical professionals needed to ensure proper medical support during a pandemic (see Emanuel et al., 2020).

The following sections discuss the data-discovered conditions that had little to no effect on the study results. First, the research setting is reviewed to illustrate whether personal or organizational conditions influenced the participants' understanding of the study. Then, demographics are presented to relay the relevant characteristics of the participants in this study. Next, a thorough description of the data collection, data analysis, and evidence of the trustworthiness of the data is presented to establish support for the results. Finally, the study results are presented to support the findings of the research problem and question.

Research Setting and IRB Approval

The data collected for this basic qualitative study was from semistructured questionnaires administered to 15 participants (see Appendix B). Ten of the fifteen questionnaires met the inclusion criteria to support the examination of this phenomenon. The IRB-approved recruitment letter was personally delivered to a small medical facility partner in Illinois with strict inclusion criteria. Participants were required to be 18 or older, be healthcare professionals, and have at least 1 year of experience in a health care facility during the COVID-19 pandemic crisis of 2020–2021. After participants understood the conditions of consent, they were scheduled to receive the semistructured questionnaires and complete them within a reasonable time. No adverse personal or organizational conditions that could have influenced the participants' experience existed during the study. For example, while conducting the study, no current crises directly influenced the participants' interpretation of working through modified operations from 2020 to 2021 during the COVID-19 pandemic.

Demographics

The participants for this study were employed during the 2020–2021 COVID-19 pandemic with different years of experience and job titles for the small local health care facilities partner. The 15 participants were knowledgeable in their health care knowledge, with experience ranging from 1 to 38 years. Only 10 of the 15 participants met the full inclusion criteria. Participants had at least 1 year of real-world experience to share in-depth information about crisis support during the COVID-19 pandemic in 2020 and 2021. Although it was unfortunate that all 15 participants did not meet the inclusion criteria,

data saturation was reached at seven, making the final number of 10 sufficient for the data analysis. After approval by the study site's IRB to only use the identifiers and characteristics, such as years of experience and position title in the data collection description, only occupation and tenure or working experience were the demographics considered essential data to identify the small medical population. Due to the focus and aim of the research, details such as gender and ethnicity were not incorporated in the data collected or input into the QDA software.

The sample demographics included the participants' job titles, years of service, and the minimum required age of 18 being met in the local small medical facility. The pseudonyms given during the initial coding were in an XY format, with the letter X representing the participants' job titles and Y for their minimum years of experience. The vague demographic details are intentionally selected to represent the small population of healthcare workers who experienced changes during the COVID-19 pandemic in 2020 and 2021. Although the number of participants in this study did not represent the experiences of all healthcare workers, they did represent the limited number of small local health care facilities. The complete demographics are shown in Table 1.

Table 1

Participants' Demographics and Characteristics

Medical participant	Job title	Experience (years)	Met minimum age requirement?
MP1	Physician	20+	Y
MP2	Certified medical assistant	5+	Y
MP3	Register nurse	20+	Y
MP4	Nurse practitioner	5+	Y
MP5	Certified medical assistant	Less than 5	Y
MP6	Licensed practical nurse	5+	Y
MP7	Physician	20+	Y
MP8	Certified family nurse practitioner	5+	Y
MP9	Nurse practitioner	5+	Y
MP10	Certified medical assistant	20+	Y

Data Collection

IRB approved the data collection phase of the study, which involved gathering data from the semistructured questionnaires until data saturation was achieved. Qualitative studies can reach saturation with as few as four participants (Hennink & Kaiser, 2021). However, data saturation is only reached when repeating themes or characteristics become apparent in the data. In the current study, documented data saturation was achieved at seven sampled participants when no new relevant details emerged from the purposeful sampling of participants' perspectives (see Robinson, 2014). Each of the 10 participants possessed the necessary characteristics or were viable representations based on their credentials, known as homogeneous sampling (see Patton, 2015). A series of identical questions were asked to ensure alignment of the research

topic with the questionnaires to ensure that unique experiences were fairly represented in the data analysis.

Participants provided brief descriptive responses to the questions when applicable or relevant to their unique experiences. The semistructured questionnaire prompted the expected formal responses about crisis support and how challenges were met. In addition to this general observation, I also noted that some responses were emotionally driven due to the policy changes caused by COVID-19, such as fear of how their medical facility would address their safety concerns, protect them by providing proper PPE, and be more transparent when actions are taken in the best interest of medical workers. The concerns fueled responses that allowed meaningful and in-depth insight.

Data Analysis

Throughout the data collection and analysis process, I sought to understand, from a medical professional's real-world experience, the lack of crisis support for medical facilities (e.g., PPE) and to what extent operations were modified that brought about changes due to possible policy needs. Thematic analysis software was used to identify patterns and trends in the data, revealing themes that evolved into more in-depth meanings from the information gathered. The thematic analysis also allowed reflection on the trustworthiness of the data and deciphered meanings from the data results.

Accordingly, a code system was developed that defined each code with an identity, allowing an easier analysis and interpretation of the data. As a result, valuable information was learned from the data to provide those interested with a better understanding of what factors are important in policies or mandates related to medical

professionals with small practices (i.e., a few doctors in a small- to mid-size building caring for multiple patients). Table 2, developed from the 10 participants' responses, defined a pattern that helped with coding categories and subthemes and supported the narratives of the participants' concerns during the COVID-19 pandemic. With the participants' responses, I issued a coding of three categories that were grounded in the conceptual framework, and the 10 redeveloped themes supported the data interpretation in addressing the research question: How do Illinois medical professionals describe policy changes that would improve their medical facilities and the support they received during the COVID-19 pandemic?

The QDA software NVivo was used to code and categorize the relevant information from the semistructured questionnaires. For the first coding category, "crisis support need during the pandemic," the themes were (a) individual staff support needs and (b) life without support causing mental stress. For the second coding category, "thoughts about limitations and policy," the themes were (a) overworked and understaffed and (b) quick multiple meetings. For the last coding category, "expressing need for better policy," the themes were (a) remote work and meetings with local hospital administration and (b) mental support. After reviewing the themes that emerged from the coding, which displayed similar features of a 5-point Likert scale, the viewpoints were rated on a scale from very negative responses to very positive responses (see Table 2).

Furthermore, Table 2 reflects the analysis computed by the QDA software. Table 2 displays a sample of four participants' responses to four questions as a percentage of agreement between their responses. Although answers varied, the themes showed that

each participant highly agreed, although the opinions were expressed negatively (see Figures 2 and 3). For example, for Q2, although each participant provided a different response, each participant agreed that a need for more resourcing was not being met.

Table 2

Coding and Themes Examples

Medical participant	Q1	Q2	Q3	Q4
MP1	N/A	Increased need	Initially prudent	Word of mouth
MP2	When the pandemic first happened in town	It was highly needed	Anger, annoyance	A day at a time
MP3	Soon after the shutdown in March 2020	Not enough support	Disgusted	Unanswered
MP4	November 2020, when the number of cases increased	The need was quite high. There was a great increase.	Fear is due to a lack of knowledge of the virus itself.	Multiple meetings
MP%	14.29%	14.29%	14.29%	14.29%

Figure 2

Participant Response Results

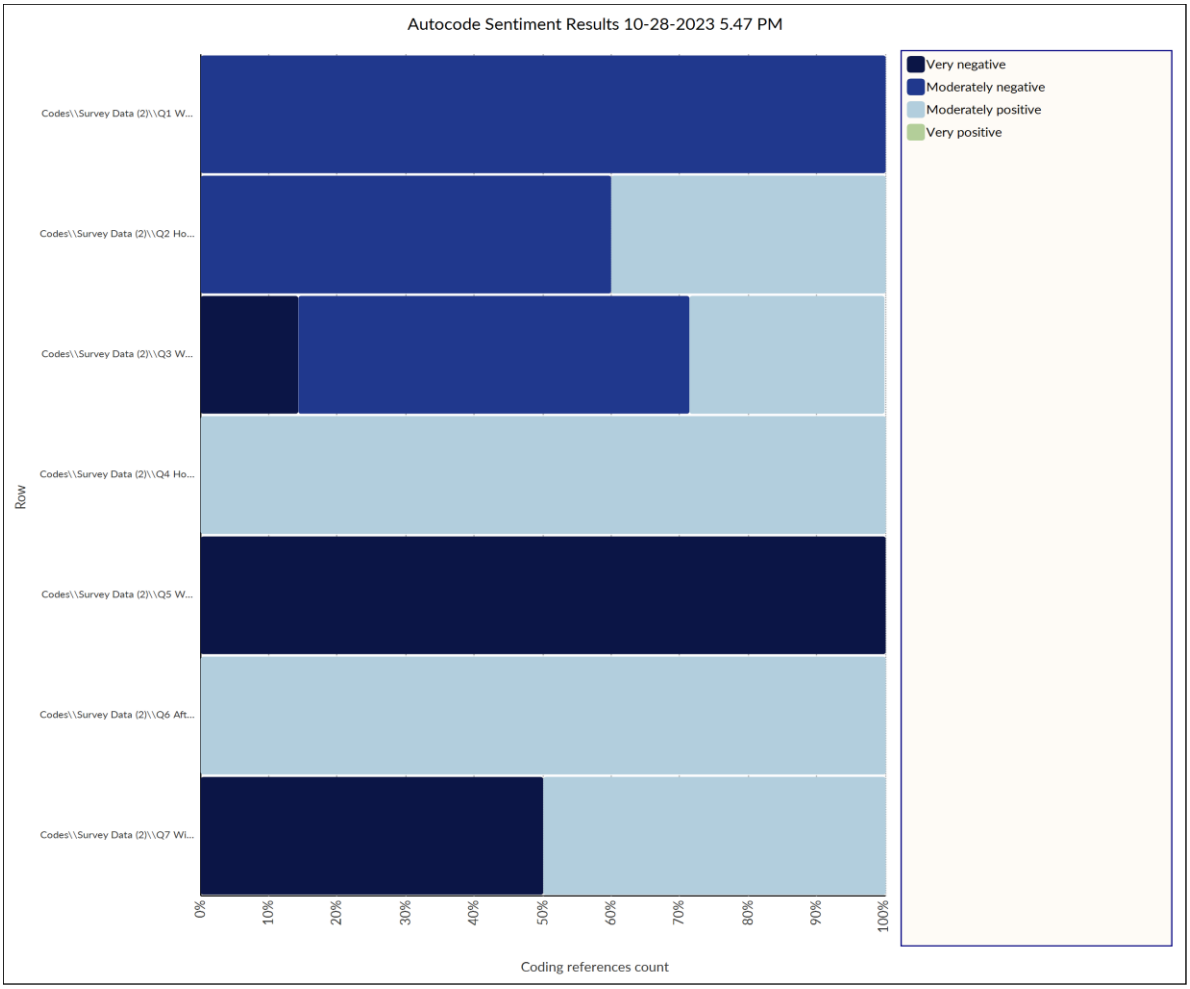


Figure 3

Matrix Coding Query Results

	A : Sentiment\\Positive	B : Sentiment\\Positive\...	C : Sentiment\\Positive\...	D : Sentiment\\Negative	E : Sentiment\\Negative\...	F : Sentiment\\Negative\...
1 : Cases\\Survey Data2...	0	0	0	0	0	0
2 : Cases\\Survey Data2...	0	0	0	2	2	0
3 : Cases\\Survey Data2...	0	0	0	2	2	0
4 : Cases\\Survey Data2...	2	0	2	1	1	0
5 : Cases\\Survey Data2...	0	0	0	1	0	1
6 : Cases\\Survey Data2...	1	0	1	1	1	0
7 : Cases\\Survey Data2...	2	0	2	2	1	1
8 : Cases\\Survey Data2...	1	0	1	3	2	1
9 : Cases\\Survey Data2...	1	0	1	0	0	0
10 : Cases\\Survey Data...	0	0	0	1	1	0

Evidence of Trustworthiness

Credibility

Providing accurate data in research involves representing the data collected in a way that fairly conveys solid credibility (Stenfors et al., 2020). The use of questionnaires supported increased credibility in data accuracy without assessing the information I interpreted. The credibility of the research was also supported by the participants' qualifying credentials and willingness to respond directly to the questions. Checking the accuracy of the data with the participants was only deemed necessary if any of the participants' handwriting was indecipherable. Although the validity of the data would have been enhanced through a post-review with participant approval, I provided a comprehensive consultation about the study's purpose instead.

Transferability

The transferability of research findings describes how the study was performed and provides reasonable findings transferable to other settings, groups, or contexts (Stenfors et al., 2020). I established the transferability of the research by providing substantial detail about the social context, cultural setting, and the target population. The data gathered from the questionnaires provided unique qualities obtained from the specific medical facility. Validating the transferability of the research is commonly used in qualitative research, with supporting data, transparency, and trustworthiness strengthened (Cloutier & Ravasi, 2021). The current study's goal was to present the information from the participants in a manner that conveyed the need for crisis support through policies that are more specific to medical professionals. Before concluding

whether themes appropriately represented the data to interpret meanings, I reviewed and cross-checked any prejudgments. The validity of the research was achieved by allowing the data collection process to be transparent in revealing the purpose of my study. I stayed unbiased toward the possible outcomes of the participant's responses to ensure the data's validity.

Dependability

Dependability refers to the extent to which research can be duplicated under similar circumstances (Stenfors et al., 2020). Dependability is a factor that demonstrates that enough information has been provided that another researcher could follow the exact procedure, although reaching different conclusions (Stenfors et al., 2020). In the current study, the research findings reflected stability drawn from credible data.

Confirmability

Confirmability establishes a clear connection between the data and results (Stenfors et al., 2020). Thus, confirmability is established through conducting unofficial follow-up consultations with the participants, which also aligns with how credibility is corroborated. The objective is to demonstrate possible connections needed to transition into data tables easily or be illustrated in a figure to support and summarize the explanation of my strategy (Stenfors et al., 2020). I accomplished this by using triangulation throughout the various instrument types, which increased the trustworthiness of this research. A thorough and balanced strategy was created, and data saturation was sustained. Therefore, I ensured quality, trustworthiness, confirmability,

and credibility in my qualitative research by staying neutral throughout the study using different techniques and methods, increasing consistency.

Results

The spectrum of results was coded, varying from very negative, moderately negative, moderately positive, and very positive. Figure 2 in the data analysis displays the participants' collective responses to each question on the negative to very positive scale through NVivo's auto-code results. The calculated results lacked many neutral or indifferent responses and were not used even though the software calculated them. In addition to that scale, it is important to notice that Figure 2 displays each category at 100%, except very positive being absent. The lack of neutral or indifferent responses detail is important because the scale displays responses for Q1 as moderately negative, Q4/Q6 as moderately positive, and Q5 as very negative as 100% from the participants collectively. However, these responses are not to be taken at face value. For example, Q1 resulted in responses that were 100% moderately negative, and this data means that the participants agreed that they experienced an increased need for pandemic crisis support. At the same time, the words were expressed with negative grammar.

The results are similar to Cohen's Kappa (Kappa coefficient), a measurement or calculation used to determine the percentage of agreement between two or more researchers' results (DATAtab Team, 2023). In this case, the matrix coding query shown in Figure 3 can represent how strongly two or more participants agree on the same sentiment code. Zero represents no agreement in response to a specific question, and three represents the strongest agreement. For example, column three, 'D:

Sentiment\Negative,' shows that some participants' agreement varied in intensity per negative response. According to the information calculated, the participants' strength or lack of agreement lies within the positive or negative expression (i.e., participants expressed negative responses but agreed to some extent in their responses).

Table 2.1 below displays excerpts of the participants' real responses to one of the research questions. Each participant expressed and used some form of negative grammar to convey their experiences during the COVID-19 pandemic, and this resulted in the data showing participants' responses as 100% agreeable to 4 of the seven questions. For example, nearly all participants' responses cross-referenced 'need' as the main developed theme, although the categories somewhat differed. The information shown in Table 2.1 was selected as the best representation of the overall responses (others as supporting data) because these details directly address the research question.

Table 3

Coding and Theme Examples: Participant Responses

Medical participant	Participant response excerpt	Category	Theme
MP3	"Follow protocol as best you can, and know that things will get worse before they get better."	Future pandemic preparation	Needs/Staff
MP4	"The number of cases increased here in Illinois. Initially, the need was quite high. Again, there was a great increase in hospitalization needs. There were multiple meetings, emails, and virtual daily meetings about policy, changes, support, etc. Use your voice. Write to Congress, HR, and local hospitals."	Hospital and medical facilities/change	Need/increased needs/meetings
MP7	"Inadequate and ill-prepared; poor/slow adoption of existing tech to address patient needs; Open dialog re: the medical community's lack of preparedness and ways to address that in the future."	Hospital and medical facilities/change	Need/increased needs/meetings
MP8	"Extreme burnout, irritability, and no energy for at-home life. Upset regarding masks, frustrated at the ability of others to do remote work while being on the front line and exposing family."	Stressors	Mental/need

The expressive nature of the results and the research question, how do Illinois medical professionals describe policy changes that would improve their medical facilities and the support they received during the COVID-19 pandemic, provides the appropriate conceptual answer in conveying the viewpoint of medical professionals. The medical professionals described a need for better preparation and appropriate communication as important. Although specific, the participants were vague about what policy changes would improve their medical facility. They articulated what needed to be improved and suggested possible improvements. Thus, the participants confirmed that medical supplies were lacking along with safety concerns, adding that mental stress was heightened and should have been an important factor. Lastly, with all data considered, the basic qualitative inquiry aligned with the research in exploring and seeking solutions to policy shortfalls. The questionnaire data showed where the participants felt support issues were weakest. However, the attempt to further understand how implemented policies could increase their effectiveness during a pandemic could have been clearer. The perceived result was speculated to be due to the participants' lack of policy knowledge or the varied responses to the questions that did not provide enough detail in the policy area. Therefore, the multiple streams approach that I utilized for data analysis in this basic qualitative research allowed me to acquire an answer to the supporting research question with revealing themes that, in the end, generated in-depth concepts.

Summary

Chapter 4 presented all participants from a selected Illinois local health care facility. Each selected participant has shared their real-world lived experience with the

phenomena under study. The sample size was determined to have reached data saturation with a minimal sample size of 7, even though I have provided 10. The participants met the inclusion criteria. The overall concerns of the medical professionals were their safety at work and understanding of new policies that would ultimately affect the change of care provided and the safety of their employees. The substantiated findings of this basic qualitative study discovered that the semistructured questionnaires allowed me to gain an in-depth understanding of each participant's perspectives while maintaining accuracy. Most of the participants expressed an answer to each research question that verified mutual feelings when describing an increased need for crisis support while working through the changes in the health care crisis. Although each participant responded differently in their wording, the overall responses implied in agreement that medical staff was overworked, understaffed, lacked medical support, did care about their mental capacity as they dealt with the health care crises, and followed the guidance of their superiors throughout the 2020 – 2021 COVID-19 pandemic.

In Chapter 5, I begin by discussing the analysis and interpretation of my findings in the context of the multiple stream framework as appropriate with the supporting literature. Describe the limitations of trustworthiness and articulate recommendations for further research that may assist in preparing all medical professionals for the future based on their current knowledge of known issues. Finally, I will describe the potential implications that may influence positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

This basic qualitative study aimed to explore small medical professionals' real-world experiences during the COVID-19 pandemic crises in 2020 and 2021. An important aspect of the research data collection was the policy information obtained from published government data on how local governments apply policies (mandates or ordinances) toward medical professionals and their facilities during an epidemic or pandemic with any medical facility in or outside Illinois. The policy information obtained from published government data assisted in determining what problem existed and how to formulate the research question. In addition to policy information, the supporting literature clarified how to identify possible ways to solve crisis-based interruptions in health care support. Examining the research problem involved surveying medical professionals and capturing their experiences working through modified operations from 2020 to 2021 during the COVID-19 pandemic. Data from the respondents revealed that numerous support issues can be improved, but they also need to be evaluated on how enacted policies could have increased effectiveness.

Key Findings

The study was framed with Kingdon's MSF, a conceptual framework to explore how the COVID-19 virus supported telehealth policy change (see Giese, 2020). Additionally, the conceptual framework guided the study, which views problems as social constructs explained through the shared experiences of individuals who agree that a concept exists (see Weible & Sabatier, 2018). The MSF conceptual framework warranted a basic qualitative approach to study reviewed literature and participants' real-

world experiences. Additionally, MSF provided the parameters, guidance, and foundation supporting this research by allowing for the review of existing causes, appropriate analysis of the context from the semistructured questionnaires, and an increased understanding of the problem. I used data triangulation to analyze and review existing data and to ensure differentiation between the collected and reviewed data.

The 10 participants' revealed the main theme of needs; only participants' responses needed to attain data saturation. Overall, there were six noticeable themes: (a) individual staff support needs, (b) life without support causing mental stress, (c) overworked and understaffed, (d) quick multiple meetings, (e) remote work and meetings with local hospital administration, and (f) mental health support. Key findings revealed that the COVID-19 pandemic set in motion an increase in the need for staff support, medical equipment support, mental health support, and communication. Although some of the information from the findings was expected because it confirmed information found in the supporting literature, the results were also interpreted to have extended knowledge of public health policy.

Interpretation of the Findings

In interpreting the knowledge gained from this basic qualitative study, I verified and contributed to the substantial findings from the literature reviews. The duration of the data analysis did not reveal any obvious inconsistencies with the emerging themes presented and the conceptual framework or the literature review. I first reviewed my findings to make comparisons. I looked for contrasting themes within the data and the scholarly literature to determine whether supporting literature was confirmed. This study

revealed that the findings from the scholarly literature confirmed the existence of the identified barriers known in the preexisting research. Those known barriers were as follows: medical professionals putting their safety at risk; confirmation that there are medical device shortages, lack of PPE, and other needed supplies were a deep concern for medical professionals; challenges extended beyond the decrease in medical staff attendance; and immediate and effective communication was not sufficient for frontline workers to address urgent issues affecting their ability to operate safely during a pandemic crisis. The data collected allowed the barriers to link to the scholarly literature to support the findings in my study.

The findings extended the knowledge of preexisting literature by highlighting that policy and proactive planning would have been beneficial. The participants' descriptions pointed out that policy changes could have offered more support by being in place before a crisis occurred or by opening dialogue with the medical community. The suggestions provided by the participants did not directly indicate a specific section of the policy that needed to be changed. Instead, they provided insight into their experiences during the COVID-19 pandemic, during which the current policy was ineffective. However, the responses implied that a better policy would address future issues by increasing preparedness and communication.

Limitations of the Study

Throughout researching the phenomenon, I discovered that change poses a challenge, and limitations revealed the need for more viable details in the data. The preexisting research discussed complications that slow the advancement of good

pandemic-related policies, such as policymakers' perceptions of obtaining information and how medical professionals perceive policy. Additionally, finding what strategic communication approaches would present credible evidence in the area specific to this study needed more in-depth research. However, providing credible evidence and recommendations presented minimal challenges (see Ashcraft et al., 2020). Other challenges became evident due to limitations within the details volunteered by the medical professionals and the timing of the return of the data. Descriptive details were minimal regarding information that expressed viewpoints on solutions; some participants opted not to answer all of the questions (or submitted a three- to four-word description only), and the final limitation was the inability to generalize any of the data in the findings. In this study, the participants may have found certain questions irrelevant to their unique experience as the reason for not answering them. Consequently, validating some data details proved challenging even though the participants surveyed expressed implied consent and understanding by volunteering as participants in this study. Also, even if no answer was given to various questions, the data obtained still allowed the study to fulfill the main objective of addressing medical professionals' overall difficulties regarding their safety and concerns.

Recommendations

The field of medicine has come far from the time of the influenza crisis, and the strain from crisis-related uncertainty appears to remain. Whatever those uncertainties may indicate, available resources are now more plentiful and should never be politicized through any government at any level. Therefore, I recommend creating a medical task

force that can be initiated to act in health care crisis to support medical staff, such as during the COVID-19 pandemic, which is critical and necessary. The appointed or volunteer medical task force would be funded by the individual facility and available government grants to support innovative efforts. The participants' collective responses validate this recommendation by exhibiting that supportive guidance through policy is lacking while a protocol is in place.

For this reason, I further recommend that one of the created positions within the medical task force be a policy entrepreneur or someone who looks for an opportunity to make a connection between a major public health problem that needs policy as a solution. According to Kingdon (1984, as cited in Weible & Sabatier, 2018), a policy entrepreneur is an advocate whose position is not defined by any special formalities but invests much time in promoting practical solutions to become adopted into policy. Furthermore, this recommendation will relieve the medical staff's anxiety and fear of the unknown. In addition, mainstream media are urged to be more responsible for delivering information about health care crises.

Policy Implications

Positive social change can begin with policies that help bring safety, clearer mandates, a quicker gathering of medical supplies for staff and their institution, and educating medical staff on preparing for a health care crisis such as COVID-19. Most medical professionals had serious concerns about their safety beyond themselves at work. According to Parsons et al. (2021), taking precautions not to transmit the COVID-19 virus to their family included creating hot and cold zones (hot zones being the spaces and

surfaces that the medical professional would inhabit or touch, cold zones being those designated to family members). The goal is to improve based on what has been learned from previous health care crises.

All major stakeholders should work together and provide supporting evidence about how to get through any health care crisis. COVID-19 changed the world, and a lesson has come from this: to be more initiative taking rather than reactive. In the current study, the empirical implications were found in the participants' unique responses to the questions. The participants in the framework were best described as the hidden participants in the policy stream who had a loose connection to the problem. The information gathered through indirect observation confirmed that reasonable beliefs were agreed upon regarding certain details within the bounds of the phenomenon. For example, the participants said that the framed problem caused by the pandemic did occur. The CDC framed the COVID-19 pandemic as the cause for exposing inequities of critically needed medical resources and disruptions in routine health care, thereby emphasizing that reasonable empirical evidence exists.

Conclusion

My study focused on a local health care facility in a medium-sized Illinois city during the COVID-19 outbreak in 2020–2021. There were serious issues with their policy, supplies (such as PPE), and assistance for care for their medical staff. The COVID-19 pandemic has brought about actions of staying preemptive instead of being reactive. The delay in action caused medical staff to fear for their safety as they tried to care for needy patients. Medical staff should not have had to fear transmitting dangerous

viruses to family and their community. These were only a few of the problems the COVID-19 pandemic health crisis caused, which revealed the need for public policy and how implementation plays a role in the effectiveness of medical services due to the many severely impacted public services that communities depend on.

Effective medical care took on a new form in a technological advance being created as a convenience for medical consultation/treatment during the COVID-19 pandemic and after, using telehealth as the most appropriate option (Lohmeyer, 2021; Menifield & Clark, 2020). However, although telehealth services benefited many, some local governmental entities were divided on appropriate societal restrictions (Ashcraft et al., 2020; Chmielewski, 2020). Those divisions stemmed from a need for more information for local governmental entities on what should be considered substantial support and what is appropriate to incorporate into current public health policies. The literature review confirmed that medical equipment shortages and safety were of great concern to medical professionals interned, creating dilemmas among patients' refusal of services, personnel accountability, loss of trustworthiness of healthcare professionals, and inequality for all medical treatment. Therefore, enacting a policy entrepreneur and task force could bring changes sooner rather than later and may ease the minds of medical professionals.

The basic qualitative inquiry approach with purposive sampling was used to obtain in-depth knowledge about the gap in the literature and the research problem. The overarching question addressed how policy changes and greater support would improve medical professionals' (and facility) needs through a pandemic. The voluntary medical

professionals in this study helped me determine a lack of policy that could ease their anxiety, fears for their safety, and many other concerns during the health care crisis so they could perform their jobs effectively. The participants' professional qualifications increased the data's quality, validity, and reliability, which supported the credible evidence needed. These were essential factors in adding to the developing body of knowledge on crisis support for medical professionals (see Swisher, 2019).

This study may reveal how policy must be adaptive for medical professionals' safety as they do their jobs in the medical field. They deserve to feel safe and assured. They have an oath to bring quality care, and their administration of medical care through local, state, and federal governments should have in-kind policies that help them do their jobs. This practice may bring positive social change among the medical facilities, which will continue to work to heal and practice safe support for the protection and well-being of medical professionals.

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Appendix A: Semistructured Questionnaire

Questionnaire data collection for my Dissertation

Position title:_____

Years of experience:_____

Initial questions

1. When, if at all, did you first experience the increased need for pandemic crisis support?

2. How would you describe the need for crisis support after the onset of the COVID-19 pandemic of 2020-2021?

Intermediate questions

1. What were your thoughts and feelings when you learned about the initial limitations?

2. How did you learn to prepare to adhere to policy and crisis support during COVID-19?

Ending questions

1. What are the most important ways to express a need for crisis support and better policy?

Follow-up question

1. After having experienced this experience, what advice would you give someone new to experiencing a pandemic?

2. Will you support future policy and crises more if faced with another pandemic health emergency?