1. Marginalization
   1.1. Due to race
   1.2. Outsider status
2. Racism
   2.1. Active discrimination
   2.2. Being visible minority
3. Pre-existing leadership roles (helped people feel better prepared)
   3.1. EMS
   3.2. Military
   3.3. University research lead
   3.4. Chief
      3.4.1. Greater feeling of empowerment
      3.4.2. Actively fostering connection between colleagues
   3.5. Disaster medicine specialist
   3.6. ER director
   3.7. Vice president of hospital medical staff association
4. New (post-COVID) leadership roles - feeling empowered
   4.1. “Disaster Specialist” part of Incident Management Team for hospital
      4.1.1. Was able to demonstrate skills to peers
      4.1.2. “Covid Lead”
   4.2. PPE training and simulations
5. Reasons for missing shifts - feeling guilty
   5.1. Mild symptoms of COVID-19
      5.1.1. Would have worked a shift before COVID-19
   5.2. Needing COVID-19 swab
   5.3. Travel
      5.3.1. Locums who cover shifts (mandatory isolation)
   5.4. Redeployment
      5.4.1. Emergency Operations Centre
   5.5. Opting out of shifts for self-protection
   5.6. Giving shifts away for own well being
6. Reasons for covering for other colleagues
   6.1. Covering for locums who travelled in to work and could not
   6.2. “Wanted to be there” to help colleagues at beginning of pandemic
   6.3. Vacation plans cancelled
   6.4. Mild URI symptoms
   6.5. Unrelated medical issue with increased risk for COVID
   6.6. Increased availability due to cancelled work
   6.7. Overworking as a coping mechanism
7. Pandemic fatigue
   7.1. “Post-deployment blues”
   7.2. Anticlimactic preparation - Waiting for Godot
   7.3. Increased complexity of routine tasks
   7.4. PPE fatigue
      7.4.1. Cognitive load
      7.4.2. Perceptions of difficulty
   7.5. Information bombardment
      7.5.1. Social media fatigue
7.5.2. Needing to rapidly learn more about COVID
7.5.3. Conflicting information

7.6. Fatigue of consultants

8. Work environment

8.1. Usual culture of ED use
   8.1.1. Entitled patients
   8.1.2. Low acuity, non-emergent cases
   8.1.3. New specialty on the block
   8.1.4. Catch all (safety net)
   8.1.5. Overcrowding

8.2. Feelings & zeitgeist

8.2.1. Fear/anxiety
   8.2.1.1. Lack of knowledge of COVID-19
   8.2.1.2. Uncertainty about...
       8.2.1.2.1. Life during the pandemic
       8.2.1.2.2. Natural history of COVID-19 as a disease
   8.2.1.3. Fear...
       8.2.1.3.1. For patients
       8.2.1.3.2. For colleagues / profession
       8.2.1.3.3. For family
       8.2.1.3.4. Of lack of PPE
       8.2.1.3.5. Of workforce ramifications
       8.2.1.3.6. For personal health
       8.2.1.3.7. About medical exams
   8.2.1.4. Vigilance of potential exposure to others
   8.2.1.5. Lack of transparency from Province/Leadership
       8.2.1.5.1. Unclear rationale for decisions [resources vs. evidence best practice]
       8.2.1.5.2. Lack of practical acknowledgement for healthcare workers

8.2.2. Anger/frustration
   8.2.2.1. Feeling dismissed by admin
   8.2.2.2. Frustration with colleagues not wearing masks social distancing
   8.2.2.3. Frustration with colleagues for not taking leadership roles/participating in system planning
   8.2.2.4. Frustration with COVID-19 self screening and whether to go to work
   8.2.2.5. Frustration with other essential sectors for expecting healthcare workers to take extra risks but not doing the same
   8.2.2.6. Frustration with extra burden in the ER (more sick, lack of primary care, etc)

8.2.3. Need for control
   8.2.3.1. Helplessness

8.2.4. Pride (524)
   8.2.4.1. Admiration for colleagues
   8.2.4.2. Admiration for and supported by administration
   8.2.4.3. Cohesiveness with other facilities/good interfacility communication

8.2.5. Sense of purpose
   8.2.5.1. Feeling validated for professional work

8.2.6. Feeling overworked/overstimulated
   8.2.6.1. Bleeding of work into life, lack of work/life divide
   8.2.6.2. Bombardment about COVID-19 via social media
8.2.6.3. COVID information overload
8.2.6.4. Maintaining long work hours despite being COVID+
8.2.6.5. Too much email

8.2.7. Relief
8.2.7.1. Prepared
8.2.7.2. After infection, now immune

8.2.8. Isolation/desire for human connection
8.2.9. Soul crushing experiences

8.3. Systems changes to COVID
8.3.1. Development of hot & cold zones
8.3.2. New innovations
8.3.2.1. Separating different zones
8.3.2.1.1. Hot/cold mixed
8.3.2.1.2. Renovations to existing units
8.3.2.2. Drive-through services
8.3.2.3. 3-D printing
8.3.2.4. Virtual care
8.3.2.5. Ideas for new innovations
8.3.2.6. Virtual meetings
8.3.2.7. Improved protocols
8.3.2.8. Increased patient care areas
8.3.2.8.1. Tents
8.3.2.8.2. Additional ICU
8.3.2.9. Hearing aids for patients
8.3.2.10. Check-ins for physician well being
8.3.2.11. Cohorting staff based on COVID risk
8.3.2.12. Procedural supply kits
8.3.2.13. Virtual translator
8.3.2.14. Increased housekeeping and cleaning
8.3.2.15. Pictures on scrubs

8.3.3. Interdepartmental collaboration/code blue teams
8.3.3.1. Failed airway team

8.3.4. Wearing universal PPE
8.3.4.1. Changes the way you relate to patients
8.3.4.2. Fear with regard to PPE efficacy
8.3.4.3. Inadequate PPE standards
8.3.4.4. Out of supplies
8.3.4.5. No choice in PPE, strict protocols
8.3.4.6. Protected code blue

8.3.5. Staffing of physicians
8.3.5.1. Additional call system (unpaid)
8.3.5.2. Additional backup system
8.3.5.3. Calling back retired physicians
8.3.5.4. Impact of pre-shift screening
8.3.5.5. Keeping empty shifts empty (impact of low volumes on schedule)

8.3.6. Changes in compensation
8.3.6.1. Unpaid work
8.3.6.1.1. Call
8.3.6.2. Pay changes decrease
8.3.6.3. Pay changes increase
8.3.6.4. Lack of hazard/pandemic pay

8.3.7. Resources changes/increasing complexities
  8.3.7.1. Availability of consultants
  8.3.7.2. Changes to patient care
  8.3.7.3. Availability of specific tests
  8.3.7.4. Difficulties with standardizing new protocols
  8.3.7.5. Shift in responsibilities

8.3.8. Cultivating a sense of community/togetherness
  8.3.8.1. Support group
  8.3.8.2. Town halls with leadership

8.3.9. Wake up call
8.3.10. New influx of COVID patients
8.3.11. Crowded staff environments
8.3.12. Visiting policy changes
8.3.13. Systems change failures
  8.3.13.1. Did not use new procedures/used old procedures

8.4. Teamwork
  8.4.1. Reasons for improved teamwork
  8.4.2. Positives
    8.4.2.1. Sense of solidarity, team building
    8.4.2.2. Commonality of experience (being “in the trenches”)
    8.4.2.3. Greater empathy for colleagues
  8.4.3. Negatives
    8.4.3.1. Hero worship of single individual (not recognizing team or luck?)
    8.4.3.2. Not a war situation
    8.4.3.3. Disappointment in lack of teamwork
      8.4.3.3.1. Loss of team-bonding due to isolation/distancing
    8.4.3.4. Scapegoating staff due to outbreaks or infection
      8.4.3.4.1. Long-term care workers

8.5. Desire for better resources/planning
  8.5.1. Better isolation facilities
  8.5.2. Palliative care resources
  8.5.3. Inequalities with rural communities
  8.5.4. Harder to recruit adequate staffing
  8.5.5. Better communication with non-hospital facilities (eg. long-term care, walk-in clinic)
  8.5.6. Better and more PPE
  8.5.7. Increased training before event (pre-planning)
  8.5.8. Structural changes/physical plant
    8.5.8.1. Negative pressure rooms
  8.5.9. COVID testing availability for healthcare workers

9. The experience of physicians’ families
  9.1. Fear
  9.2. New home protocol
  9.3. Explaining to kids
  9.4. Hard on partner
  9.5. Unable to (choosing not to) isolate from family within the home
9.6. More time with family
9.7. Socializing with those not fearful of COVID
9.8. Loss of alternate care givers and childcare
9.9. Isolation from family outside of household
9.10. Separation from core family members

10. Overall experience during the pandemic
10.1. Early (first 3 weeks) = enthusiasm
10.1.1. Fear of going outside
10.1.2. Not what they expected
10.1.3. Fear of spreading COVID
10.1.3.1. Bringing COVID home to family
10.1.4. Uncertainty about COVID
10.1.5. Lack of pandemic preparedness
10.1.5.1. Overwork of administration/leaders
10.1.5.2. Inadequate admin support for physician leadership
10.1.5.3. Poor coordination with public health unit
10.1.6. Increased responsiveness from other hospital colleagues
10.1.7. Quality improvement
10.1.7.1. Improvisation
10.1.7.2. Rapidly changing protocols
10.1.7.3. Simulations
10.1.8. Feeling appreciated by public
10.1.8.1. Temporary appreciation
10.1.9. Patient care more difficult (PPE, fear of COVID, new protocols)
10.2. Middle (4-7 weeks)
10.2.1. Chronic & usual illnesses that were ignored now acute ill
10.2.2. Lower volumes
10.2.2.1. Decreased mental health patients
10.2.2.2. Decreased waiting times
10.2.2.3. Increased time to spend with patients
10.2.3. Fear for patients not presenting even though sick
10.2.4. Fear for patients who have had elective surgeries cancelled
10.2.5. End-of-life care
10.2.6. Less fear of COVID due to immunity
10.2.7. Pandemic effect on elderly patients
10.3. Late (weeks 8+) = annoyance with PPE, increasing volumes
10.3.1. Return to pre-COVID-19 behaviours
10.3.2. Anxiety
10.3.2.1. Provider dissipation of anxiety
10.3.2.2. Increase in patients with anxiety issues
10.3.3. Complacency with PPE
10.3.3.1. Personal
10.3.3.2. Supply stock
10.3.4. Lack of primary care providers/resumption of healthcare services occurred at different rates
10.3.5. General supplies unavailable
10.4. 4th wave (beyond initial 3 waves) - economic/psychosocial
10.4.1. Increased stressors for patients
10.4.2. Psychosocial supports for healthcare workers
   10.4.2.1. Lack of supports
   10.4.2.2. Presence of supports

10.5. Bracing for 2nd wave of COVID-19/recurrence

11. Desire for change in the healthcare system
   11.1. Entire system needs to be blown up and reassembled
      11.1.1. Desire to end hallway medicine
      11.1.2. Functioning electronic medical record
      11.1.3. Lack of primary care access for patients (driving ED volumes/poor care)
   11.2. Inadequate pandemic response for provision of medical supplies/equipment
   11.3. Inappropriate utilization and distribution of specialists and experts
   11.4. Improved communication required
      11.4.1. Bad communication from health authority
      11.4.2. Unified electronic health record
      11.4.3. Intercommunication issues between ED staff
      11.4.4. Communication with patients and family
      11.4.5. Sharing of resources/learnings
      11.4.6. Check ins for physician well being
   11.5. Overcrowding in emerge
   11.6. Need for change in outpatient services
      11.6.1. Poor patient flow through the department/hospital

12. Desire for change outside of the healthcare system
   12.1. Closing of borders

13. Physician health & well-being
   13.1. COVID-19 illness
   13.2. Other health
      13.2.1. Mental health deterioration
      13.2.2. Physical health deterioration
   13.3. Effects of pandemic on physician life
      13.3.1. Physical distancing/quarantine
      13.3.2. Cancelling of major life events
      13.3.3. Continuing education cancelled
      13.3.4. Physical activity/exercise
      13.3.5. Called back from vacation
      13.3.6. More time to be with family due to self-isolation
      13.3.7. New long-term goals
      13.3.8. Social Isolation from others
   13.4. Coping mechanisms
      13.4.1. Increased physical activity/exercise
      13.4.2. Engaging in hobbies
      13.4.3. Keeping in contact with friends and family
      13.4.4. Overworking
      13.4.5. Identifying as a hero
      13.4.6. Acknowledging benefits of...
      13.4.7. Being with nature
      13.4.8. Less time spent watching the news
      13.4.9. More time spent watching the news
      13.4.10. Meditation
13.4.11. Maintaining/reinforcing self-awareness techniques
13.4.12. Increased virtual meetings with friends/family
13.5. Dissatisfaction with career
13.6. Financial worries