

Forces to Be Reckoned with: Countervailing Powers and Physician Emotional Distress during COVID-19

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Abstract

The “countervailing powers” framework conceptualizes health care as an arena for power contests among key stakeholders, drawing attention to the moves, countermoves, and alliances that have challenged physicians’ dominance since the 1970s. Here, we focus on one of the lesser known micro-level consequences of such forces for physicians: emotional distress. We draw on 145 interviews with frontline physicians across four U.S. cities during the COVID-19 pandemic to trace physicians’ experiences with three countervailing forces: the state, health care organizations, and patients. We find that threats to physician dominance eroded physicians’ sense of mastery (perceived personal control) at work, thereby prompting emotional distress, including anger and moral conflict. Conversely, in certain cases, acts of resistance may have helped increase mastery, thus moderating distress. Our findings advance the countervailing powers framework by elucidating some of the micro-level, personal consequences of macro-level power struggles and offer practical implications for understanding contemporary threats to physician dominance.

Keywords

countervailing powers, distress, mastery, physician dominance, stress

Since the 1970s, physicians have faced growing challenges by various actors—including governments, third-party payers, courts, and patients, among others—vying for more control over medical matters. In response, sociologists have developed theories of the profession that account for the dynamic, interdependent, and pluralistic nature of power within health care. One such theory, the “countervailing powers” framework,¹ conceptualizes health care as an arena for power contests among key stakeholders. The framework draws attention to the moves, countermoves, and alliances that comprise these contests (Hafferty and Light 1995; Hartley 2002; Light 1995, 1997, 2010). Previous research has explored how physicians strategically push back against and adapt to such countervailing forces as patient empowerment (Vinson 2016), interprofessional competition (Adams and

Curtin-Bowen 2021), and pharmaceuticalization (Vallée 2019).

Less is known, however, about the personal consequences of countervailing forces for physicians themselves—specifically, how such macro forces may contribute to emotional distress at the micro level. Such an examination is particularly timely given current events, including dwindling public

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trust in physicians (Leonard et al. 2022) and increasing legal restrictions on medical practice, including abortion (Sabbath et al. 2024) and gender-affirming care (Mallory, Chin and Lee 2023). With physician authority plainly “under siege” (Stivers and Timmermans 2020), sociology can help to explain how such threats are experienced by individuals, particularly as distress levels are at fever pitch within the profession (Harvey et al. 2021).

In this article, we argue that countervailing forces can contribute to physician emotional distress because they can erode their sense of mastery, or perceived control over given situations in their work—a well-known protector against the negative effects of stress (Aneshensel 1992; Pearlin 1999). We draw on 145 interviews with physicians across four U.S. cities during the COVID-19 pandemic, a time of precipitous change in the health care balance of power. We trace how three countervailing forces—the state, health care organizations, and patients—challenged physicians’ dominance, contributing to different forms of emotional distress. We further explore how physicians’ resistance may have moderated their experiences of distress. We conclude by discussing theoretical implications for the countervailing powers framework and practical implications for physician well-being.

BACKGROUND

A Profession in Flux

Following World War II, during the so-called “Golden Age” of medicine, U.S. physicians enjoyed relatively unconstrained professional autonomy and high degrees of public trust, bolstered by self-employment and a state-sanctioned monopoly over medical matters (Hafferty and Light 1995; Light 1995; Mechanic 1991; Starr 1982). This monopoly, largely predicated on the effectiveness of scientific medicine and the rigor of professional training, was hard-won after decades of professional resistance against competitors to create a health care system that maximized physician rewards (Light 2004). By the late 1960s, however, the advent of private insurance and Medicare/Medicaid coupled with allegations of excessive spending, greed, and poor patient outcomes prompted an accountability backlash by health care corporations and the state. This “buyer’s revolt” (Light 2010) imposed new restrictions on the previously unbridled profession (Hafferty and Light 1995; Light 1995, 2010; Mechanic 1991) and reflected a broader societal distrust in physicians (Light 2004). Managed care

emerged in the 1980s to curb costs and increase efficiency. This led to growing levels of corporatization, bureaucratization, and patient consumerism—all of which constrained physicians’ authority (Light 2010; Mechanic 1991). Such changes left sociologists debating the consequences for the profession, with some concluding that physicians would successfully protect their professional dominance through internal reorganization (Freidson 1985; Mechanic 1991) and others expecting physicians to proletarianize (McKinlay and Arches 1985).

The Countervailing Powers Framework

Scholars have since critiqued professional dominance/proletarianization theorists for focusing on static professional states at single points in time (Light 1995). The debate has shifted toward theoretical perspectives that emphasize the contextual, dynamic, and pluralistic nature of power (Hafferty and Light 1995; Light 1995, 2010). The countervailing powers framework situates professionals within a broader arena of health care actors who actively compete over power (Hafferty and Light 1995; Light 1995). As one party gains power, others respond, sometimes forming complex alliances to counteract power shifts (Hartley 2002). Light (1995) identified at least four competing social actors/powers/parties: the state, the medical industrial complex (including payers and health care organizations), patients/clients, and the medical profession itself. Scholars have since broadened Light’s framework, separating the medical industrial complex into corporate buyers and sellers of health care (Hafferty and Light 1995), dividing the monolithic state into constitutive agencies (Senier, Lee, and Nicoll 2017), adding other health professions (Hartley 2002), and introducing academic/research organizations as additional countervailing forces (Hartley and Coleman 2008).

Medical sociologists have applied the countervailing powers perspective to a broad range of contexts, illustrating its theoretical relevance and utility. Much of this work has focused on the macro level, examining larger-scale power struggles between states, patients, and professions with pharmaceutical companies (Hartley and Coleman 2008; Vallée 2019) or complementary/alternative medicine providers (Almeida and Gabe 2016), for example.

More recently, scholars have engaged in micro-level research exploring how everyday interactions between individuals reflect and indeed constitute the larger countervailing power struggles that are

theorized at the macro level. Significant macro changes in the field may take place over decades (Hafferty and Light 1995:135), but “hidden [micro] forms of resistance” (Adams and Curtin-Bowen 2021) occur regularly—even when a distribution of power appears stable at the macro level (Light 2010). Micro-resistance takes place when individual social actors engage in strategic behavior, including small acts of subversion, aimed at distancing themselves from and “reposition[ing]” against challengers (Hodson 2001; Oh 2017:126). Studies in this vein have explored how resistance gets enacted during mundane interactions between hospitalists and recalcitrant patients (Oh 2017), pediatric specialists and resistant parents (Stivers and Timmermans 2020), and medical trainees and empowered patients (Vinson 2016). Compared to other workers, professionals tend to resist in relatively subdued ways, making micro-resistance often quite subtle—even symbolic (Hodson 2001)—such as a doula narrating what a physician is doing to alert her patient to a procedure she may not have realized was happening (Adams and Curtin-Bowen 2021). A micro-level perspective can thus allow for a better appreciation of how power in health care is eminently dynamic, even when subtle.

Distress: A Micro-level Consequence of Countervailing Powers

A micro-level approach can also shed light on some of the lesser known implications of these power struggles for individual actors. Many macro-level consequences of countervailing powers for the medical profession have been well documented, including the erosion (Pescosolido 2006) or, in certain cases, reinforcement (Hartley 2002; Light 2010; Senier et al. 2017) of physician dominance. In this article, we consider a micro-level consequence for physicians: emotional distress. Only limited research on countervailing powers has considered emotions, such as how trainees are taught to use emotional labor strategically to help manage rising consumerism in health care (Underman and Hirshfield 2016; Vinson and Underman 2020). Without explicitly invoking the countervailing powers framework, Jenkins (2023) linked macro-structural stressors (e.g., corporatization) to burnout and dissatisfaction among pediatricians, arguing that if physicians still enjoy professional dominance, it is because they must absorb such shocks/stressors and “make it work.” Similarly, the moral distress literature examines the relationship between macro-structural forces and feelings of distress

resulting from situations in which clinicians know the right course of clinical action but are unable to carry it out (Buchbinder et al. 2023a; Jameton 1984). However, these framings largely cast physicians as passive or powerless rather than as engaged actors in a dynamic power contest, actively pushing back against threats. Understanding how health care power dynamics shape physicians’ emotional distress is thus critical for theorizing countervailing powers both to anticipate the potential personal consequences of power struggles and to better understand the implications of such consequences for physician behavior. We therefore ask: How do physicians experience dynamic power struggles? And how might their resistance further shape their emotional experiences with such challenges?

There is good reason to believe that countervailing powers may contribute to physicians’ emotional distress. Countervailing powers impinge on physicians’ professional authority and autonomy—the terms and content of their work (Hafferty and Light 1995:141; Pescosolido 2006:28). Countervailing powers can therefore constitute “stressors” insofar as they constitute “external circumstances that challenge or obstruct” one’s ability to “attain sought-after ends” (Aneshensel 1992:16)—including the ability to offer competent medical care, exercise clinical autonomy, and receive expected levels of professional respect. This can lead to “discrepancies between those [external] conditions and characteristics of the individual—his or her needs, values, perceptions, resources, and skills” (Aneshensel 1992:16). The resulting state of arousal is classically defined as stress and can lead to both physical and emotional distress (Aneshensel 1992). Here we focus on the latter, and in accordance with the sociological literature on stress, we define emotional distress broadly to include (1) feelings such as anger and sadness; (2) symptoms of moral distress, including powerlessness and guilt; and (3) symptoms of more enduring psychological distress, such as anxiety or depression, which could indicate underlying psychopathology (Aneshensel 1992; Ross and Mirowsky 2013:395; Schieman 2010).

Countervailing powers may especially reduce physicians’ sense of mastery,³ or perceived control over “the forces that affect their lives” (Pearlin 1999:409), thereby moderating the relationship between stressors and distress. When an individual’s sense of personal control is eroded, they are less able to reduce “discrepancies between those [external] conditions and [their individual] characteristics” (Aneshensel 1992:16), thereby becoming more susceptible to emotional distress (Pearlin

1999; Ross and Mirowsky 2013). Indeed, a lack of control over work conditions is the defining characteristic of moral distress, which is increasingly considered a driver of burnout among clinicians (Sherman and Klinenberg 2024).

Mastery is positively correlated with socioeconomic status (Ross and Mirowsky 2013), so as high-status professionals, physicians may be particularly sensitive to perceived threats to their ability to control and accomplish work (Pearlin et al. 2007). Research in organizational psychology finds that reduced job control in the face of high job demands can cause burnout (Bakker, Demerouti, and Sanz-Vergel 2014). At the same time, because they are powerful actors within the health care arena, physicians may also be able to marshal their individual power to resist challenges through “workarounds,” thereby reducing distress (Buchbinder et al. 2023a). Building on these findings, we argue that countervailing powers contribute to physicians’ emotional distress by reducing their sense of mastery. We further suggest that in certain cases, when physicians use their personal power or agency to resist countervailing powers—even in subtle ways—they may be able to reaffirm their sense of mastery, thereby moderating their emotional experience of countervailing powers.

Study Context: The COVID-19 Pandemic

Our analysis focuses on drivers of physicians’ emotional distress during the COVID-19 pandemic. We conceptualize the pandemic as a formidable “extrinsic force” (Light 1997) that led to a sudden shift in the health care power arena, rendering more visible some of the tensions already predating that shift. Patient trust, for example, decreased rapidly during the pandemic (Leonard et al. 2022) as ideological attacks on medical science grew (Bailey 2020). Federal and local governments suddenly became much more involved in day-to-day U.S. health care operations (Alexander et al. 2022). Health care organizations facing simultaneous logistical and financial crises rapidly enacted policy changes aimed at stemming the damage (Grimm 2021), often without involving health care workers (Shuster and Lubben 2022). Although these changes to the balance of power were abrupt, they represent exaggerated manifestations of preexisting challenges to physician dominance: growing corporatization, increasing interference by the state, and declining patient trust (Light 2004). COVID-19 may thus have been a temporary shock, but the underlying social tensions that it uncovered were long-standing.

The pandemic therefore presents an important case for understanding the relationship between these dynamic forces and physicians’ emotional distress, which was also heightened during that time. This distress manifested in several ways, including increased rates of mental illness (Harvey et al. 2021), burnout, social withdrawal, and hopelessness among physicians during COVID-19 and an uptick in so-called “inappropriate feelings,” such as anger (Price, Seligson and Hollister 2021). Uncertainty and resource shortages during the pandemic were also associated with moral distress among health care workers (Sherman and Klinenberg 2024; Trachtenberg et al. 2023), which has been linked to burnout (Sherman and Klinenberg 2024). These findings help frame our study of how perceived threats from different countervailing powers during the COVID-19 pandemic may have differently shaped physicians’ emotional distress—and how physician responses to these demands, in turn, may have further shaped their experiences.

DATA AND METHODS

We conducted interviews with 145 hospital-based frontline physicians caring for COVID-19 patients during the pandemic as part of two comparative studies: one with physicians in New York City (NYC) and New Orleans (NOLA) and another with physicians in Los Angeles (LA) and Miami (M). Each study was guided by a socio-ecological conceptual model (Buchbinder et al. 2023b; National Academies of Sciences, Engineering, and Medicine 2019) emphasizing how upstream systems factors, such as state and federal policies, institutional practices, and professional norms, shape physicians’ work-related stress. We selected each pair of cities because their initial surges occurred at roughly the same time but in different sociopolitical climates; NYC and LA are in states with more liberal electorates, whereas NOLA and Miami are in states with more conservative electorates, even if the cities themselves are liberal compared to their surroundings. We then recruited physicians from a range of hospitals in each city to examine how organizational and sociopolitical factors contributed to their emotional distress. Both studies received approval from the University of North Carolina-Chapel Hill Institutional Review Board. To protect respondent confidentiality, we identified interviewees using their respondent IDs followed by their self-reported gender and city initial, as applicable.

We recruited participants with assistance from local consultants in each city using email, snowball

sampling, and purposive techniques. Physicians were eligible to participate if they were hospital-based attending physicians or fellows in emergency medicine, hospital medicine, critical care/pulmonology, or palliative care—specialties with the highest contact with COVID-positive patients—who had spent at least four weeks caring for hospitalized COVID-19 patients. We also included some physicians from other specialties who were redeployed to work in COVID-19 units. Our purposive sample included physicians from a range of specialties, career stages, and demographic backgrounds.

The final sample across the two studies included 80 women (55%) and 65 men (45%). Most participants were ages 30 to 49 years ($n = 117$, 81%), White ($n = 103$, 70%), and non-Hispanic ($n = 130$, 90%). Participants worked in hospital medicine ($n = 53$), emergency medicine ($n = 31$), pulmonary/critical care ($n = 35$), palliative care ($n = 13$), and other specialties ($n = 13$), with a mean of 10 years of experience.

We conducted semi-structured Zoom interviews lasting approximately 60 to 90 minutes, with questions about (1) personal and professional backgrounds, (2) onset of the crisis and government and institutional responses, (3) work conditions and stressors, (4) institutional practices and policies, (5) personal well-being, and (6) suggested changes to promote physician well-being. Interviews were audio-recorded and professionally transcribed verbatim. Data collection occurred between February 2021 and October 2021 (NYC and NOLA) and October 2021 and June 2022 (LA and M).

We de-identified interview transcripts and analyzed them using Dedoose software. We followed an abductive analytic approach using both inductively derived and *a priori* themes to arrive at the current theoretical framing (Timmermans and Tavory 2012). We developed and refined a structured coding guide during an initial training period in which at least two researchers independently coded the same transcript. We discussed discrepancies and revised definitions as needed to ensure consistency across users. After coding the first 10% of transcripts and reaching sufficient agreement on procedures to ensure rigor and consistency across coders, the remaining transcripts were then coded by one of five or six coders per study. Uncertainties during coding were discussed and resolved collaboratively with the coding team in weekly meetings. Afterward, we created coding report memos to examine patterns and subthemes across domains and cities. We report findings in the following, with some quotes edited for length, clarity, or confidentiality.

RESULTS

Virtually all respondents reported experiencing some degree of emotional distress during the pandemic, such as feelings of anger, guilt, powerlessness, sadness, and isolation. Sixty-five respondents (44%) specifically reported symptoms of more enduring psychological distress, such as anxiety or depression. In the following, we do not include an exhaustive account of all reported stressors; instead, we focus on stressors from the entire sample that we categorized as falling under one of three different countervailing powers: the state, health care organizations, and patients. A smaller proportion of respondents ($n = 13$, 9%) also identified instances of micro-resistance where they acted in opposition to these countervailing powers. Although small in number, these instances emerged organically during interviews and came up as physicians described how they managed challenges during the pandemic. We discuss these examples where relevant in the following.

For heuristic purposes, we organize the results by each countervailing power, acknowledging that they often overlap and work together as complex “systems of alignments” (Hartley 2002). Visitor policies, for example, could be the product of both the Centers for Disease Control and Prevention (CDC) recommendations and hospital decisions, but we classified them under health care organizations because each hospital sets its own policies, resulting in significant variation across organizations (Jaswaney et al. 2022). We categorized stressors as coming from the state when they referred to policies, statements, actions/inactions, and responses to the pandemic by federal-, state-, and city-level politicians and bureaucrats. We classified stressors as coming from health care organizations when they touched on the decisions and responses of individual hospitals and administrators. Finally, we categorized stressors under patients when they related to physicians’ direct clients and their proxies (e.g., relatives). We did not include the medical profession as a separate countervailing force because physicians did not identify it as a source of distress.

The State

Forty-one percent of physicians across cities found the federal government’s initial politicization of COVID-19 and its promotion of misinformation to be distressing because it challenged their reality and undermined their authority. In Miami, this percentage rose to 67%. One hospitalist, for example,

described the lack of respect shown to health care professionals:

[At the] beginning, for sure, [the federal government's response] was definitely a stressor. It felt like we weren't doing enough, and then it felt like we weren't emphasizing vaccines enough . . . I really wish there had been more respect shown to our leaders in health care, and I wish it wasn't polarizing. (0427, male, M)

Several respondents expressed anger at how "political shenanigans" (0236, female, NOLA) took precedence over biomedical science—an area over which physicians typically exercised authority—and downplayed the severity of the pandemic and the intensity of their work. One physician described President Trump's politicization of the virus as "really discouraging," adding: "To hear someone just making it seem like masks aren't needed . . . was definitely extremely stressful" (0305, female, LA). These physicians viewed the government's politicization of science and medicine as incursions into their domain, resulting in distress and anger.

Other physicians argued that the federal government's politicization of COVID-19 made the pandemic worse, thereby undermining their work. As one physician expressed, "When our former president was saying things that basically created mistrust . . . [it] made the pandemic a lot worse. And by making the pandemic worse, that definitely increased my stress and probably that of every single one of my colleagues" (0302, female, LA). Some blamed the White House for high mortality rates, such as one physician who ranked the federal government's response "really high at the top of [her] list" of stressors, noting: "Honestly, the worst thing that could have happened [happened], and it made all of our jobs 5,000 times harder. . . . Just stop this crazy, crazy banter, this rhetoric that's literally killing people! I blame him [President Trump] for over half of the deaths. They didn't have to occur" (0213, female, NOLA). Excess deaths caused by the federal government's flouting of medical science thus prompted feelings of distress in the physicians who worked tirelessly to mitigate those deaths. Conversely, several respondents expressed relief at the advent of a new administration in 2021, in which health care leaders, such as Dr. Anthony Fauci, were "now free to do the right thing" (0213, female, NOLA).

The federal government's maldistribution of resources also contributed to physician distress.

Although NYC respondents praised the government for initially sending aid to bolster human resources, others were distressed by the Trump administration's relief efforts. One LA-based hospitalist explicitly labeled government funding decisions as "a big stressor," specifically, "seeing their priorities, like releasing emergency funds for meat factories, and not helping with supplies or blood or oxygen" (0318, male). Physicians were especially upset when the government's misallocation of resources deprived them of necessary work tools, such as one palliative care physician who deplored the early oxygen shortage that forced her to ration patients' oxygen supply. When asked how that made her feel, she replied:

Supposedly we live in the U.S., the greatest country in the world . . . and none of that was true. I think one of the hardest things about the pandemic was . . . the disconnect between what was actually happening and what the federal response was. For me, there was a big sense of abandonment. (0131, female, NYC)

Still others expressed anger when the government sent inappropriate resources, like the USNS Comfort, a Navy hospital ship dispatched to NYC early in the pandemic that did not alleviate the burden of treating COVID-positive patients: "It was so ridiculous, I mean, it was so maddening," said one internist (0139, female, NYC). Thus, by misallocating basic and critical resources, the state deprived some physicians of the tools necessary to do their jobs, provoking feelings of distress and anger.

The perceived ineffectiveness of federal agencies, particularly the CDC, was an additional source of distress and frustration. Although technically an autonomous agency, the CDC experienced more government interference during COVID-19 than during previous health crises, which, combined with intraagency bureaucratic failures, led to the CDC's ineffective handling of the pandemic (Schiff and Mallinson 2023). The result was "confusion and . . . chaos" (0106, Male, NYC) as different public health authorities offered conflicting advice. This confusion contributed to physicians' distress: "The lack of a unified voice that knows the science behind it and [is] trying to research the science has been extremely frustrating," one emergency medicine physician said, adding: "The stressors of just watching the lack of research and the lack of guidance I feel from the CDC and from . . . the flippant kind of attitude that I think they've had about this . . .

I think that's been the most stressful thing for me" (0222, male, NOLA). Another emergency medicine physician agreed: "It was definitely confusing because [federal guidelines were] constantly in flux . . . which led to frustration because . . . everyone's already burnt out and work was becoming depressing" (0332, female, LA). This frustration left several physicians feeling "hung out to dry" (0119, female, NYC) by the whole country, particularly the CDC: "I feel like I woke up from a dream about [American exceptionalism]. I mean, the CDC, which is usually considered the best infectious disease public health organization in the world, just became this failing entity" (0116, male, NYC). The CDC's ineffective, chaotic response to the pandemic thus left physicians feeling disillusioned and frustrated.

State and local governmental decisions were also stressors, particularly in Miami, where 47% of respondents expressed such concerns. As one pulmonary-critical care physician explained: "I think we all feel as health care workers that . . . we've been let down, unfortunately, because of some of the [state] policies" (0410, male, M), including, he said, the 2021 appointment of a new state surgeon general with anti-vaccination views. "So, it's become much more politicized," he continued, "which certainly adds to the stress and to the burden of an already stressful job." In contrast, nearly all respondents from other cities felt that their states did a good job and in some cases, even helped buffer the distress caused by the federal government:

[NOLA] did well and . . . to be perfectly honest, I think part of it is because we had a Democratic governor who believed in science, and we had a mayor who also believed in science. And she's had to balance a lot of madness from everybody to try to make sure that the city's safe. (0213, female, NOLA)

Similarly, another physician expressed: "I think I'm lucky living in California and that I felt like at least my local and state government's response . . . was adequate . . . [so] I don't know that [the federal response] added a personal layer of stress" (0303, male, LA). These examples illustrate how dynamic countervailing powers are, with the actions of one state actor—state government—moderating the actions of another state actor—the federal government—shaping physicians' sense of control over the crisis and thus, their distress.

Resistance. State-level stressors prompted some physicians to resist government interference in their

work, such as one internist who frustratedly described the federal stockpile of personal protective equipment (PPE) as a joke: "I mean we were reusing fucking trash bags!" (0231, male, NOLA). He took initiative by contacting a local university's engineering department to start designing and 3-D printing masks, gowns, and BiPap components: "That was one of [my] coping mechanisms. I [would] get home, I [would] jump on a Zoom call and be like, 'All right, I'm going to Lowe's and we're gonna like get PVC piping and we're gonna rig this shit up, you know?' Because . . . we gotta do something!" By reclaiming some control over the terms of his work, which he felt had been threatened by the government's poor planning, this physician was thus able to mitigate some of his frustration.

Still other respondents resisted more symbolically, such as an emergency medicine physician who described how someone placed a "Home of the Brave" banner in the resuscitation room to reclaim some of the recognition that physicians felt was lacking from the state: "That's kind of how we felt . . . despite the country essentially working against us . . . we developed this collective sense of pride that made us feel like we could come into the hospital and keep working" (0119, female, NYC). Through this small act of subversion, she and her colleagues tried to recoup some of the respect that they felt they were owed and foster community at a time when they felt abandoned. In this way, by resisting countervailing forces—even in small, symbolic ways—physicians may have felt more in control of certain aspects of their work.

Health Care Organizations

Respondents were also distressed by their hospitals and administrators interfering with their practice. Physicians already faced decreasing autonomy due to increasing corporatization and bureaucratization long before the pandemic (Light 2010). Some physicians explicitly tied these prepandemic changes to declining quality of care and, in turn, an increased burden of physician distress. The pandemic accelerated this trend due to an onslaught of often haphazard organizational policies specific to COVID-19, which were developed by administrators who were typically distant from patient care. This was especially true in larger hospitals where direct access to leadership was more difficult, making physicians feel less heard and more distressed than in smaller hospitals.

Organizational policies specifically constrained the two aspects of physician autonomy (Hafferty and Light 1995; Pescosolido 2006): control over (1) the

content (patient care) and (2) the terms of medical work (work conditions/safety). These prompted different types of distress, which we describe in turn.

Organizational constraints to the content of medical work. Seven participants mentioned that infection control policies interfered with patient care. Some physicians described being unable to procure necessary diagnostic testing while COVID results were still pending, even for patients presumed to be COVID-negative, with significant consequences for patient health. One physician recounted, “I could not get any further diagnostics on this [minimally responsive] person that I felt were necessary until that [COVID test] came back [negative] seven days later. But she . . . [had] died by day three” (0210, female, NOLA). This physician, still haunted by this case, reflected,

I would not [normally] wait for a test that I don’t think is going to come back positive before I started a diagnostic workup on someone. Would she have died anyway? I have no idea. But that’s the one time where I felt very professionally like this is not how I practice and [I felt] very uncomfortable.

In this case, a hospital policy forced this physician to provide what she perceived as suboptimal care, prompting moral distress.

Forty-eight percent of participants reported that hospital visitation restrictions were a potent source of moral conflict and associated distress. Although most physicians found visitation restrictions reasonable for infection control early on, they made less sense to many over time. One physician criticized them for being “in many cases, very unreasonable and morally injurious” (0301, male, LA). Another physician interviewed in February 2022 described caring for a dying patient the previous week. The patient was COVID-negative and had already experienced significant miscommunication with the medical team. The physician explained,

The patient who was dying had eight siblings. And they were all very, very much involved with her care. And it was very difficult when we said okay, “Two of you can come in, and we will sit down and talk, and the rest of the people can be on a cell phone or Zoom.” I think that that institutional policy really makes care hard. (0330, female, LA)

In this way, visitation policies directly interfered with physicians’ sense of professional autonomy

and their perceived ability to provide good care for patients and families, thereby producing moral distress.

Many physicians expressed further distress that hospital administrators had prioritized revenue over patient care during the pandemic. An emergency medicine physician described how his community hospital held off on canceling elective surgeries until later in the pandemic because it was “very profit-driven” (0315, male, LA). Other hospitals in his city had approached things differently, saying, “We need to put all resources to fixing it and solving it and then we’ll figure out the rest of it on the backend.” A different physician who left his position in emergency medicine said, “A discouraging thing about the medicine in this country is that . . . so much of it is mixed with optics and business. . . . That’s probably I think why I left the ER as I kind of got burned out” (0128, male, NYC).

In this way, physicians demonstrated how corporate medicine was routinely pitted against patient care, thereby compromising their professional integrity and producing distress that was distinctly moral in nature. As a countervailing power, health care organizations were even more dispiriting for physicians than the state because their policies constrained physicians in ways that cut directly to the moral dimensions of medicine, making many physicians distrustful of institutional leaders. As one emergency medicine physician lamented, “They won’t even come down to look at what their policies are doing to human beings. I mean, that’s what I call moral injury” (0313, female, LA).

Organizational constraints to the terms of medical work. The second way that organizational policies constrained physicians’ autonomy was by impinging on their working conditions. This prompted frustration and anger more than moral conflict.

Organizational policies rationing PPE, for example, were distressing for some physicians, particularly early in the pandemic, when 11% of NYC and NOLA respondents cited them as stressors. One physician described how the lack of centralized PPE distribution at her public hospital created a scarcity mindset that “made people feel unsafe, and . . . uncared about” (0203, female, NOLA). More than a year later, she fumed, “They still haven’t listened to us about it. They still haven’t changed.” Such comments reveal how organizational policies that imposed distance between physicians and the supplies necessary to do their work prompted feelings of anger and outrage.

Others decried seemingly irrational policies that not only unnecessarily constrained them but further undermined their confidence in hospital leaders. An emergency medicine physician noted the absurdity of one hospital policy that in order to conserve PPE, deemed a computer station work area “clean,” meaning free of viral exposure, and an area “on the other side of a desk, six inches away” dirty (0120, male, NYC). Describing his department chair’s failure to speak up against this nonsensical policy, he said, “Common sense was lost to [the] administrative party line.” He felt this particular department chair “killed [morale], absolutely, I think, more than anything else”—including patient deaths. This physician longed for both a department head willing to advocate for the faculty and a hospital administration willing to grant emergency department physicians the autonomy to ensure workplace safety using common sense. Another physician shared how “all the administrators were telling people there wasn’t a PPE shortage . . . when there actually was one. So, it creates some distrust, you know?” (0235, male, NOLA).

Frontline physicians also resented having to fight with hospital administrators to have their perspectives acknowledged. One physician described developing a system for exposure notification for employees and then fighting “tooth and nail every step of the way against the C-suite” (0301, male, LA): “That was very frustrating.” Another physician shared how a colleague had tried to warn administrators early about how the coming surge would strain hospital capacity: “He was like, ‘I am livid!’ . . . ‘I feel like I’m pounding on the gates of a palace, and no one’s listening’” (0111, male, NYC). During a time when physicians already felt powerless toward a novel virus, such disregard from organizational leaders further eroded their sense of control over their work, creating frustration and distrust.

Resistance. Although many nonphysician health care workers felt similarly abandoned and disillusioned by their hospitals during the pandemic (Sherman and Klinenberg 2024), physicians had more power to push back (Buchbinder et al. 2023a). Some respondents described ways that they subtly resisted against encroachment on the terms and content of their work by health care organizations, helping them regain control and, in some cases, diffuse distress. Many physicians admitted to sneaking in family members despite visitor restrictions because, in the words of one physician, “Screw that, man! That’s not why I became a doctor” (0301, male, LA). This act of resistance helped him reassert his

sense of purpose in his work as a physician and reduce moral quandaries, potentially mitigating associated distress.

Similarly, an emergency medicine physician noted that “one of the things that made my department . . . feel successful was the fact that we had . . . this sense of permission to break the rules a little if it meant doing the best things for our patients” (0119, female, NYC). This participant directly acknowledged the power that regaining control over patient care had on her and her colleagues’ sense of success. By bending the rules, they could more easily act in their patients’ best interest and thus potentially reduce their exposure to moral distress.

The emotional effects of resistance were not always straightforward, however. One physician who was tasked with overseeing a specialized COVID unit at the beginning of the pandemic was vocally opposed to his hospital’s practice of intubating COVID patients early in their disease course. He responded to this moral dilemma by resisting institutional guidelines: “I really felt that this was right. I felt like I had a message I should get out because . . . I had a duty to the patients. And I honestly didn’t care if they fired me.” After voicing these concerns internally and then sharing them publicly, he was “kicked off that [COVID unit] because I was creating issues within the institution” (0128, male, NYC), eventually prompting him to leave the hospital altogether. Initially, he said, “I wasn’t frustrated when they kicked me out.” Over time, however, he grew angrier with hospital leaders for their intransigence and harsh treatment, suggesting that although his resistance efforts may have helped mitigate moral distress, they did not necessarily eliminate his anger, particularly when his organization retaliated.

Patients

Finally, some physicians identified patients as a countervailing force that interfered with their ability to fulfill basic professional roles. The conventional role of the physician includes that of a healer, advocate, teacher, and communicator. Each of these roles was uniquely compromised during the pandemic, however, thereby undermining fundamental aspects of a physician’s identity, prompting distress and taboo emotions, including anger toward patients.

Although the pandemic was an exceptional situation for hospitals and staff, our findings uncovered transcendent tensions in the patient–physician dynamic. As a crucible of heightened emotions and

uncertainty, the pandemic revealed what happens when doctors on a large scale are vulnerable and overworked and encounter powerful challenges to their authority from patients, making it more difficult to do their work. One physician described a “double whammy” of feeling disrespected and underappreciated by patients while recognizing his responsibility for their lives: “At one point, people were clapping every night and banging their pots and pans for health care heroes, and now it’s like, ‘Well, you know, this is just, like, a conspiracy from Fauci, from the FDA!’ . . . It’s very insulting” (0318, male, LA). Physicians faced sudden and explicit challenges to their expertise from some patients, which undermined their usual sense of control at work and produced feelings of frustration. These feelings became more common as the pandemic progressed and vaccines became more widely available because being unvaccinated became viewed as more of a conscious choice. In NOLA and NYC, where most of our interviews were completed before vaccines were widely available, few physicians reported unvaccinated patients as a source of stress (0 in NYC and 5% in NOLA), whereas such stress was much higher in LA (86%) and Miami (70%), where we collected data once vaccines were more available.

To be sure, respondents’ positive encounters with patients outnumbered the difficult ones; negative experiences, however, were most distressing to physicians. They were also usually linked to patients’ exposure to rampant misinformation, making them more patterned and common during the pandemic than before—so much so that the American Medical Association (AMA) issued a rare statement condemning the “assault on physicians and science” (Bailey 2020). Thus, because these recalcitrant patients explicitly challenged physicians’ dominance (Light 1995), we conceptualize them as a countervailing power.

Misinformation designed to undermine conventional medical expertise was often the trigger for unsettling interactions with patients and families. One physician described these challenges while recounting an ICU shift:

Seven of [the] eight people that were super sick [in the unit] were transfers in from rural places in Louisiana, which were huge areas of Trump supporters, anti-vaxxers, COVID deniers. And their family members were coming in railing about problems with China. . . . They just weren’t really getting it, and they didn’t believe us. (0205, female, NOLA)

Misinformation led to frequent impasses between doctors and patients, with an intensity that was new for many physicians. As one described,

That made me so angry, so angry that I was putting myself at risk and . . . having to talk to families [who were] demanding that we give hydroxychloroquine . . . I had never had that happen before. That was completely new thing to me that people were getting directions from the president about what they should tell their doctors to do. (0236, female, NOLA)

Another physician, who described himself as “a Republican before all this started,” deplored “a lot of the right-wing-driven awfulness we’ve had to deal with,” including being called a “murderer” (0336, male, LA).

The mistrust and political messaging around COVID-19 treatment further intensified once the vaccine was available. Vaccine refusal was a common trigger of moral condemnation among the physicians because the unvaccinated posed a preventable threat to patients, staff, and the entire health system. One physician described how she was unable to educate a patient who fired her for recommending the COVID vaccine prior to beginning chemotherapy: “Now I’m just angry because my job is to provide guidance and the most up-to-date information about the science, and then I’m just getting yelled at about it” (0236, female, NOLA). Frustrations mounted as ICUs began to fill with largely unvaccinated patients. Another physician found himself pitted against his colleagues as he attempted to rein in their frustrations: “I told the doctors and nurses, ‘Please be very mindful of this.’ Because then they would say [in a denigrating tone], ‘Oh, this patient’s not vaccinated.’ Like, What the fuck?” (0334, male, LA). Instead of commiserating with other providers’ quick judgments, this physician tried to encourage them to treat unvaccinated patients no differently than patients who smoked tobacco and developed lung cancer or used alcohol and developed cirrhosis.

Yet for many, patients hospitalized with COVID-19 were distinct from others with preventable conditions because of the highly polarizing political viewpoints tied to vaccine refusal. Even among those who strived to suspend judgment, their reactions were laced with ambivalence:

I think in my mind [about those patients] . . . “Oh, you’re unvaccinated, how could you?” . . . I still treat them like a human being, and I will

hopefully continue to do that till my dying days. . . . But nowadays, I feel like I'm that person. If they're unvaccinated at this point, they've had ample time to do their research, ample time to talk to doctors. (0327, female, LA)

This physician's description of becoming "that person" underscores the consequences of getting frustrated with recalcitrant patients during the pandemic, including guilt and threats to professional identity for many. One participant wanted a patient and their family to leave the hospital if they disagreed with his approach. He said,

[Here was] another patient telling me, "Oh, I know what's best." And I was like, "Well, why are you here to ask me for help? You should stay at home if you can take care of yourself!" You know, the patients now are getting more combative. They bring up conspiracy theories. You know, they're constantly questioning my medical expertise. It's frustrating. It's very dissatisfying work. (0318, male, LA)

This quote is particularly revelatory of the refashioning of the patient-physician relationship and touches on core aspects of physician identity because doctors by definition do not exist without their patients. As physicians increasingly found themselves feeling cynical and at odds with the very people they were tasked with helping, they began to question who they were, how they became that kind of doctor, or in the words of one respondent, "What *Twilight Zone* am I in that I have to endure this while I'm at work?" (0236, female, NOLA).

The anger and erosion of professionalism reached a breaking point for some physicians who considered leaving because their anger with patients had reached an untenable level; one physician even moved out of state. Another explained,

I'm just pissed. I don't want to take care of these people anymore. And I know that sounds terrible and I feel like a terrible person saying it, but you could have prevented this. So, why should I put myself at risk and take care of you? It might be time to get another job because you're not supposed to feel that way [as a doctor]. (0236, female, NOLA)

Resistance. A few physicians actively fought feelings of cynicism by drawing on their internal moral compass to avoid disconnecting from patients emotionally and compromising their care. As one

put it, "That was a really hard thing emotionally for me, to be very obvious with my boundaries with myself and be like, 'I can't cross this line. That's not professional. This is not appropriate to even engage in these conversations'" (0205, female, NOLA). However, sometimes standards were breached, and physicians found themselves on opposing sides from their patients and patients' families. In these cases, resistance did not always make physicians feel better; instead, it could exacerbate feelings of anger, such as in this palliative care physician:

We pride ourselves on being very good with families and giving time and space, but we got to the point where we're sick of hearing that we're killing patients for money. That's so disrespectful. I don't want to hear that from you. And so, we would have a short temper. I mean, all of us I think ended up developing a very short temper, which was wrong, but . . . we would get into verbal arguments with family members. If someone's disrespectful to my staff, I would just tear them a new one over the phone, which I don't know if that's the right thing, but . . . don't fucking talk to my staff like that. And that would obviously escalate and not go well. (0334, male, NOLA)

Although this is not the first time that physicians have had lapses in professionalism navigating the demands of a high-pressure job, the stakes were different at the height of the pandemic. The patient-physician relationship was threatened in an unprecedented way as state and political interests percolated down to the micro level of the clinical encounter, stripping providers of the basic tools of medicine. The politicization of physician expert knowledge and treatment decisions alongside the concomitant anger against patients that surfaced in physicians during the pandemic arguably impacted physicians' sense of self more than other countervailing forces because they cut against basic definitions of medical professionalism. Such distress among participants was existential in nature as politically driven misinformation, patient consumerism, and widespread fear eroded physicians' sense of control over their work, creating an adversarial relationship between patients and physicians and leading some to question their very identity and purpose.

DISCUSSION

This article examined how physicians experience challenges to their dominance and how resistance shapes their experiences of such challenges. We found

that the COVID-19 pandemic created sudden power shifts in the health care field, prompting overt challenges to physicians from at least three countervailing forces: the state, health care organizations, and patients. These challenges interfered with physicians' ability to "attain sought-after ends" (Aneshensel 1992:16), including their customary sense of power and control over medical matters, thereby prompting stress and often emotional distress. Incursions into medicine's technical core, such as organizational policies that interfered with physicians' ability to fulfill ethical obligations to patients, produced moral distress with accompanying guilt and powerlessness in respondents. In contrast, efforts by health care organizations to interfere in physicians' working conditions or by the state and patients to cast doubt over physicians' expertise prompted anger, frustration, and even threats to professional identity when those emotions were directed at patients or their proxies. Reactions to challenges to professional dominance can take multiple forms, but importantly, physicians themselves described these varied emotional responses as types of stress or distress.

Physicians were not always passive in the face of power struggles (Adams and Curtin-Bowen 2021; Oh 2017; Stivers and Timmermans 2020). Their power may have been weakened during the pandemic, but they were not powerless, the way proletarianization theorists might predict (McKinlay and Arches 1985). Some respondents marshaled their individual agency to resist subtly, from the physician in Louisiana who started 3-D printing his own PPE to the many respondents who snuck visitors into hospitals in spite of visitation restrictions. Physicians described efforts to reclaim even symbolic degrees of control over their work as forms of "coping," feeling more "successful," and feeling like they could "keep working" despite "the country essentially working against us." They also used resistance to resolve moral dilemmas, like the physician who snuck in visitors because "[t]hat's not why I became a doctor." In such cases, resistance may have increased their sense of mastery—a key factor known to buffer the effects of stressful circumstances (Pearlin 1999).

In other cases, the emotional impact of resistance was more complicated. One physician's act of overt resistance—publicly denouncing perceived harmful intubation practices—helped mitigate his guilt ("I had a duty to the patients"), but it also prompted retaliation from the hospital in the form of a demotion from the COVID unit, eventually prompting new forms of distress for this physician—specifically, frustration with the institution, to the

point of eventually leaving. Similarly, when physicians acted out against mistrustful or disrespectful patients and their families, their anger sometimes intensified. In such cases, they sometimes acted in ways that countered powerful professional norms, triggering feelings of guilt that made some physicians feel worse. Thus, our findings suggest that micro-resistance against countervailing forces may be beneficial for physicians, but it may also be harmful in certain cases, just as resisting stigmatizing diagnostic labels can both improve and worsen distress among mental health sufferers (Marcussen, Gallagher, and Ritter 2021). Knowing more about how resistance makes physicians feel could be a helpful target for future research.

These findings make three important theoretical contributions to the countervailing powers framework. First, we find that macro-level power struggles can have significant micro-level personal consequences for physicians. Physicians directly pointed to interference by the state, health care organizations, and patients as macro forces that undermined their individual sense of control over their work at a time when their professional services had never been more essential, thereby contributing to various forms of emotional distress. Second, we bridge two as yet disconnected areas of medical sociology: classical research on the stress process with the countervailing powers framework. We find that challenges to physicians' dominance and autonomy can provoke significant distress because they can destabilize physicians' sense of mastery—a well-known protector against the negative effects of stress (Aneshensel 1992; Pearlin 1999). These challenges may be particularly unnerving for professionals such as physicians, who have a long track record of personal achievement (Pearlin et al. 2007). Finally, we draw renewed attention to the foundational importance of resistance in the countervailing powers framework. Our findings suggest not only that micro-resistance happens routinely, as others have found (Adams and Curtin-Bowen 2021; Light 2010; Oh 2017), but that such resistance may have important personal consequences for physicians.

Our findings also underscore the practical relevance of a macro-micro countervailing powers framework. First, it can help us make sense of how the post-COVID landscape may impact individual physicians. Recent laws have restricted medical interventions in obstetrics and gender-affirming care, which used to fall exclusively under physicians' jurisdiction (Mallory et al. 2023; Sabbath et al. 2024). Early evidence suggests that physicians' well-being is

already being threatened by these policies; in one study, 93% of OBGYNs felt that state-level abortion laws had restricted their or their colleagues' ability to provide standard-concordant care, prompting emotional distress in 70% of respondents (Sabbath et al. 2024). Much like the physicians in our study, affected physicians are now facing relatively sudden, unprecedented threats to their sense of control over patient care, with consequences for their mental health. Our findings offer a theoretical framework for understanding these policy consequences while also offering suggestive evidence on how micro-resistance may moderate those effects.

Our findings may also provide insight into how micro-resistance shapes larger macro power dynamics. Alongside the individual reports of resistance mentioned in our study were concomitant large-scale collective action efforts organized by the broader profession to address many of the same issues, including increasing access to PPE (AMA 2022; He et al. 2020), reducing misinformation (AMA 2022; Blankenship, Nakano-Okuno, and Zhong 2021), and debating whether to treat unvaccinated patients (Smith 2021). Although we cannot directly link the micro-efforts in our data to these macro-efforts, future research should consider the relationship between physicians' micro-experiences and their likelihood of engaging in such macro-resistance efforts. Does feeling distressed due to perceived lack of control increase a physician's likelihood of joining a union, for example? Conversely, what are the pathways between macro-resistance efforts and micro-experiences? Would professionally sanctioned civil disobedience of unjust laws (Wynia 2022) mitigate physicians' stress? Additional research in this vein would not only advance scholarly understandings of physician stress but also potentially improve the predictive ability of the countervailing powers framework by better understanding the catalysts and consequences of macro forms of resistance.

Our study has several limitations. First, despite interviewing a large and varied sample of physicians across four U.S. cities, the findings may be limited by selection bias. Some physicians may have chosen not to participate perhaps because they did not feel stressed or more troublesomely, because they were especially traumatized by the pandemic. The findings are also subject to recall bias. We further explicitly sampled physicians from large cities, which means we were unable to capture narratives from rural areas, where differences in resources, politics, and socioeconomic status may have uniquely shaped physicians' experiences. Also,

temporality may have affected the salience of certain themes; Physicians in LA and Miami, for example, were interviewed between October 2021 and June 2022, when COVID vaccines were particularly contentious, whereas respondents in NYC and NOLA were largely interviewed prior to the vaccine becoming widely available, which likely shaped the prominence of certain stressors in their responses. Finally, because of the small sample size, our findings regarding the relationship between resistance and distress should be interpreted with caution and taken up in future research.

In sum, we found that threats from countervailing powers produced emotional distress in physicians. We also found suggestive evidence that resistance to those powers may moderate distress, often for better but sometimes for worse. Our findings advance the theory of countervailing powers by (1) elucidating some micro-consequences of these macro-powers on physicians, (2) linking the theory to sociological research on stress, and (3) underscoring the importance of resistance in the framework by exploring its micro-level impacts on physicians. Future research should continue exploring the relationship between micro-experiences and macro social forces in the health care power arena and in particular, the emotional consequences of micro-resistance.

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NOTES

1. Following the example of some scholars (e.g., Light 2010; Mechanic 1991; Vallée 2019), we use the terms "countervailing forces" and "countervailing powers" interchangeably.

2. Ironically, it was this same professional dominance that sparked the eventual corporatization of medicine and the profession's relative decline—for a full historical account see Light (2004).
3. Although sociologists have used a range of terms to describe mastery, including “self-efficacy,” “locus of control,” and “empowerment/powerlessness,” they all consider personal control to be an essential moderator in the stress process (Ross and Mirowsky 2013).

REFERENCES

- Adams, Crystal, and Mica Curtin-Bowen. 2021. “Countervailing Powers in the Labor Room: The Doula–Doctor Relationship in the United States.” *Social Science & Medicine* 285:114296. doi: 10.1016/j.socscimed.2021.114296.
- Alexander, Mathew, Lynn Unruh, Andriy Koval, and William Belanger. 2022. “United States Response to the COVID-19 Pandemic, January–November 2020.” *Health Economics, Policy and Law* 17(1):62–75.
- Almeida, Joana, and Jonathan Gabe. 2016. “CAM within a Field Force of Countervailing Powers: The Case of Portugal.” *Social Science & Medicine* 155:73–81.
- American Medical Association. 2022. “COVID-19: AMA’s Recent and Ongoing Advocacy Efforts.” <https://www.ama-assn.org/delivering-care/public-health/covid-19-amas-recent-and-ongoing-advocacy-efforts>.
- Aneshensel, Carol. 1992. “Social Stress: Theory and Research.” *Annual Review of Sociology* 18:15–38.
- Bailey, Susan. 2020. “The Assault on Physicians and Science Must End.” <https://www.ama-assn.org/about/leadership/assault-physicians-and-science-must-end>.
- Bakker, Arnold, Evangelia Demerouti, and Ana Isabel Sanz-Vergel. 2014. “Burnout and Work Engagement: The Jd-R Approach.” *Annual Review of Organizational Psychology and Organizational Behavior* 1:389–411.
- Blankenship, Sydney B., Mariko Nakano-Okuno, and Rocksheng Zhong. 2021. “Physicians’ Role in the COVID-19 Infodemic: A Reflection.” *Southern Medical Journal* 114(12):812–14.
- Buchbinder, Mara, Alyssa Browne, Nancy Berlinger, Tania Jenkins, and Liza Buchbinder. 2023a. “Moral Stress and Moral Distress: Confronting Challenges in Healthcare Systems under Pressure.” *The American Journal of Bioethics*. doi:10.1080/15265161.2023.2224270.
- Buchbinder, Mara, Alyssa Browne, Tania Jenkins, Nancy Berlinger and Liza Buchbinder. 2023b. “Hospital Physicians’ Perspectives on Occupational Stress During Covid-19: A Qualitative Analysis from Two Us Cities.” *JGIM* 38(1):176–84. doi: 10.1007/s11606-022-07848-z.
- Freidson, Eliot. 1985. “The Reorganization of the Medical Profession.” *Medical Care Review* 42(1):11–35.
- Grimm, Christi. 2021. “Hospitals Reported That the COVID-19 Pandemic Has Significantly Strained Health Care Delivery: Results of a National Pulse Survey February 22–26, 2021.” Office of Inspector General Report in Brief. <https://oig.hhs.gov/oei/reports/oei-09-21-00140.pdf>.
- Hafferty, Frederic W., and Donald Light. 1995. “Professional Dynamics and the Changing Nature of Medical Work.” *Journal of Health and Social Behavior* 35(Extra Issue):132–53.
- Hartley, Heather. 2002. “The System of Alignments Challenging Physician Professional Dominance: An Elaborated Theory of Countervailing Powers.” *Sociology of Health & Illness* 24(2):178–207.
- Hartley, Heather, and Cynthia-Lou Coleman. 2008. “News Media Coverage of Direct-to-Consumer Pharmaceutical Advertising: Implications for Countervailing Powers Theory.” *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine* 12(1):107–32.
- Harvey, Samuel, Ronald Epstein, Nicholas Glozier, Katherine Petrie, Jessica Strudwick, Aimee Gayed, Kimberlie Dean, and Max Henderson. 2021. “Mental Illness and Suicide among Physicians.” *The Lancet* 398(10303):920–30.
- He, Shuhan, Ayotomiwa Ojo, Adam L. Beckman, Suhas Gondi, Megan Ranney, Marian Betz, Jeremy S. Faust, Esther Choo, Dara Kass, and Ali S. Raja. 2020. “The Story of #Getmepe and Getusppe. Org to Mobilize Health Care Response to COVID-19: Rapidly Deploying Digital Tools for Better Health Care.” *Journal of Medical Internet Research* 22(7):e20469. doi: 10.2196/20469.
- Hodson, Randy. 2001. *Dignity at Work*. Cambridge, UK: Cambridge University Press.
- Jameton, A. 1984. *Nursing Practice: The Ethical Issues*. Englewood Cliffs, NJ: Prentice Hall.
- Jaswaney, Rohit, Arlene Davis, R. Jean Cadigan, Margaret Waltz, Elizabeth Brassfield, Bex Forcier, and Benny Joyner. 2022. “Hospital Policies during COVID-19: An Analysis of Visitor Restrictions.” *Journal of Public Health Management and Practice* 28(1):E299–306.
- Jenkins, Tania. 2023. “Physicians as Shock Absorbers: The System of Structural Factors Driving Burnout and Dissatisfaction in Medicine.” *Social Science & Medicine* 337:116311. doi:10.1016/j.socscimed.2023.116311.
- Leonard, Mary B., DeWayne M. Pursley, Lisa A. Robinson, Steven H. Abman, and Jonathan M. Davis. 2022. “The Importance of Trustworthiness: Lessons from the COVID-19 Pandemic.” *Pediatric Research* 91(3):482–85.
- Light, Donald. 1995. “Countervailing Powers: A Framework for Professions in Transition.” Pp. 25–41 in *Health Professions and the State in Europe*, edited by T. Johnson, G. Larkin, and M. Saks. New York, NY: Routledge.
- Light, Donald. 1997. “The Rhetorics and Realities of Community Health Care: The Limits of Countervailing Powers to Meet the Health Care Needs of the Twenty-First Century.” *Journal of Health Politics, Policy and Law* 22(1):105–45.

- Light, Donald. 2004. "Introduction: Ironies of Success: A New History of the American Health Care 'System.'" *Journal of Health and Social Behavior* 45(Extra Issue):1–24.
- Light, Donald. 2010. "Health-Care Professions, Markets, and Countervailing Powers." Pp. 270–89 in *Handbook of Medical Sociology*, edited by C. E. Bird, P. Conrad, A. M. Fremont, and S. Timmermans. Nashville, TN: Vanderbilt University Press.
- Mallory, Christy, Madeline Chin, and Justine Lee. 2023. "Legal Penalties for Physicians Providing Gender-Affirming Care." *JAMA* 329(21):1821–22.
- Marcussen, Kristen, Mary Gallagher, and Christian Ritter. 2021. "Stigma Resistance and Well-Being in the Context of the Mental Illness Identity." *Journal of Health and Social Behavior* 62(1):19–36.
- McKinlay, John, and Joan Arches. 1985. "Towards the Proletarianization of Physicians." *International Journal of Health Services* 15(2):161–95.
- Mechanic, David. 1991. "Sources of Countervailing Power in Medicine." *Journal of Health Politics, Policy and Law* 16(3):485–98.
- National Academies of Sciences, Engineering, and Medicine. 2019. *Taking Action against Clinician Burnout: A Systems Approach to Professional Well-Being*. Washington, DC: The National Academies Press.
- Oh, Hyeyoung. 2017. "Resisting Throughput Pressures: Physicians' and Patients' Strategies to Manage Hospital Discharge." *Journal of Health and Social Behavior* 58(1):116–30.
- Pearlin, Leonard. 1999. "The Stress Process Revisited." Pp. 395–415 in *Handbook of the Sociology of Mental Health*, edited by C. Aneshensel and J. Phelan. New York, NY: Kluwer Academic.
- Pearlin, Leonary, Kim Nguyen, Scott Schieman, and Melissa Milkie. 2007. "The Life Course Origins of Mastery among Older People." *Journal of Health and Social Behavior* 48(2):164–79.
- Pescosolido, Bernice. 2006. "Professional Dominance and the Limits of Erosion." *Society* 43(6):21–29.
- Price, Gary, Robert Seligson, and Ripley Hollister. 2021. "2021 Survey of America's Physicians COVID-19 Impact Edition: A Year Later." <https://physiciansfoundation.org/wp-content/uploads/2021-Survey-Of-Americas-Physicians-Covid-19-Impact-Edition-A-Year-Later.pdf>.
- Ross, Catherine, and John Mirowsky. 2013. "The Sense of Personal Control: Social Structural Causes and Emotional Consequences." Pp. 379–402 in *Handbook of the Sociology of Mental Health*. 2nd ed., edited by C. S. Aneshensel, J. C. Phelan, and A. Bierman. New York, NY: Springer.
- Sabbath, Erika, Samantha McKetchnie, Kavita Arora, and Mara Buchbinder. 2024. "Us Obstetrician-Gynecologists' Perceived Impacts of Post-Dobbs v Jackson State Abortion Bans." *JAMA Network Open* 7(1):e2352109. doi:10.1001/jamanetworkopen.2023.52109.
- Schieman, Scott. 2010. "The Sociological Study of Anger: Basic Social Patterns and Contexts." Pp. 329–47 in *International Handbook of Anger: Constituent and Concomitant Biological, Psychological, and Social Processes*, edited by M. Potegal, G. Stemmler, and C. Spielberger. New York, NY: Springer.
- Schiff, Eleanor, and Daniel Mallinson. 2023. "Trumping the Centers for Disease Control: A Case Comparison of the CDC's Response to COVID-19, H1N1, and Ebola." *Administration & Society* 55(1):158–83.
- Senier, Laura, Rachel Lee, and Lauren Nicoll. 2017. "The Strategic Defense of Physician Autonomy: State Public Health Agencies as Countervailing Powers." *Social Science & Medicine* 186:113–21.
- Sherman, Melina, and Eric Klinenberg. 2024. "Beyond Burnout: Moral Suffering among Healthcare Workers in the First COVID-19 Surge." *Social Science & Medicine* 340:116471. doi:10.1016/j.socscimed.2023.116471.
- shuster, stef, and Noah Lubben. 2022. "The Uneven Consequences of Rapid Organizational Change: COVID-19 and Healthcare Workers." *Social Science & Medicine* 315:115512. doi:10.1016/j.socscimed.2022.115512.
- Smith, Timothy M. 2021. "No COVID-19 Vaccination, No Care? Why That's the Wrong Path." American Medical Association. <https://www.ama-assn.org/delivering-care/ethics/no-covid-19-vaccination-no-care-why-s-wrong-path>.
- Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York, NY: Basic Books.
- Stivers, Tanya, and Stefan Timmermans. 2020. "Medical Authority under Siege: How Clinicians Transform Patient Resistance into Acceptance." *Journal of Health and Social Behavior* 61(1):60–78.
- Timmermans, Stefan, and Iddo Tavory. 2012. "Theory Construction in Qualitative Research." *Sociological Theory* 30(3):167–86.
- Trachtenberg, Sophie, Tara Tehan, Sara Shostak, Colleen Snyderman, Mariah Lewis, Frederic Romain, Wendy Cadge, et al. 2023. "Experiences of Moral Distress in a COVID-19 Intensive Care Unit: A Qualitative Study of Nurses and Respiratory Therapists in the United States." *Nursing Inquiry* 30(1):e12500. doi:10.1111/nin.12500.
- Underman, Kelly, and Laura Hirshfield. 2016. "Detached Concern? Emotional Socialization in Twenty-First Century Medical Education." *Social Science & Medicine* 160:94–101.
- Vallée, Manuel. 2019. "The Countervailing Forces behind France's Low Ritalin Consumption." *Social Science & Medicine* 238:112492. doi:10.1016/j.socscimed.2019.112492.
- Vinson, Alexandra. 2016. "'Constrained Collaboration': Patient Empowerment Discourse as Resource for Countervailing Power." *Sociology of Health & Illness* 38(8):1364–78.
- Vinson, Alexandra, and Kelly Underman. 2020. "Clinical Empathy as Emotional Labor in Medical Work." *Social Science & Medicine* 251:112904. doi:10.1016/j.socscimed.2020.112904.

Wynia, Matthew. 2022. "Professional Civil Disobedience—Medical-Society Responsibilities after Dobbs." *New England Journal of Medicine* 387(11):959–61.

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