Safety, Autonomy, Discrimination, and Religious Exemptions:
Three Papers on How Long-Term Care Facility Staff Navigate Conflicting Rights

by

Angela K. Perone

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Doctoral Committee:

Emeritus Professor Berit Ingersoll-Dayton, Co-Chair
Associate Professor Sandra R. Levitsky, Co-Chair
Professor Elizabeth A. Armstrong
Professor Ruth E. Dunkle

Angela K. Perone

peronea@umich.edu

ORCID iD: 0000-0002-3307-9662

Dedication

Dedicated to my wife Cassie and son Oliver for their perpetual love and laughter and to nursing facility staff and residents whose daily experiences, challenges, and creative problem-solving left me constantly learning more.

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ABSTRACT

Individual rights are revered in the United States. As political polarization has grown, media attention has increasingly focused on how this polarization presents conflicting rights between liberals and conservatives. However, this dichotomy may be overstated and more nuanced on the ground, particularly in healthcare, given the centrality of patient care. Long-term care facilities present an ideal case for studying conflicting rights in healthcare as spaces where residents receive 24-hour residential care in an increasingly patient-centered workplace. This dissertation examines how long-term care healthcare staff navigate three areas of conflicting rights: (1) safety and autonomy rights among residents; (2) staff rights to a workplace free of discrimination and resident rights to autonomy and decision-making; and (3) staff rights to religious freedom and resident rights to quality care.

This three-paper dissertation employs a multi-method qualitative comparative case study of three levels of staff in long-term care facilities to examine how staff understand and respond to conflicting rights. Data includes in-depth semi-structured interviews (n = 90) of three levels of staff (floor staff, mid-management, upper-level management), observation of staff meetings (n = 30), review of facility policy documents (n = 376), and review of federal and state laws on fall prevention, food intake, and medication management. The first empirical study (Chapter 2) incorporates all four types of data to include an in-depth case comparison between two facilities and three levels of staff, whereas the other two empirical studies (Chapters 3 and 4) incorporate only the semi-structured interviews to compare three levels of staff.

Data from these three empirical studies reveal several key findings. First, staff at all three levels relied on interprofessional teams across staff hierarchy to navigate conflicting rights, particularly regarding residents' rights to safety and autonomy (i.e., fall prevention, food intake, and medication management). Second, while sex and race-based discrimination from residents was common, staff rarely reported discrimination. Staff often framed discrimination experiences as a condition of employment or attributed discrimination to residents' health or cognitive status, which precluded staff from naming experiences as discrimination, blaming residents, and claiming their rights and reporting discrimination. Third, when confronted with religious exemptions, staff moved beyond dominant juxtapositions of religious liberty and equality to center patient care. By foregrounding patient care, staff reconciled cultural discord (competing cultural frames) and achieved social coherence (a justifiable conclusion after harmonizing conflicting principles) in ways that still permitted some staff to support both nondiscrimination principles for LGBTQ residents and religious exemptions by staff (exclusions to providing care based on religious or moral reasons). While team approaches, understandings of discrimination, and approaches to social coherence varied among staff level, all staff experienced conflicting rights while working at a long-term care facility. This dissertation examines the complexities and nuances of their understandings and responses to conflicting rights and presents implications for theory, social work practice, and social policy.

CHAPTER 1: INTRODUCTION

A growing polarization around individual rights has emerged in the United States (Bose, 2019; Heltzel & Laurin, 2020) and sparked significant debate about conflicting rights, particularly in healthcare (Erstad, 2019; Huq, 2021; Raifman & Galea, 2018). Amidst the COVID-19 pandemic, policies mandating that individuals wear masks spurred protests from Americans who stressed individual liberty and autonomy over public health and safety. The stakes are even higher in healthcare when healthcare workers must resolve questions regarding conflicting rights that could affect quality of life and mortality. Conflicting rights in healthcare can emerge when patients present issues that require healthcare workers to make determinations about patient care (e.g., patient autonomy or safety) or when patients assert rights (e.g., autonomy) that may conflict with staff rights (e.g., nondiscrimination). Staff may also assert individual rights (e.g., religious exemptions) that conflict with patients' rights to care.

Long-term care facilities present an ideal case study to examine conflicting rights, particularly in healthcare, given the centrality of patient care as well as growing concern for workers' rights in the wake of COVID-19. Long-term care facilities provide residential care for older adults and people with disabilities. Because long-term care facilities serve a particularly vulnerable population, state and federal governments heavily regulate them, especially if they receive federal funding from Medicare or Medicaid (Hardy, 2012; Swagerty, 2014). The Nursing Home Reform Act (2010 [1987]) includes a Residents' Bill of Rights that outlines various rights for nursing home residents, including quality of life, the right to be fully informed and participate in one's care, the right to privacy and confidentiality, the right to dignity, freedom, and respect,

the right to visitors, and the right to make independent choices. Staff also enjoy rights to be free from discrimination based on race, color, sex, national origin, and religion (Civil Rights Act, 1964). As obligations for long-term care facilities have burgeoned, a cultural shift has resulted in a new emphasis on de-institutionalization of nursing homes, a focus on person-centered care (Zimmerman et al., 2014), and improved worker conditions (Grabowski et al., 2014; Koren, 2010). Conflicting rights can emerge in long-term care when residents' own rights conflict (e.g., autonomy versus safety) and when residents rights (e.g., autonomy) conflict with staff rights (e.g., nondiscrimination, religious liberty). This dissertation examines conflicting rights through five research questions in the following chapters:

1. How do long-term care facility staff understand and respond to conflicting rights for residents involving safety and autonomy? (Chapter 2)
2. How do long-term care facility staff from three occupational levels understand experiences of discrimination by residents? (Chapter 3)
3. Why do long-term care facility staff underreport experiences of discrimination by residents? (Chapter 3)
4. How do long-term care facility staff respond when colleagues refuse care to LGBTQ residents because of individual or moral beliefs? (Chapter 4)
5. Why do long-term care facility staff who support nondiscrimination principles for LGBTQ people also support religious exemptions among staff? (Chapter 4)

Conceptual and Theoretical Frameworks

This dissertation uses several conceptual and theoretical frameworks to examine how long-term care facility staff navigate conflicting rights: street-level bureaucracy theory (Lipsky,

2010), legal consciousness theory (Ewick & Silbey, 1998; Hirsh & Lyons, 2010; Hoffmann, 2003), social coherence (Tebbe, 2017), and cultural frames (Cucchiara, 2020; Goffman, 1974). These conceptual and theoretical frameworks help answer this dissertation's research questions examining how three levels of staff navigate conflicting rights in long-term care facilities.

Street-level-bureaucracy theory provides a theoretical framework for examining how long-term care facility staff exercise discretion to resolve conflicting rights regarding resident safety and autonomy. Street-level-bureaucracy theory examines how policy emerges from the ground up (Lipsky, 2010). "Street level bureaucrats" refer to workers who use their discretion on-the-ground to interpret and implement vague and ambiguous rules. Long-term care facility staff provide resident care under a complex set of regulations, rules, and policies. When these regulations, rules, or policies are vague or ambiguous, staff use their discretion to interpret how they should respond on the ground. An emerging body of research has begun applying street-level bureaucracy theory to healthcare (Forsyth & Mason, 2017; McHugh et al., 2020; Walton et al., 2019) but has not yet applied this theory to long-term care settings. Moreover, no study known to this author has employed street-level bureaucracy in the context of conflicting rights. Chapter 2 uses street-level bureaucracy theory to examine how staff use their discretion to resolve conflicting residents' rights between safety and autonomy when vague and ambiguous policies present no clear guidance.

Legal consciousness theory describes how individuals invoke legal concepts, such as race and sex discrimination, to define everyday experiences (Ewick & Silbey, 1998; Hirsh & Lyons, 2010; Hoffmann, 2003). Long-term care comprises a heavily regulated industry that grants significant rights to residents as patients and consumers that could shape how workers understand their own rights to nondiscrimination. Chapter 3 uses legal consciousness theory to

examine how long-term care facility staff at three levels understand experiences as potential discrimination when staff rights (e.g., nondiscrimination) may conflict with resident rights (e.g., quality care, autonomy) and how these understandings shape underreporting.

Social coherence (Tebbe, 2017) describes a process of reflection that individuals use to harmonize conflicting principles and reach a justifiable conclusion. Tebbe (2017) introduced this concept to describe how policymakers and judges could reconcile conflicts regarding religious exemptions, which allow individuals and organizations to avoid adherence to laws and policies because of their religious or moral beliefs. I argue that social coherence can also include an outcome (e.g., a decision) that one reaches through this process of reflection. Thus, social coherence includes both the process of reconciling conflicts and the final resolution such that one engages in a process of social coherence and can achieve social coherence once they resolve any conflicts. Long-term care facility staff at varying levels may apply different cultural frames – mental structures, or schema, that guide one's actions and help make sense of ideas and experiences (Cucchiara, 2020; Goffman, 1974) – to determine how to reconcile religious exemptions to care that other staff assert. When staff refuse to provide care to a resident based on moral or religious beliefs, their colleagues must reconcile what I call "cultural discord," or conflicts among cultural frames to ensure that the resident continues to receive quality care. Chapter 4 uses conceptual frameworks for social coherence (Tebbe, 2017) and cultural frames (Cucchiara, 2020; Goffman, 1974) to examine how long-term care facility staff navigate religious exemptions by other staff and why staff can support both nondiscrimination and religious exemption principles in long-term care facilities.

Design and Methods

This dissertation incorporates a multi-method qualitative comparative case study design (Meier, 2015; Mills, Durepos, & Wiebe, 2012) that compares three levels of staff in long-term care facilities in three studies. This dissertation's three studies compare floor staff, mid-level management, and upper management to examine how different levels of staff respond to conflicting rights. Floor staff (e.g., floor nurses, certified nursing assistants), mid-level managers (e.g., nurse managers, social workers), and upper managers (e.g., directors of nursing, administrators) have varying levels of discretion and resident interaction that may shape how they respond to conflicting rights regarding autonomy and safety (Chapter 2), resident autonomy and staff nondiscrimination (Chapter 3), and LGBTQ resident care and staff religious exemptions to caregiving (Chapter 4).

The first empirical study (Chapter 2) also includes a comparison between two facilities (corporate structure versus independent facility). While both facilities are nonprofits, one is an independent facility, and the other facility is affiliated with a larger corporation that has other facilities throughout Michigan. This distinction allows for more in-depth comparison in how organizational structure may shape how staff engage in street-level-bureaucracy in Chapter 2. On the one hand, staff at a corporate facility may have access to more resources that could expand staff's confidence in exercising discretion. On the other hand, staff at a corporate facility may feel constrained to exercise discretion if a larger hierarchical structure (including management at a corporate headquarters external from the facility) dictates facility policy and practice. Additional hierarchy embedded in a corporate structure may provide more written policies than an independent facility that could provide either clear guidance (and thus less need to exercise discretion) or ambiguous and conflicting guidance (and thus more need to exercise discretion).

Data incorporates in-depth semi-structured interviews of facility staff (n = 90) at three levels (floor staff, mid-management, upper management) (*See* Appendix A: Interview Protocol), observation of staff meetings (n = 30), review of facility policy documents (n = 376), and review of federal and state laws on fall prevention, food intake, and medication management. The first empirical study (Chapter 2) incorporates all four types of data to include an in-depth case comparison between two facilities and three levels of staff, whereas the other two empirical studies (Chapters 3 and 4) incorporate only the semi-structured interviews to compare three levels of staff. Chapter 4 also incorporates hypothetical scenarios from semi-structured interviews that include religious exemptions to caregiving, an approach commonly used when topics are infrequent and/or controversial but important to study (e.g., Callahan & Zukowski, 2019; Takla et al., 2020) *See* Appendix B: Additional Description about Hypothetical Cases for more details about how I incorporated hypothetical scenarios into this project.

To recruit participants, I used a combination of selective and snowball sampling procedures to obtain a stratified purposive sample (e.g., Silver & Williams, 2018). Purposive sampling comprises a commonly used approach in qualitative research to identify and select rich cases that provide depth on a particular phenomenon (Van Humbeeck, Dillen, Piers, & Van Den Noortgate, 2020). Here, the purposive sample included long-term care facility staff that were stratified among three levels (floor staff, mid-level management, and upper management). I recruited participants from two long-term care facilities near an urban region in Michigan in the United States from flyers disseminated through staff email and posted in staff spaces (e.g., break rooms), through verbal announcements at staff meetings, and through snowball sampling from other participants. *See* Appendix D: Additional Description about Accessing the Two Facilities. Both facilities are nonprofits and accept Medicaid and Medicare, have fewer than 110 beds, are

continuing care retirement communities (CCRC), have resident councils but no family councils, and provide care outside a hospital. Both also received a minimum of 4 stars in the Centers for Medicare & Medicare Services' (CMS) quality measures (above average), minimum of 4 stars for CMS's health inspection rating (above average), and 1 star in CMS's staffing rating (much below average). Because only a handful of upper managers work in a facility, I also recruited upper managers from facilities throughout Michigan to increase the sample size and data from this group to incorporate into Chapter 4. I recruited additional upper managers by attending state-wide conferences for long-term care facility staff, including one that specifically focuses on upper managers. *See* Appendix C: Additional Description about Upper-Level Staff.

To analyze my data, I coded staff interviews and field notes using Dedoose (2020), a qualitative software program. After each interview, I wrote a brief memo that summarized key points, emerging themes, and identified similarities and differences from other interviews. As interviews were transcribed, I conducted line-by-line open coding to identify concepts and emergent themes that further informed subsequent interviews. To offset potential researcher bias, I assembled a data coding team of four research assistants who helped triangulate the data analysis process. The four research assistants conducted another round of open coding before assisting with axial coding, which explores relationships between the codes and organizes them into themes. We produced individual weekly memos and met weekly to discuss similarities and differences in the coding and identify emergent themes and patterns. Earlier memos and discussions informed subsequent interviews. All coders received inter-reliability scores of 0.83 and 0.84 (very high agreement) after taking an inter-rater reliability test in Dedoose, which included a subset of 87 randomly chosen excerpts.

Reflexivity is an important or "core" (Rankl, Johnson, & Vindrola-Padros, 2021) part of qualitative research (Day, 2012; Gabriel, 2015; Probst, 2015) that I employed throughout this project through self-reflection, rapport-building, and memo-writing. While multiple definitions exist regarding reflexive research (Day, 2012), a key component of reflexivity is the act of reflecting on oneself as the researcher and how one's "self-location" (Rankle, Johnson, & Vindrola-Padros, 2021) regarding gender, class, ethnicity, and other social locations or positionalities, and one's interests, assumptions, and life experiences shape how a researcher approaches participants in a study and the knowledge produced. In this project, I deeply reflected on how my social identities impacted my research (Jacobson & Mustafa, 2019) and wrestled with what Denzin and Lincoln refer to as the "triple crisis of representation, legitimation, and praxis" (2000: 17). For more details on how I incorporated reflexivity into this project, *see* Appendix F: Reflexivity.

Dissertation Structure

This dissertation employs the three-paper model, which includes three empirical studies within an overarching theme. The overarching dissertation theme focuses on how long-term care facility staff navigate conflicting rights in three areas: resident safety and autonomy, discrimination by residents, and religious exemptions to caregiving by staff. Each paper briefly discusses the salience of race, gender, and intersectionality in each topic; however, subsequent papers with different conceptual and theoretical framings will further examine the nuances of how race, gender, and intersectionality shape staff understandings and responses to conflicting rights in long-term care facilities. *See* Appendix E: Salience of Race, Gender, and Intersectionality in this Project.

Building on street-level-bureaucracy theory (Lipsky, 2010), Chapter 2 examines how long-term care facility staff at various levels (floor staff, mid-level managers, top management) exercise discretion to resolve conflicting rights regarding resident safety and autonomy. Autonomy and safety presented conflicting rights for staff in three situations: fall prevention, food intake/refusal, and medication management. Staff at various levels employed unique tools to exercise discretion, including via interpersonal conversations, documentation, and organizational lenses / resources. Staff understood and responded to conflicting rights by invoking interprofessional team approaches across staff hierarchies, especially among floor staff and mid-level managers. Even when upper-level managers sought external guidance (e.g., attorneys/risk managers) to resolve conflicting rights, they deferred to the discretion of floor staff and mid-managers to communicate and implement decisions on the ground, which still left room for discretion. Team approaches across staff hierarchy were less common when conflicting rights arose in medication management. Differences in organizational structure became relevant only when conflicting rights regarding autonomy and safety arose in the context of food intake.

Chapter 3 invokes legal consciousness theory (Ewick & Silbey, 1998; Hirsh & Lyons, 2010; Hoffmann, 2003) to examine how long-term care facility staff at three levels (floor staff, mid-level management, and upper management) understand experiences of discrimination by residents and why staff fail to report discrimination. Findings reveal rampant unreported instances of race and sex discrimination by residents. Staff at all levels rarely invoked the concept of discrimination to describe interactions between residents and staff. Floor staff framed residents' discriminatory behavior as a condition of employment or attributed resident behavior to their health or cognitive status. Mid-management framed experiences around staff safety. Upper management acknowledged staff rights without invoking discrimination rhetoric. By

avoiding naming experiences as discrimination and blaming residents, floor staff never reported discrimination. Managers' framings also shaped how staff named, blamed, and claimed experiences of discrimination and help explain why staff may be hesitant to report discrimination by residents. These findings suggest the need for new and targeted policy and practice approaches that address the nuances accompanying how staff understand workplace experiences as discrimination.

Chapter 4 answers two research questions that examine how long-term care facility staff navigate religious exemptions by other staff – when staff invoke religious or moral beliefs to avoid providing care to lesbian, gay, bisexual, transgender, and/or queer (LGBTQ) residents. This chapter examines how staff achieve social coherence (Tebbe, 2017) when confronted with religious exemptions and why some staff who support nondiscrimination principles also support religious exemptions, which would allow staff to deny care to LGBTQ residents. While dominant narratives present religious exemptions as a conflict between religious liberty and equality, staff employed a variety of cultural frames (Cucchiara, 2020; Goffman, 1974) to reconcile cultural discord and achieve social coherence (Tebbe, 2017) about whether or not to accommodate a colleague who refused care to an LGBTQ resident. Cultural frames included staff rights, fairness, resident safety and comfort, religion, job obligations, and laws and policies. Staff who supported both nondiscrimination and religious exemptions centered patient care (as opposed to religious liberty or equality) when invoking these frames. They reasoned that accommodating religious exemptions by swapping caregivers better ensured resident care.

In the conclusion, I summarize and interpret major findings from each study before discussing their implications for theory, social work practice, and broader policy. The conclusion

also discusses the overall significance of the dissertation, its limitations, and areas for future research.

CHAPTER 2: Street-Level Bureaucracy and Conflicting Rights in Long-Term Care Health Facilities: Safety versus Autonomy

INTRODUCTION

Long-term care facilities represent one of the most heavily regulated industries in the United States. Front-line workers like certified nursing assistants (CNAs) or floor nurses usually provide care to older adults who have complex medical needs (Zimmerman et al., 2014), including assistance with Activities of Daily Living (ADLs) (e.g., bathing, grooming, dressing, eating, toileting), Instrumental Activities of Daily Living (IADLs) (e.g., meal preparation, shopping, phone usage, medication / money management), psycho-social care, and overall care management. Because long-term care facilities serve a particularly vulnerable population, state and federal governments heavily regulate them to ensure resident safety, especially if they receive federal funding from Medicare or Medicaid (Hardy, 2012; Swagerty, 2014). The Nursing Home Reform Act outlines various rights for residents, including quality of life, care participation, privacy, confidentiality, dignity, respect, and the right to make independent choices (OBRA, 1987). Several of these rights can be subsumed under a larger right to autonomy (e.g., respect for independence, freedom, privacy) (Hall et al., 2019). States often have their own policies regarding residents' rights (e.g., MCL 333.20201, 2020). As policies for long-term care facilities have burgeoned, a cultural shift has also emphasized person-centered care (Zimmerman et al., 2014) that has sharpened a focus on resident autonomy to make decisions about their care.

Researchers and practitioners have identified potential conflicts between residents' rights to safety and autonomy in long-term care facilities, including in the use of monitoring technologies in long-term dementia care (Calkins, 2007; Hall et. Al., 2019), caring for frail older adults (Maitland, 2012), and caring for adults with learning disabilities (Heyman & Davies, 2006). When safety and autonomy conflict, staff must resolve these tensions despite little to no guidance. While federal and state regulations require that long-term care facilities respect safety and autonomy rights of residents, they lack guidance for how staff should respond when these rights conflict. Errors could potentially result in harm to the resident, liability for the facility or staff members, and/or disciplinary actions (e.g. sanctions, loss of license, employment termination and loss of livelihood). This chapter examines three areas where these rights may conflict: fall prevention, food intake, and medication management. These three topics arose in the data as the prevailing areas where conflicts between residents' rights to safety and autonomy emerged in long-term care facilities in this study.

Long-term care facilities provide 24-hour care to residents. They operate as both health care facilities and homes for the residents they serve. Like other healthcare contexts, facility staff have increasingly adopted team approaches to providing care (Archbald-Pannone et al., 2020; Arnett et al., 2017; Barry et al., 2019). However varying levels of resident interaction may shape the ways that different levels of staff understand – and possibly work together – to resolve conflicting rights between safety and autonomy. Floor staff (e.g., certified nursing assistants, floor nurses) have significantly more resident interactions than mid-level managers (e.g., nursing managers, social workers) and upper managers (e.g., directors of nursing, administrators), which may invoke particular tools for resolving these conflicts. Mid-level managers may differ in approach from floor staff and upper managers, given that they have some resident interactions as

well as facility management responsibilities. Upper-managers may respond differently from floor staff and mid-managers, given that they have the least resident interaction yet significant investment in resident care from an organizational and administrative perspective. Still, team approaches to healthcare, and caregiving in long-term care facilities specifically, suggests that staff may share tools that can lead to new understandings of how staff at multiple levels navigate legal ambiguity and conflicting rights. This chapter thus poses the following research question: How do long-term care facility staff at various levels (floor staff, mid-management, upper-management) and two facility structures (independent versus corporate) understand and resolve conflicting rights for residents between safety and autonomy?

Street-Level Bureaucracy

While many federal and state policies enumerate resident rights in long-term care facilities, these policies rarely provide guidance on implementation for staff on the ground. When rights conflict, staff have significant discretion on how to respond. Street-level bureaucracy theory provides a useful framework for examining conflicting rights within long-term care facilities.

Street-level bureaucracy theory posits that policy often emerges from "street level bureaucrats" from the ground-up when front-line workers use discretion to interpret and implement vague and ambiguous rules (Lipsky, 2010, 1980). While conventional policy analysis focuses on formal laws, bills, and regulations that state and federal policymakers pass, street-level bureaucracy posits that workers on the ground (for whom formal policies are meant to guide) actually become policymakers by using their discretion to determine how (and if) formal policies apply and in how they implement them (Gilson, 2015; Lipsky, 2010; Lipsky, 1980).

Ultimately, the routines and practices that street-level bureaucrats develop become the public policies that they execute (Lipsky, 2010) – meaning that because the policies are vague and ambiguous, street-level bureaucrats must adopt new routines and practices to interpret these policies that contribute new substance (and policy) to the laws. Street-level bureaucrats must often grapple with work that is "highly scripted to achieve policy objectives" (Lipsky, 2010, xii) but also simultaneously requires an individualized approach to respond to the particular needs of clients (Gilson, 2015). In the context of unemployment claims, for example, an officer engages in street-level bureaucracy when using her discretion to determine whether a client is eligible for unemployment. Similarly, in a long-term care context, a social worker exercises discretion in determining whether a client is eligible for social services; and a nurse exercises discretion in deciding whether or not to administer certain types of medical treatment.

Lipsky (1980) argued that street-level bureaucrats had several characteristics: they have significant discretion because they need to use their professional expertise to respond to clients' needs, they lack direct managerial control over and observation of their work, they possess abilities and skills to develop techniques to override organizational constraints, and they interact with policies that are often vague and open for interpretation. Here, because federal and state policies lack much guidance on how long-term care facility staff should respond to conflicting rights regarding safety and autonomy, staff must use their own discretion to make decisions on how to resolve these conflicting rights when they arise.

Discretion is a core feature of street-level bureaucracy. Vedung (2015) defines discretion as freedom to act or judge on one's own. Lotta and Santiago (2017) argue that discretion directly relates to rules and laws. According to Lotta and Santiago (2017), organizational parameters and individual factors shape street-level bureaucrat discretion. Organizational factors that can help

understand certain discretionary decisions include fear of litigation or risk management (Ceci & Purkis, 2009; Green & Sawyer, 2010; Taylor & Donnelly, 2006), resource availability (Ash, 2013; Savi, 2014), benefit for the organization, including attention to inspections (Peckover, White, and Hall, 2008), and prestige or legitimacy among other organizations (Edelman, Smyth, and Rahim, 2016). Individual factors that shape discretionary decisions include motivation to improve individual work conditions by making work easier, safer, or more rewarding (Maynard-Moody, 2000), advancing one's own interests at the organization (Kaler and Watkins, 2001), individual morals (Maynard-Moody & Musheno, 2003; Muller et al., 2016; Shdaimah & McGarry, 2017) or religious beliefs (Willis, Raithby, Maegusuku-Hewett, & Miles, 2017), professional values or identity (De Witte, 2016; Hughes & Condon, 2016; Webb, 2001; Shdaimah & McGarry, 2017; Walker and Gilson, 2004), desire to help another individual (Burton and van den Broek, 2009; Kaler and Watkins, 2001), desire to help the larger community (Walker and Gilson, 2004), or a general commitment to social justice (Vincent & Marmo, 2018).

Street-level bureaucracy theory has rarely examined how various levels of staff implement vague and ambiguous policies. Lipsky (1980) drew a sharp distinction between managers and front-line staff by arguing that managers aim to restrict discretion to create consistent organizational policy. However, this sharp distinction may be less salient today as healthcare street-level bureaucrats more readily participate in interprofessional healthcare teams that foster shared leadership and group identification (Forsyth & Mason, 2017), collaboration (Walton et al., 2019), and communication (McHugh et al., 2020) across staff hierarchy.

Given the assumption in street-level bureaucracy theory that front-line staff and managers have conflicting goals and objectives, research on street-level bureaucracy infrequently includes managers (e.g., Olaison, Torres, and Forssell, 2018; Willis, Raithby, Maegusuku-Hewett, and

Miles, 2017; Scott et al., 2014). The inclusion of top-level organizational staff has only recently emerged (Gonzales Benson and Panaggio Taccolini, 2019). Scott (2014) found that healthcare managers in an HIV/AIDS and STI (sexually transmitted infections) program used their discretion when interpreting vague policies about service delivery and coordination to strengthen relationships at the local level by building collaborative norms and values among various actors. Olaison, Torres, and Forssell (2018) found that the length of work experience among care managers in elder care shaped their comfort level in exercising discretion in their work. Willis Raithby, Maegusuku-Hewett, and Miles (2017) found that care staff and managers in long-term care exercised discretion to interpret vague and ambiguous policies regarding serving lesbian, gay, and bisexual residents. Applying street-level bureaucracy theory to upper-level leaders, Gonzales Benson and Panaggio Taccolini (2019) found that organizational leaders used their discretion to interpret vague and ambiguous refugee resettlement policies to redefine self-sufficiency as a resettlement policy goal. In all of these studies, managers were also involved in client interactions. Healthcare and care managers directly interacted with patients. Organizational leaders worked closely with refugees. As scholars increasingly apply street-level bureaucracy theory to contexts outside its original application of government workers, more opportunities are emerging to understand how street-level bureaucrats may involve a broader swath of staff. Mid- and upper managers in long-term care facilities who interact with and have a vested interest in resident care may exercise discretion to interpret vague and ambiguous policies in ways that differ from managers in other contexts from healthcare.

Different levels of street-level bureaucrats may enjoy various levels of discretion that shape how they resolve conflicting rights. On the one hand, evidence suggests that street-level bureaucrats with professional training and education may exercise more discretion and enjoy

more freedom from supervision than other front-line staff because of the credibility that their professional roles afford (Corazzini, 2000; Hughes & Condon, 2016; Lipsky, 1980). For example, nurse managers or social workers may have more discretion than certified nursing assistants (CNAs) or licensed practical nurses (LPNs). Upper managers with professional education (e.g., graduate degrees in nursing or business) and facility responsibilities may have even more discretion to interpret vague policies that impact resident care. On the other hand, significant resident interactions and floor experience may afford floor staff more discretion to interpret vague policies that affect day-to-day resident care than mid- or upper-managers with more professional training and education. The reliance on team approaches in healthcare may also shape how staff at various levels collaborate regarding the tools that they use to resolve conflicting rights when vague or ambiguous policies provide little guidance.

The organizational structure of long-term care facilities may also shape how staff exercise discretion when resolving conflicting rights regarding safety and autonomy. Nearly 58% of long-term care facilities operate as corporate chains (Harrington et al., 2021). On the one hand, staff at a corporate facility (with multiple sites) may have access to more resources that could expand staff's confidence in exercising their discretion. On the other hand, staff at a corporate facility may feel constrained to exercise discretion if a larger hierarchical structure (including management at a corporate headquarters external from the facility) dictates facility policy and practice. Additional hierarchy embedded in a corporate structure may provide more written policies than an independent facility that could provide either clear guidance (and thus less need to exercise discretion) or ambiguous and conflicting guidance (and thus more need to exercise discretion). This study contributes new empirical data to fill a research gap regarding

how healthcare workers at various levels, including long-term care facility staff, and facility structures exercise discretion when interpreting vague policies.

DESIGN AND METHODS

This study employs a multi-method qualitative extended comparative case study (Meier, 2015; Mills, Durepos, & Wiebe, 2012) (interviews, observation, and written policies) of three levels of staff in two long-term care facilities to examine how staff understand and respond to conflicting rights for residents. Data includes in-depth semi-structured interviews (n = 80) of three levels of staff (floor staff, mid-level management, upper management), observation of staff meetings (n = 30), review of facility policies (n = 376), and review of federal and Michigan laws and regulations regarding fall prevention, food intake, and medication management (three prevailing areas of conflicting rights that arose during data collection). When probing staff about various situations that invoked conflicting rights, staff at all levels consistently raised concerns about quandaries involving resident safety and autonomy. This article thus focuses on answering the following research question: How do staff understand and respond to conflicting rights for residents involving safety and autonomy?

Participants and Design

This study used a combination of selective and snowball sampling procedures to recruit facility staff from three levels (n = 80) through a stratified purposive sample (e.g., Silver & Williams, 2018). Purposive sampling comprises a commonly used approach in qualitative research to identify and select rich cases that provide depth on a particular phenomenon (Van Humbeeck, Dillen, Piers, & Van Den Noortgate, 2020). Here, the purposive sample included

long-term care facility staff that were stratified among three levels (floor staff, mid-level management, upper management). I used similar approaches to recruit participants from two long-term care facilities near an urban region in Michigan in the United States from flyers disseminated through staff email and posted in staff spaces (e.g., break rooms), through verbal announcements at staff meetings, and through snowball sampling from other participants. See Table 1a for a description of participants' race/ethnicity and gender by staff level.

I selected the two facilities to compare organizational structure. Both facilities accept Medicaid and Medicare, have fewer than 110 beds, are continuing care retirement communities (CCRC), have resident councils but no family councils, and provide care outside a hospital. Both also received a minimum of 4 stars in the Centers for Medicare & Medicare Services' (CMS) quality measures (above average), minimum of 4 stars for CMS's health inspection rating (above average), and 1 star in CMS's staffing rating, which provides information about the number of hours of care provided to each resident by nursing staff (much below average). While both facilities are nonprofits, one is an independent facility, and the other facility is affiliated with a larger corporation that has other facilities throughout Michigan. This distinction allows for more in-depth comparison in how organizational structure may also shape how staff engage in street-level bureaucracy. For more details about the two facilities, *see* Appendix D: Additional Description about Access the Two Facilities.

I conducted 73 interviews face-to-face and 7 interviews by phone from August 2019 to March 2020. Phone interviews were particularly helpful for floor staff who often had multiple jobs and less flexibility for scheduling interviews. Interview topics included educational/professional background, job duties, discretion, conflicting rights, and organizational policy. *See* Appendix A: Interview Protocol. Interviews lasted between 30 minutes and 2 hours

and averaged approximately one hour. All participants received a $50 gift card. Upon conclusion of their interview, participants completed a short socio-demographic survey through Qualtrics about age, race, gender, gender identity, sexual orientation, and religion. To preserve confidentiality, participants used a participant identification number instead of their name.

I also attended all-staff monthly meetings and meetings with only mid-level and top management at the two facilities. I attended weekly management meetings when mid and upper-managers discussed issues regarding residents, family, and staff. I also attended several CNA morning meetings where Certified Nursing Assistants and other floor staff primarily discussed issues with residents. One or two mid-managers were also present at CNA morning meetings to discuss various policy issues (e.g., changes in documentation) and other issues raised from management meetings and to share concerns raised from CNAs at these meetings to management. I also attended weekly upper-management meetings at the two facilities, which usually involved departmental reports and larger organizational issues, including discussions of policies. I further attended several ad-hoc staff meetings that were scheduled to discuss new and immediate issues that could not wait until the next weekly staff meeting (e.g., discussing resident transfers, resident medical or diet issues). Finally, I attended three diversity events, including one panel discussion and two all-staff trainings.

I gathered data from interviews and staff meetings concurrently, which allowed me to probe topics that arose from staff meetings in interviews and observe topics raised in interviews at staff meetings. I also reviewed facility policies (n = 376) from the two facilities to identify written policies that addressed topics raised by staff during interviews or staff meetings. All facility policies originated from a central facility database that I accessed on site and from

employee handbooks. After completing my interviews, I identified 67 written policies that included topics raised by staff during interviews or staff meetings.

Once I completed my primary data collection from long-term care facility staff interviews, observations, and policy documents, I gathered data on federal and state laws and regulations that governed three areas of conflicting rights raised from this primary data: fall prevention, food intake, and medical management. I gathered these data from Lexis Nexis Academic database, Centers for Medicare & Medicaid Services Regulations and Guidance public database, and the Michigan Legislature public database. These legal data supplemented the primary data from long-term care facilities by providing context about the legal and regulatory landscape that addressed (or did not address) these conflicting rights and how this vacuum created ambiguity that presented opportunities for staff discretion in these three areas.

Data Analysis

I coded all staff interviews and field notes from staff meetings using Dedoose (2020), a qualitative software program. After each interview and meeting, I wrote a brief memo that summarized key points (e.g., issues regarding autonomy and safety, responses), emerging themes, and identified similarities and differences from other interviews and meetings. After initial interviews were transcribed, I conducted line-by-line open coding to identify concepts and emergent themes that further informed subsequent interviews. Through this process of coding, I identified 25 separate codes (e.g., autonomy, discretion, safety, conflicting rights, professional background). I asked more focused questions regarding types of conflicting rights between autonomy and safety that emerged in earlier interviews and meetings (e.g., fall prevention, food

intake) to further examine variation and boundaries of these theoretical concepts (Charmaz & Bryant, 2016).

To offset potential researcher bias, I assembled a data coding team of four research assistants to conduct another round of open coding before conducting axial coding. Open coding consists of broader codes to identify theoretical possibilities, whereas axial coding draws connections between the previously identified codes (Charmaz & Bryant, 2016). All coders received inter-reliability scores of 0.83 and 0.84 (very high agreement). We produced individual weekly memos and met weekly to discuss similarities and differences in the coding and identify emergent themes and patterns. Earlier memos and discussions informed subsequent interviews. This process of coding revealed recurring themes under codes for conflicting residents' rights for safety and autonomy, including falls, food intake, and medication management. It also helped identify emergent themes and patterns in how staff at various levels engaged with other staff to resolve conflicting rights.

I subsequently conducted legal analysis of federal and Michigan state laws and court cases relevant to the three areas identified above (falls, food intake, and medication management) that incorporated several distinct steps. First, I created an Excel spreadsheet of relevant laws and cases that included basic details, including a summary of the law and regulation. Laws and cases were deemed relevant if they addressed the larger topic within these three areas. Second, I added codes in Excel to each law and regulation identified that provided more context and to help organize them into themes. For example, I coded regulations about food as either "care" regulations or "rights" regulations. "Care" regulations prescribe rules about procedures for developing care plans and clinical guidance about a resident's diet. Examples of "rights" regulations for food include regulations that allowed residents to decline medical

therapy involving food and providing a reasonable accommodation for dining place and time. Third, I created brief memos for each of the three topics that synthesized this information coded and identified connections to the facility data.

FINDINGS

Three core themes emerged that presented challenges for staff in navigating conflicting rights for residents regarding autonomy and safety: (1) fall prevention; (2) food intake; and (3) medication management. Conflicting rights arose in situations involving fall prevention regarding bed rails that were seen as both limiting autonomy and protecting safety. Food intake invoked conflicting rights when residents with certain health conditions requested or rejected particular diets prescribed for their health and safety. Medication management involved residents' autonomy to make decisions about pain medication that may compromise their health and safety.

For each of these three issues, formal guidance (e.g., laws and regulations) and organizational written policies varied in their degree of ambiguity. Fall prevention had the most formal guidance through federal regulation and organizational written policies about bed rails, but none of this guidance prescribed how staff should respond when bed rails posed a conflict between residents' rights to safety and autonomy. Food intake was addressed more generally through federal guidance and organizational policies, which left even more discretion for staff to respond. Medication management was heavily regulated in some contexts (e.g., dosage, procedure) but devoid of guidance in either federal regulations or facility policy on how staff should respond when presented with conflicting rights.

All three levels of staff were keenly aware of their obligations to respect both the autonomy and safety of any given resident for all three of these situations but ultimately had little to no guidance on how to respond when these rights conflicted. Relying on varying levels of discretion, staff responded in diverse ways to resolve these conflicting rights. Table 2 illustrates how discretion varied (from low to high) among the three levels of staff in each of the three scenarios of conflicting rights (falls, food, medication). Low discretion included little freedom to act or interpret policies regarding medication management among floor staff, especially CNAs. Moderate discretion included situations where some nurses, particularly registered nurses (RNs), reported some freedom to act or interpret policies to manage medication. Most staff described situations where they had significant freedom to act or interpret policies, representing high discretion in Table 2.

The findings below are divided into the three core themes / subsections: fall prevention, food intake, and medication management. Each subsection theme begins with findings from legal data (laws and regulations) and organizational policies, which provides context for street-level bureaucracy in that topic (and how ambiguous and vague policies shape staff discretion to resolve conflicting rights in that area). Each subsection theme next includes findings from semi-structured interviews and meeting observations to compare how three levels of staff understand and respond to residents' conflicting rights to autonomy and safety for that topic (i.e., fall prevention, food intake, medication management). The findings next include a subsection about a key conclusion regarding collaboration among staff levels across the themes. The findings conclude with a subsection comparing data between the two facilities (independent and corporate structure).

Fall Prevention

The Nursing Home Reform Act requires that residents be free from physical or chemical restraints used for discipline or convenience to ensure resident dignity and autonomy. In 2016, CMS updated its Guidance Manual for Long-Term Care Facilities by noting that side rails on beds could constitute a restraint (CMS, 2016). Both facilities also had organizational policies and trainings on fall prevention that included definitions of a "fall," discussed procedures for assessing fall risks and responding to falls and identified best practices in fall prevention. Both facilities also included written policies about residents' right to be free from restraints, but these policies failed to describe or define restraints beyond the federal guidance or offer any guidance about side rails as a restraint. Neither federal guidance nor organizational written policies outlined how staff should respond when side rails present conflicting rights between resident safety and autonomy. This ambiguity presented space for staff to exercise discretion as street-level bureaucrats to resolve conflicting rights.

Fall prevention is a significant topic in long-term care, given the prevalence (Bergen, Stevens, & Burns, 2016), cost (Florence et al., 2018), and health consequences of falls among older adults (Morrison, Fan, Sen, & Weisenfluh, 2013). Not surprisingly, staff at all three levels were aware of government regulations regarding side rails as a restraint. However, front-line workers and mid-managers were deeply concerned that the governmental guidance overemphasized autonomy and put residents' safety at risk. One social worker noted that "the state regulations come from a place of wanting to make it better for the resident but in theory and reality…it doesn't always translate well." She expressed deep concern for residents who were fall risks and noted several conversations she had with floor nurses and nurse managers about how they could protect the safety of these residents without compromising their autonomy or

freedom of movement. Several staff asserted that federal guidance that prohibited side rails as a restraint (to preserve resident autonomy) actually limited both autonomy and safety, particularly when residents themselves requested side rails for their safety.

Floor staff and management invoked their discretion in different ways when addressing fall prevention and side rails. When residents expressed concerns for safety and demanded bed rails, floor staff relied on interpersonal conversations and direct negotiations with residents to navigate safety and autonomy. For example, after witnessing a resident lose balance several times while trying to rise from bed, one nurse spoke with the resident to identify what supports could be implemented besides side rails and ultimately added padding along each bed side. When confronted with these challenges, floor staff also used their discretion to determine whether the situation warranted intervention by a mid-manager and regularly relied on managers to help problem-solve these conflicting rights.

When addressing fall risks, mid-managers used documentation to creatively identify ways a resident could qualify for side rails. For example, one nurse manager documented a resident's mobility concerns in a way that invoked physical therapy. She noted that "if physical therapy says that the side rail is necessary for mobility, you can keep it." Here, she collaborated with other floor staff and managers from an interprofessional caregiving team. Ultimately, she invoked her discretion as a nurse manager to provide sufficient documentation from this team to justify use of a side rail.

In contrast, upper-managers resolved these conflicting rights by invoking discretion to address organizational factors and concerns about litigation. For example, when a Director of Nursing (DON) was addressing side rails with floor staff during a staff meeting, the floor staff foregrounded resident autonomy when insisting that residents "have a right to fall." A social

worker and nurse manager agreed with the floor nurse's assertation that residents have "a right to fall"; although they added that if a resident requested side rails, that request should be honored. The DON challenged this paradigm by responding that "patients do not have a right to fall. They do not have a right for self-harm. Self-harm is illegal." Another upper manager agreed with the DON and expressed concerns about litigation and resident safety. In his interview, this DON subsequently emphasized that falls are "the number one litigation for any health care facility" and are considered "low hanging fruit—if someone falls on your watch and they get an injury, it's a very easy lawsuit." Here, upper managers foregrounded safety over autonomy by focusing on the needs of the facility (e.g., avoiding litigation) through a lens of resident safety. Since resident safety invoked more litigation than resident autonomy, upper managers emphasized the importance of resident safety over autonomy. Upper managers also expressed more caution than mid-managers in advocating for side rails on beds because of how that could impact the organization's professional standing as a "no-restraint" facility. After expressing these reservations in staff meetings, upper-managers ultimately deferred to mid-managers and floor staff on whether and how to use side rails when residents pose safety concerns about falling. In subsequent interviews with mid-managers, they warily interpreted these sentiments from upper-managers as a shared concern for resident safety and affirming their discretion to invoke side rails as needed—albeit as a last resort. This finding accords with street-level bureaucracy literature suggesting that the goals of front-line workers and managers are misaligned (Lipsky, 2010). However, this data departs from much of this body of literature in that mid-level managers (e.g., nurse managers) disagreed with upper managers in their approach and instead foregrounded resident autonomy (similar to floor staff). The similar approaches by floor staff and

mid-managers may be explained by the fact that mid-managers also interact with residents—albeit with less frequency than floor staff.

When addressing resident safety versus autonomy in the context of fall risks, staff at all levels were concerned primarily with resident safety for different reasons. Floor staff framed their responses as navigating residents' needs. If residents or staff were concerned about a resident falling, floor staff added padding next to their bed. They were extensively trained to avoid side rails and rarely turned to them as a solution. If padding was insufficient, they turned to mid-managers to help problem-solve this dilemma. Mid-managers who were also extensively trained to avoid side rails, however, leaned into their professional autonomy and creatively invoked documentation to justify the use of side rails when they believed they would keep residents safe. In contrast, upper managers invoked their discretion to place primacy on resident safety over autonomy but with a lens of avoiding litigation. Instead of providing clear guidance on side rails, however, they prescribed general principles for staff to apply when making decisions that encouraged resident safety, minimized litigation risk, and upheld the organization's reputation as a no-restraint facility. Here, they relied on mid-managers to use their discretion to keep residents safe from falls while minimizing the use of side rails. This collaboration reveals ways that healthcare staff may depart from street-level bureaucrats in other contexts by exercising their discretion to collaborate on various tools to resolve conflicting rights (e.g., interpersonal negotiations with residents, documentation).

Food Refusal and Intake

Food refusal and intake involved conflicting rights between autonomy and safety for residents when they refused to follow a health care provider's medical order regarding food. The

decision about what food to ingest presents a fundamental right to autonomy about a basic necessity of life. However, this right to autonomy can conflict with a resident's right to safety when the food they want or refuse to ingest presents a safety hazard to them, particularly if they have health conditions where certain foods may present significant risk of harm or cause them to choke and die.

Food refusal and intake generally falls under federal and state regulations regarding residents' rights to self-determination and decision-making in medical care as well as care regulations that require evidence-based and clinical expertise. However, unlike side rails and restraints for fall prevention, food choice is not expressly outlined in governmental regulations and no guidance exists for staff when navigating safety versus autonomy regarding food. Both facilities had similarly vague policies regarding residents' rights that could apply to food (e.g., right to quality care, right to dignity, right to make choices about medical care), but only the corporate facility had a separate written policy about food refusal. This brief written document states a policy that the facility will provide adequate nutrition to all residents per physician's orders and outlines a five-step procedure when residents refuse food. The procedure identifies the process for documenting food refusals but provides no guidance for helping staff make decisions beyond documentation or when residents are consuming food contrary to a health provider's orders. Once again, vague policies left much room for staff discretion when navigating conflicting resident rights to safety and autonomy in the context of food.

When a resident exercised their autonomy by refusing to eat their prescribed food, floor staff deferred to safety by encouraging them to eat. If a resident refused, floor staff were often cognizant of their limitations as pointed out by one direct care worker: "if they don't want it, we can't force them" and ultimately deferred to resident autonomy. Floor staff initially foregrounded

safety and used interpersonal tools to persuade and negotiate with residents who were violating medical orders regarding food. When these tools failed, resident autonomy prevailed. However, floor staff often then turned to mid-managers to help navigate these conflicting rights, given their likelihood of recurrence. For example, when confronted with a resident refusing to abide by a doctor's requirement for a liquid diet, one CNA deferred to the swallow evaluation, the doctor, and the speech therapist, which comprised "a group that [could] change the person's diet." Another CNA underscored how she turned to a floor nurse for guidance when a resident did not want to add honey as a liquid thickener despite a requirement for a thickened liquid diet. She emphasized that the floor nurse was able to talk to other managers and directors to change the residents' care plan and identify a solution that helped her maintain autonomy by choosing the food she wanted without compromising her safety. When referencing residents who refused to follow their prescribed mechanical soft diet (chopped, ground, pureed foods), this CNA also turned to mid-level nursing managers who not only managed care plans but also managed people and regularly interacted with multiple levels of staff and residents' family. She subsequently underscored the motivation of relying on a team that spanned a staff hierarchy, particularly in decisions where autonomy and safety involved residents' health: "you never try to do it on your own because you'll come up short." While street-level bureaucracy theory suggests that floor staff would unlikely collaborate with managers (Lipsky, 2010; 1980), the floor staff at the two facilities sometimes did.

Mid-managers (e.g., nurse managers, social workers) took a more proactive approach that centered on documentation and education. As one manager noted, this approach "allowed for some wiggle room," particularly if the doctors, nurses, and speech therapists were aware of the resident's wishes. In one circumstance, a dietician manager documented a diabetic resident's

strong desire for apple pie and educated other staff (dieticians, cafeteria workers, aides, nurses) to allow the resident to occasionally eat apple pie for dessert, even though the doctor's order did not expressly provide for this. Mid-managers also relied on other levels of staff to resolve conflicting rights between autonomy and safety, but to varying degrees. Manager meetings provided many more opportunities to get guidance from other managers compared to such opportunities for floor staff. While floor staff were rarely present at these meetings, mid-managers still relied on their floor expertise and experience. For example, one nurse manager described how a resident wanted to eat solid foods but was restricted to a mechanically soft diet. She underscored the conflict between the resident's right to safety and autonomy to make medical decisions about his care. To resolve this conflict, the nurse manager turned to a team of co-workers to revise his care plan. Her team predominantly included an upper-level nurse manager (Director of Nursing) and other mid-managers (e.g., nurse managers, speech therapist) who helped problem-solve during manager meetings. However, it also included floor nurses who reported about resident care during daily nursing meetings. While she acknowledged that CNAs did not assist with developing care plans, she insisted that constant communication with CNAs was important because of their role on the floor. However, because CNAs were not involved in meetings, it is unclear how she engaged in constant communication with CNAs who were very busy on the floor.

Upper-managers' response regarding food intake varied by facility (as described in more detail below). In the independent facility, upper-managers deferred to resident autonomy, whereas in the corporate facility, upper-managers deferred to resident safety. Upper-managers at both facilities still relied on mid-managers and floor staff discretion on how to best communicate with the resident and resident's family about the facility's decision.

Medication Management

Medication management presented conflicting rights between autonomy and safety when residents (or their family) requested pain medication that compromised resident health and safety. This issue also posed significant ethical issues for some staff that invoked individual beliefs about death and dying. Federal and state regulations prescribe a bevy of requirements about medication processing, administration, and management but fail to provide clear guidance about how staff should respond when residents' rights to safety and autonomy about medication conflict. Death with dignity laws allow a terminally ill individual to make end-of life decisions by permitting a physician to withhold treatment or prescribe medication that facilitates death. State law regarding death with dignity (also referred to by some as assisted death) varies tremendously with most states having no law at all. Eight states and the District of Columbia have death with dignity statutes (California, Colorado, District of Columbia, Hawaii, Maine, New Jersey, Oregon, Vermont, and Washington). In 2006, the United States Supreme Court upheld Oregon's Death with Dignity Act, the first such law in the United States (*Gonzales v. Oregon*, 2006). Michigan has no such statute. However, Michigan did pass a Dignified Death Act in 1996 that acknowledged the need for increased awareness about a terminal patient's right to make decisions to receive, continue, discontinue, or refuse medical treatment and requires healthcare providers to discuss this information with patients (Michigan Public Health Code 333.5652). Two attempts to pass Death with Dignity Acts in Michigan in 2015 and 2017 have failed, and no bill currently exists in this State.

Both of the facilities have written policies providing that residents have the right to make choices regarding their treatment but no other guidance for staff to help them when patient's

right to autonomy and safety conflict regarding medication management, especially if medication may facilitate death. Neither facility outlines whether or how staff can object to services they are asked to perform based on their religion or moral beliefs.

Medication management created a particularly challenging space for floor staff and mid-managers resolving conflicting rights because administering pain medication invoked subjective assessments of pain that some staff struggled to navigate. Mid-managers (particularly nurse managers) spent much more time discussing concerns about medication management than other staff, which may be explained by their dual roles in administration and direct patient care. Floor staff and mid-managers oscillated between which right they foregrounded (safety or autonomy). While federal regulations and facility policy provided little guidance for resolving these conflicting rights, staff at all levels expressed less discretion in this context, particularly when families became involved.

Several floor staff and mid-managers described situations where residents requested significant pain medication. In each of these situations, residents pointed to pictures to indicate that they were experiencing significant pain. These activities measured subjective levels of pain. Some floor nurses responsible for distributing pain medication lamented that some of the residents were overmedicated and did not need the level of pain medication that had been prescribed. Yet, they felt they had little discretion to object and that they must defer to resident autonomy in this context.

Several nurse managers further described how federal regulations for assessing pain constrained discretion and created problematic information suggesting the facility failed to keep residents safe. One nurse manager described how she felt constrained by CMS's Resident Assessment Instrument Manual, which outlines specific questions to ask residents about pain.

Facilities must provide appropriate pain medication to reduce their pain score. She noted that some residents always selected the highest level of pain, regardless of their pain medication dosage, or that some residents' subjective indication of pain did not seem to match the pain medication they received. For her, it was hard to trust resident autonomy when it produced such inconsistent results. She also noted that CMS uses these scores to evaluate the quality of care at facilities. This nurse manager expressed frustration that such subjective measures for determining pain and pain management dictated objective measures of quality of care at the facility. A resident with inconsistent pain scores may produce a lower CMS quality rating for the facility, suggesting inferior attention to safety. For this nurse manager, the lower quality score could, however, reflect heightened attention to resident autonomy over safety. If a resident preferred to be alert and in pain, the facility may receive a lower quality score, but only because facility staff have deferred to the resident's autonomy. This nurse manager, thus, disagreed with this process of medication management but felt little room to exercise discretion in this context.

Another nurse manager described how she used her discretion to navigate a situation where a resident's rights to autonomy and safety were further complicated by family who exercised healthcare power of attorney. She recounted how the family demanded use of morphine for a resident on hospice who was expected to live at least several more months. She explained that regular use of morphine meant a more rapid death by decreasing respiration. In one instance, she had used her discretion to administer a less drastic pain medication that allowed the resident to remain alert but without pain that she felt protected both the resident's autonomy and safety. This drug also allowed the resident to communicate her pain medication needs. A family member with healthcare power of attorney then formally requested morphine administered at scheduled times to prevent her mother from experiencing any pain. The resident

was no longer alert or able to communicate. The nurse manager expected the resident to live at least several more months, but once the resident regularly received morphine, she died quickly. Here, the resident had no legal rights to make her own healthcare decisions yet had at one time been alert enough to communicate her wishes prior to receiving morphine. According to the nurse manager, the resident indicated she wanted morphine for pain but never indicated she wanted enough to facilitate her death. To the nurse manager, the family's healthcare power of attorney trumped the resident's intent for particular pain medication as well as the nurse manager's professional experience. The nurse manager was able to exercise her discretion as a professional nurse manager to administer the less drastic drug until a formal legal document (healthcare power of attorney) demanded a different action. While she never mentioned the phrase "assisted death," or "death with dignity," the description of this event invoked some of the principles of death with dignity. In her demographic survey, this nurse manager described herself as religious and she regularly attended church; however, her description of the rights at stake never invoked morality or religion. Instead, she relied heavily on her professional experience and judgment to navigate these conflicting rights and to frame her understanding of which right should prevail. For this nurse manager, this situation implicated a violation of both the resident's autonomy and safety that was ultimately dictated by legal documentation that usurped her discretion. While she was a nurse manager, her experience fits squarely in Lipsky's (1980, 2010) conceptualization of a street-level bureaucrat who used her discretion to navigate vague and ambiguous policies. While she felt constrained to exercise discretion once the resident's family invoked legal documentation, she creatively exercised her discretion to balance the resident's safety and autonomy by determining how and what medication to administer.

Upper-managers deferred significantly to floor staff and mid-managers (particularly floor nurses and nurse managers) on how to resolve conflicting rights between safety and autonomy regarding medication management. However, several upper- managers noted that increased attention on opioids had required facilities to employ additional considerations about pain medication that could require facility staff to deny a resident's request for particular pain medication (and foreground safety)—although this had not yet occurred. Here, upper-managers exercised their discretion as administrators to defer to floor staff and mid-managers with more regular resident interaction.

Collaboration among Staff Levels

Floor staff and mid- and upper managers collaborated across professions and staff hierarchies to resolve conflicting rights for residents regarding autonomy and safety. For floor staff like CNAs and nurses, resolving conflicting rights often involved discussions with other floor staff (lateral support) and mid-managers (vertical support) that produced revised care plans, new documentation, or other interventions. Mid-managers similarly relied on lateral support from other mid-managers in informal conversations and vertical support from upper managers through manager meetings.

Initial reliance on lateral support aligns with street-level bureaucracy theory, which suggests that floor staff and managers would not collaborate when encountering conflicting rights. However, floor staff and mid-managers also sought support when problem-solving these conflicting rights from an interprofessional caregiving team that transcended these hierarchical boundaries. Nurses collaborated with certified nursing assistants (CNAs), nurse managers, and social workers to identify a plan when residents posed fall risks or refused to follow food orders.

While floor staff did not have the same professional credentials as managers, managers recognized that the professional experience of floor staff gave them a particular expertise that managers valued and often needed when navigating conflicting rights regarding resident autonomy and safety. The high stakes in healthcare (e.g., quality of life, mortality) may help explain why managers used their discretion to collaborate with floor staff and vice versa in ways that extend traditional street-level bureaucracy theory.

Upper managers often resolved conflicting rights regarding autonomy and safety by collaborating with other staff through a lens of liability. Regarding falls, upper-managers deferred to mid-managers and floor staff to exercise their discretion to determine whether and how to use side rails but encouraged judgments that minimized the use of side rails, given CMS guidelines. Regarding food, upper managers discussed conflicting rights mostly through manager meetings with staff from multiple levels but also through guidance from others outside the facility (especially at the corporate facility). The corporate nonprofit deferred heavily to risk managers and attorneys from its corporate headquarters in the ultimate outcome but deferred to floor staff and managers in the process for communicating the outcome. In contrast, the independent facility deferred to their staff's professional judgment and experience in documentation to insulate the facility from liability. Street-level bureaucracy theory would suggest that upper-managers would present obstacles to front-line workers because they have different foci (e.g., organizational concerns, litigation), and that presented itself here when upper-managers centered decision-making on liability and organizational issues like concerns about organizational reputation as a no-restraint facility. However, upper-managers also deferred to the work experience and professional background of its staff in many situations when staff were presented with resolving conflicting resident rights regarding autonomy and safety.

While concerns about conflicting rights regarding falls and food fostered interprofessional cross-hierarchical collaboration, medication management presented a different response among staff. Staff reported diminished discretion in this context, even though guidance was still somewhat vague on how to navigate conflicting rights in this space. Staff also described individual responses that rarely invoked a team approach (elaborated more in the Discussion below).

Comparisons between Facility Structure (Independent v. Corporate Facility)

Whereas front-line worker and mid-manager responses did not vary between the two facilities regarding conflicting rights for food intake or medication management, upper-manager responses did vary by facility regarding fall prevention. In the independent facility, the upper-managers (e.g., director of nursing, administrator) deferred to resident autonomy. While they expressed some concern for litigation, they were satisfied that appropriate documentation would shield them from liability. In contrast, upper managers at the corporate facility deferred to resident safety and expressed stronger concerns about insulating the facility from liability, as evidenced by one administrator:

> A patient has a right to self-determination, the patient has the right to eat what they want to, but we are not obligated to provide that patient with ways to hurt themselves.

When presented with specific situations where residents refused to comply with a healthcare provider's medical order regarding food, upper managers at the nonprofit corporate facility discussed the situation at manager meetings but ultimately invoked external guidance from the corporation's attorney and relied heavily on the professional discretion and expertise of

the corporation's risk managers. While the administrator at this facility sought input from other staff during manager meetings, she noted subsequently in her interview that "there isn't a lot of support at the top. It's kind of a tough job. It's kind of like an island job." She also underscored the importance of seeking input from CNAs but noted that few formal opportunities exist (e.g., meetings) to solicit this input. Deference to the risk management professional lens foregrounded resident safety over autonomy, and residents who refused to follow a healthcare provider's medical order regarding food and diet could be discharged from the facility. When this situation arose during the data collection period, the family opted to remove the resident from the facility before discharge proceedings occurred. Upper-managers' deference to professionals external to the interprofessional management team or staff meetings (e.g., risk managers) signaled to some staff that in this context, their professional discretion, expertise, and experience was less salient in the ultimate outcome. However, upper-managers still relied on mid-managers and floor staff discretion on how to best communicate with the resident and resident's family about the facility's decision.

DISCUSSION

Long-term care staff must navigate the vague and ambiguous wording of policies that create conflicting resident rights regarding autonomy and safety. With little to no guidance on how to implement these policies, staff have considerable discretion on how to navigate these conflicting rights. Here, staff understood and responded to conflicting rights for residents regarding safety and autonomy in a variety of ways that invoked unique tools to exercise their discretion (e.g., interpersonal conversations, documentation) by staff level. Floor staff invoked discretion during interpersonal conversations. Mid-managers invoked discretion for

documentation. Upper managers invoked discretion when applying organizational lenses (e.g., facility liability). Contrary to the bulk of street-level bureaucracy literature outside of healthcare (e.g., De Witte, Declercq & Hermans, 2016; Lipsky, 1980, 2010), staff collaborated across professions and staff hierarchies by leveraging these various tools. However, team approaches across staff hierarchy were less common when conflicting rights arose in medication management. Differences in organizational structure became relevant only when conflicting rights regarding autonomy and safety arose in the context of food intake.

Collaboration: Staff regularly collaborated across professions and staff hierarchy to resolve conflicting rights for residents between autonomy and safety, particularly in the context of fall prevention and food intake. However, staff did not collaborate to resolve conflicting rights in the context of medication management. This failure to invoke other team members stemmed less from concerns about conflict with managers (as suggested by street-level bureaucracy) and more from a sense of resignation that they had little discretion to follow what they perceived was the right course of action. In this context of heightened ethical and moral quandaries, staff may have felt more compelled to defer to resident autonomy, even if requested pain medication presented some harm to their health and safety. Nonetheless, mid-management found ways to creatively exert their discretion to resolve conflicting rights (until legal documentation required a different response) by determining the type and manner of the medication they administered. When family presented legal documentation that foregrounded resident autonomy, staff felt even more constrained in their discretion. In contrast, legal documentation did not arise for staff when they navigated conflicting rights regarding falls and food, even though risk managers and attorneys were involved in food decisions.

Discretion by Organization Structure: Staff responses varied by facility structure only in the context of food intake for upper managers. In the independent facility, the upper-managers deferred to resident autonomy, whereas in the corporate facility, the upper-managers deferred to safety. The variation between the two facility responses among upper managers may be attributed to the different structures within each facility. The independent facility does not have a corporate structure that includes a corporate attorney and has less experience with litigation. The independent facility is managed by leadership staff that oversee only that facility. In contrast, the corporate facility has a corporate headquarters with a corporate attorney and risk managers that assess liability risk for the facility. While liability concerns existed for fall risks for the corporate facility, staff there responded differently when food intake issues presented conflicting rights for residents between safety and autonomy. When food intake was involved, upper managers from the corporate facility deferred less to the discretion of their caregiving team (e.g., nurses, social workers) than to corporate attorneys and risk managers. When probed about why these responses varied for food versus falls, one upper manager explained that guidance is "murkier" with food intake and thus requires a more cautious approach. For upper-level administrators, this cautious approach necessitated drawing expertise from corporate attorneys and risk managers who had significant experience assessing litigation and liability risk. The floor staff and mid-managers also recognized the ambiguity in this situation but took a very different approach that involved much more collaborative problem-solving among floor staff and mid-managers from their formal caregiving team. Not once did floor staff or mid-managers invoke the need to consult with external risk managers or attorneys during their interviews or staff meetings. This approach suggests that formal caregiving staff from these two tiers of workers at the corporate facility

were comfortable with relying on their discretion to resolve these conflicting rights – even if their upper-level bosses were not.

The findings above suggest a more nuanced approach to discretion that may be helpful for understanding street-level bureaucracy, particularly when interprofessional teams rely on the tools that various levels of staff use to resolve conflicts (e.g., interpersonal conversations, care plans). Unlike government claims officers, which comprise much of the street-level bureaucracy literature (Lipsky, 2010; Van Leeuwen, Tummers, and van de Walle, 2017), street-level bureaucrats in this study of long-term care facilities relied on discretion from interprofessional team members across staff hierarchies, particularly when legal documentation was not present. Interprofessional teams are becoming more popular, especially in healthcare (Forsyth & Mason, 2017; McHugh et al., 2020; Walton et al., 2019), where diverse patient experiences, discretion to act, and professional discretion are valued to ensure optimal health, wellbeing, and quality of life. If someone errs when resolving conflicting rights regarding autonomy and safety for a resident (or patient), a resident could be severely harmed, the worker could be terminated or lose their professional license, and an organization could face litigation and loss of prestige. Front-line staff and managers are also working in an organizational context that values person-centered care and employs staff from helping professions such as nursing and social work. Extending street-level bureaucracy to include managers makes practical sense, particularly in healthcare, where managers have more interaction with clients (patients/residents) and investment in their care than street-level bureaucrats may in other contexts. Future research should further examine the complexities of street-level bureaucracy in other healthcare contexts, including hospitals, outpatient services, and primary care.

CONCLUSION

This study has several limitations. First, because the interviews and observations were based on a purposive sample, these findings are not generalizable; however, they instead provide rich description and theoretical explanation on how long-term care facility staff at various levels (floor staff, mid-managers, upper managers) resolve conflicting rights. Future quantitative research could build off this study to produce generalizable data with representative samples that examine types of conflicting rights and attitudes about and experiences with various conflicting rights among healthcare providers. Second, while this case study included many diverse perspectives, only staff who voluntarily agreed to participate were included, and the overall sample of upper managers was small. Thus, the experiences of staff who did not sign-up for an interview or participate in team meetings are not represented in this data. Future research could target hard-to-reach samples, including upper-managers across multiple facilities or CNAs at one or two facilities.

Furthermore, this paper included very little attention on race and gender (and the intersections within). Gender and race norms drive perceptions about acceptable work behavior, which may have influenced some of how the staff I interviewed responded. This finding was further complicated by uneven racial composition of staff at various levels, particularly in Facility 2 – and further shaped by diverse perceptions by white and Black staff about how race shaped perceptions about commitment to care and work ethics. These complex dynamics will be further explored in a subsequent paper, which will pull from a separate body of theoretical and empirical scholarship.

This research has several contributions for theory, practice, and policy. First, this research extends street-level bureaucracy theory by revealing how staff across staff hierarchy and

profession collaborate to resolve conflicting rights. This finding contradicts earlier literature on street-level bureaucracy that pits front-line workers against managers. One key tenet of street-level bureaucracy is that front-line staff and managers are in conflict given varying goals. While many of those conflicting goals remain here (e.g., administrators are more concerned with liability), the necessity for team approaches for resolving conflicting rights, especially in a healthcare-related space like a long-term care facility, often created a space of collaboration instead of conflict. In healthcare, staff at multiple levels interact with patients, are invested in their care, and rely more heavily on team approaches than in other contexts to provide that care. Second, building on emerging street-level bureaucracy literature that includes managers (Gonzales Benson and Panaggio Taccolini, 2019), this study applies street-level bureaucracy to multiple levels of managers in healthcare. While managers in healthcare have administrative responsibilities, some still have floor responsibilities, too. Here, nursing managers regularly interacted with residents, even if that interaction was far less frequent than CNAs or floor nurses. Even upper managers like Directors of Nursing and Administrators occasionally interacted with residents to check on their care. Healthcare presents a space where including managers as street-level bureaucrats may make more sense than in other contexts; although, more research is needed to examine this outside of long-term care. Finally, this study applies street-level bureaucracy theory to a new domain: conflicting rights. Previous literature has examined how front-line staff understand and respond to vague or ambiguous policies. This article extends this theory to examine how staff understand and respond to vague or ambiguous policies that pose conflicting rights.

This research also has important practice and policy implications. This study's findings on varying team approaches to conflicting rights reveals the importance of team collaboration

across professional and hierarchical boundaries. Team meetings provided an optimal structure for widespread information dissemination and discussion but only when all participants (including front-line staff like CNAs) are equal contributors. Facility leadership could initiate a CNA Leadership Council that provides structural supports and inclusion of CNAs in team meetings. Other structural supports could better ensure participation of CNAs and floor nurses whose busy demands on the floor pose challenges for meeting attendance (e.g., offer additional pay or gift cards or prize raffle for attendance, alternate meeting times and days, identify CNA leadership to help run the meetings and get buy-in from other CNAs). Policymakers could also provide funding that supports opportunities for team collaboration, and particularly more formal opportunities for CNAs to participate in team approaches to decision-making about resident care. As patient-centered care continues to grow in healthcare contexts, practitioners and policymakers can incorporate more formal opportunities to support collaboration that crosses staff hierarchy and profession.

CHAPTER 3: Constructing Discrimination Rights:

Comparisons among Staff in Long-Term Care Health Facilities

INTRODUCTION

Recent social movements have raised awareness about racial and gender justice. In 2006 Tarana Burke coined #MeToo to address sexual harassment and abuse, which grew into a movement after a viral hashtag in 2017. Between 2016 and 2020, once lauded entertainment giants Roger Ailes, Bill Cosby, and Harvey Weinstein experienced a rapid fall from grace when after decades of discrimination and harassment toward women, they were convicted of sexual assault and/or terminated from their high-profile jobs. Black Lives Matter sparked a movement for racial justice after the acquittal of George Zimmerman in 2013. The 2020 filming of George Floyd's murder by police and stark racial disparities during the COVID-19 pandemic brought renewed calls for antiracism resources and structural changes to address systematic racism in criminal justice, employment, and healthcare (Anyane-Yeboa, Sato, & Sakuraba, 2020; Hardeman, Medina, & Boyd, 2020; McCluney et al., 2021). Amidst this cultural moment, business leaders throughout the United States (and world) have produced written antiracism policies, expanded diversity, equity, and inclusion (DEI) efforts, and developed plans to better address race and sex discrimination in the workplace (Friedman, 2020; Kantor, 2018; Stankeiwicz, 2020). Despite this renewed focus on racial and gender justice, many experiences of race and sex discrimination in the workplace continue to go unreported in the United States (EEOC, 2016; Society for Human Resource Management, 2018; Xiao et al., 2021).

Discrimination laws place the burden on employees to report discrimination. When instances of discrimination go unreported, discrimination persists. When repeated incidences of discrimination occur, a culture of abuse can develop that can make work conditions intolerable for workers. While significant structural reform is needed to address discrimination at a macro or institutional level, an important step for achieving structural reform is to understand at the micro and mezzo levels how individuals understand discrimination experiences.

Using legal consciousness theory, this chapter examines why workers fail to report discrimination through qualitative data from 80 long-term care workers about their experiences of discrimination from residents. Long-term care provides an ideal case study for examining why workplace discrimination remains underreported because it presents a space of conflicting rights that may shape reporting in other spaces, given its position as a healthcare facility and residential facility. Short-term healthcare facilities may encounter these conflicting rights, too, because of a growing emphasis on patients' rights (e.g., quality care, autonomy, safety), patient-centered care (Hawes et al., 2012; Patient Protection and Affordable Care Act, 2010; Zimmerman et al., 2014), and customer service (Kirkland & Hymann, 2021; Han, Han, & Kim, 2018) that could conflict with staff protections. Patients' rights may conflict with workers' rights to be free from discrimination, particularly when patients who need care exhibit racial or sexual harassment. Patients with health conditions, including conditions that impair executive functioning, may heighten this dilemma of conflicting rights for healthcare staff. Individuals receiving residential medical care are entitled to a bevy of residents' rights associated with long-term care facilities and patient care. This context provides rights for potential perpetrators of discrimination that do not exist in other workplaces. Given the population that long-term care staff serve, they may

more frequently encounter circumstances where patients' (i.e., residents) rights collide with workers' rights for staff.

Healthcare workers are not a homogenous group and may experience and interpret discrimination by patients differently depending on their level of interaction with patients and role in their organization. Variations in understandings could further help explain underreporting. This study thus compares experiences of discrimination by front-line staff (e.g., certified nursing assistants, licensed practical nurses), mid-level managers (e.g., nurse managers, social workers), and upper managers (e.g., directors of nursing, administrators) to better understand this social phenomenon.

Discrimination in the Workplace

Federal law prohibits employment discrimination based on certain protected categories, including race, color, religion, sex, and national origin through Title VII of the Civil Rights Act (Civil Rights Act, 1964). Between 2018 and 2020, employees filed 37,291 claims of sex-based discrimination with the U.S. Equal Employment Opportunity Commission (EEOC, Sex-Based Charges, 2021), the federal agency responsible for enforcing Title VII. Of those claims, 58% (21,710 claims) alleged sexual harassment (EEOC, Sex-Based Charges, 2021). During this time, employees also filed 70,640 claims of race-based discrimination with the EEOC (EEOC, Race-Based Charges, 2021). Research suggests that the actual incidences of discrimination are much higher (Blackstone, Uggen, & McLaughlin, 2009; EEOC, 2016; Hernandez, 2006; Illies et al., 2003; Kohlman, 2004; Snyder & Schwartz, 2019; Society for Human Resource Management, 2018; Tucker, 1993). In a sample of 120 female workers, women of color (defined as Black, Hispanic, and Asian) were five times less likely to report sexual harassment to human resources

and ten times less likely to report sexual harassment to a supervisor compared to white women (Hernandez, 2006). Research has found that workers fail to report discrimination in the workplace for a number of reasons, including to avoid damage to their career or reputation (EEOC, 2016), to maintain a perception of competence and as a team player (Collinson & Collinson, 1996), to avoid perceptions as a victim or troublemaker (Bumiller, 1987; Kaiser & Miller, 2003; Kaiser, Dyrenforth, & Hagiwara, 2006), fear of retaliation (EEOC, 2016), because managers took sides in supporting alleged perpetrators (EEOC, 2016; Marshall, 2005) or minimized experiences of discrimination (Xiao et al., 2021), and because of structural barriers in the complaint process (Bumiller, 1987; Hernandez, 2006).

While much of the literature on discrimination in healthcare focuses on discrimination toward patients (Popper-Giveon & Keshet, 2018), healthcare workers also experience discrimination by patients, including racist assumptions (Chen et al., 2010; Johansson et al., 2011; Lee, Muslin, & McInterney 2016; Wheeler, Foster, & Hepburn, 2014), inappropriate touching (Banerjee et al., 2012; Burgess et al., 2018; Grigorovich & Kontos, 2020; Villar et al., 2020), name-calling (Nunez-Smith et al., 2007; Ramirez, Teresi, & Holmes 2006; Wheeler, Foster, & Hepburn, 2014), being mistaken as a nonhealthcare worker (Moceri, 2014; Nunez-Smith et al., 2007; Wros, 2009), and refusal of care (Kulwicki, Khalifa, & Moore, 2008; Moceri, 2012; Wheeler, Foster, & Hepburn, 2014; Wilson, 2007). Researchers have identified several cultural norms in healthcare that may further discourage staff from reporting workplace discrimination by patients, including a "culture of accommodation" (i.e., healthcare practices of yielding to patients' racial preferences) (Paul-Emile, 2012) and cultural norms about "neutrality in medicine" (i.e., an ethos of impartiality in medicine) (Keshet & Popper-Giveon, 2017). Researchers investigating violence toward frontline workers in residential care in Canada and

Scandinavia attributed underreporting, in part, to "structural violence," which they described as systematic and organizational factors such as poor quality of working conditions and inadequate levels of support for workers (Banerjee et al., 2012). In a study of hospital managers (i.e., senior nurses, department heads) and healthcare professionals (i.e., doctors, nurses), Popper-Giveon and Keshet (2018) argue that "a clash of fundamental values" (p. 712) between patients and healthcare practitioners emerge when staff experience discrimination. Popper-Giveon and Keshet (2018) elaborate that informed consent and patient-centered care represent medical values that sometimes clash with an "ethos of neutrality in medicine" that requires healthcare practitioners provide services objectively and equally to diverse patients. Building on Popper-Giveon and Keshet (2018)'s paradigm of a "clash of fundamental values," I argue that conflicting rights between patients (e.g., quality care, autonomy, safety) and healthcare workers (e.g., nondiscrimination) may shape experiences of discrimination and reporting by healthcare workers. The limited research on workplace discrimination by patients suggests these experiences may vary among different levels of staff (e.g., Banerjee et al., 2012; Popper-Giveon and Keshet, 2018), which this study examines in the context of long-term care facilities.

Long-Term Care Facilities

Long-term care facilities provide residential care for older adults and people with disabilities. Front-line long-term care workers like certified nursing assistants (CNAs) and nurses provide care to older adults who have complex medical needs (Zimmerman et al., 2014), including assistance with ADLs (e.g., bathing, grooming, dressing, eating, using a toilet), IADLs (e.g., meal preparation, shopping, using a phone, taking medication, managing money), psycho-

social care, and overall care management. They – along with facility management – must balance the needs and rights of all the residents along with needs and rights of the staff who work there.

Because long-term care facilities serve a particularly vulnerable population, state and federal governments heavily regulate them, especially if they receive federal funding from Medicare or Medicaid (Hardy, 2012; Swagerty, 2014). The Nursing Home Reform Act (2010 [1987]) includes a Residents' Bill of Rights that outlines various rights for nursing home residents, including quality of life, right to be fully informed and participate in one's care, right to privacy and confidentiality, right to dignity, freedom, and respect, right to visitors, and the right to make independent choices. Staff also enjoy rights to be free from discrimination based on race, color, sex, national origin, and religion (Civil Rights Act, 1964).

As obligations for long-term care facilities have burgeoned, a cultural shift has resulted in a new emphasis on de-institutionalization of nursing homes, a focus on person-centered care (Zimmerman et al., 2014), and improved worker conditions (Grabowski et al., 2014; Koren, 2010). In fact, one key objective of the Affordable Care Act included the adoption of a more community-based and person-centered long-term care system (Hawes et al., 2012; Patient Protection and Affordable Care Act, 2010). While an increased focus on person-centered care and customer service can improve health outcomes and quality care (Arora, 2003; Saha, Beach, & Cooper, 2008; Stewart et al., 2000), it may pose challenges for staff wrestling with discrimination from residents who do not want to upset a "customer" or resident who is paying for their services. Workers may be even less inclined to raise nondiscrimination rights when experiencing discrimination by residents with health conditions that impair executive functioning and/or affect behavior (e.g., mild cognitive impairment or dementia). The stakes are particularly high for front-line staff who experience much of the in-person interactions with residents (and

increased exposure to discrimination by residents). Staff who experience discrimination may fear negative repercussions from residents or staff if a resident subsequently complains of poor treatment. When a resident files a complaint against a worker, the facility must immediately investigate and remove the staff member. Facilities have discretion not to pay the worker during this time, which has significant financial repercussions for low-income workers who comprise a majority of the front-line staff. These challenges could shape how staff understand and construct discrimination rights and help explain why they fail to report experiences of discrimination by a resident.

Recent research suggests that staff level may shape experiences of discrimination (Allen, 2020; Roscigno, 2019). A study of data from the Survey of Midlife in the U.S. found that gender did not significantly shape perceptions of workplace discrimination until accounting for supervisory status (Allen, 2020). A study of nearly 6,000 full-time workers' survey responses about discrimination in the workplace found a heightened likelihood of sex discrimination for those in higher status occupations (e.g., supervisors) but uniform vulnerabilities across occupational hierarchy for sexual harassment and race discrimination (Roscigno, 2019). Support by supervisors and coworkers reduced the likelihood of discrimination and sexual harassment (Roscigno, 2019). Roscigno (2019) argues that one's power in the workplace can shape one's vulnerability to discrimination and harassment. A worker's legal consciousness and experience of discrimination may be shaped by workplace power and the occupational level that they hold. Front-line workers with significant in-person interactions with residents may be more constrained in workplace power than mid- and upper-managers. Mid-managers who still have some interactions with residents (e.g., nurse managers, social workers) may feel beholden to residents who can file grievances about poor quality care against them. Upper-managers may

also feel beholden to residents to meet organizational and governmental compliance, secure financial stability for the facility, and maintain facility prestige and reputation to continue attracting new residents. Each of these groups have varying work experiences and concerns that could shape legal consciousness and reporting of discrimination by residents. This study examines these issues by asking the following two research questions before turning to legal consciousness theory to help answer them:

1. How do long-term care facility staff from three occupational levels understand experiences of discrimination by residents?
2. Why do long-term care facility staff underreport experiences of discrimination by residents?

Legal Consciousness Theory

While staff have the right to be free from discrimination at work, they must first recognize the existence of discrimination. Legally, discrimination requires differential treatment of similarly situated employees on the basis of a protected category (e.g., race, color, sex, national origin, religion) (Civil Rights Act, 1964). However, when employers treat employees differently, employers (and employees) often cite a number of reasons to justify the disparate treatment other than discrimination (e.g., poor performance, inadequate experience) (James & Wooten, 2006; Roscigno, 2007). Interpretations of a workplace incident – and one's legal consciousness about that event – are "tied inextricably to the study of subjectivity" (McCann, 2019: xiv). This article, thus, does not examine the legal veracity of staff members' claims to discrimination but instead examines how they understand their experiences at work as potential discrimination and how that may shape reporting.

Legal consciousness describes the extent to which individuals invoke legal concepts, such as race and sex discrimination, to define everyday experiences (Ewick & Silbey, 1998; Hirsh & Lyons, 2010; Hoffmann, 2003). Scholars have invoked legal consciousness to describe how workers import legal principles of race discrimination into their everyday life to understand events or experiences as injurious and deserving redress (Hirsh & Lyons, 2010). This study extends legal consciousness theory to examine how workers understand experiences as potential discrimination when their rights may conflict with the rights of others. Here, a heavily regulated industry grants significant rights to residents as patients and consumers of long-term care that may shape how workers understand their own rights to nondiscrimination.

Literature on legal consciousness has examined the ways that individuals "lump it," or choose to do nothing when they could otherwise invoke legal action (Felstiner, 1974; Morrill & Edelman, 2021; Poppe, 2019). Workers may "lump" discrimination complaints when they fail to name, blame, or claim the experience of discrimination. Felstiner, Abel, and Sarat's (1980) seminal article on "naming, blaming, and claiming" identifies a process of legal consciousness that can help explain why workers report (or do not report) an experience of discrimination. Naming involves the process of defining and redefining the experience as unjust, unfair, or harmful (Felstiner, Abel, & Sarat, 1980; Kimhi, 2020; Levitsky, 2008). Blaming attributes the injustice, inequity, or harm to a particular source (Felstiner, Abel, & Sarat, 1980; Fuller & Putnam, 2018). Claiming involves taking action to rectify the injury (Felstiner, Abel, & Sarat, 1980; Wofford, 2017). Naming, blaming, and claiming provide a framework for understanding legal consciousness and how staff experience discrimination at work.

When a worker experiences a negative interaction at work, that individual will usually engage in a process of causal attribution and search for explanations (Hirsh & Lyons, 2010).

Whether or not they attribute the event to discrimination based on race or sex may be shaped by their own sense of fairness, moral responsibility, and understanding of the law. In a study of family caregivers, Levitsky (2008; 2014) found that beliefs about family responsibility shaped their perceptions about injustice around their caregiving. Caregivers did not perceive injustice or a legal harm when they experienced no disparity between the care they believed they owed a family member and their capacity to fulfill that obligation (Levitsky, 2008; 2014). Many of these caregivers reported a belief that families should bear the full cost and burden of care provision and thus did not perceive their care obligations as unjust or unfair (Levitsky, 2008; 2014). While formal caregivers in long-term care may be less motivated by beliefs about family responsibilities, other moral responsibilities may shape their legal consciousness, including a sense of duty to help someone with limited capacity and/or health conditions that shape a resident's quality of life.

The race and gender of the worker and conditions at work may also shape their legal consciousness (Hirsh & Lyons, 2010). In a secondary analysis of 830 linked household-employer records from the Multi-City Study of Urban Inequality, Hirsh and Lyons (2010) found that ascriptive status (e.g., race, gender) was associated with perceptions of discrimination with African American and Hispanic workers who were more likely than white workers to perceive racial discrimination. While African Americans and women were both more likely to perceive race discrimination, African American women were less likely to perceive workplace discrimination than white women (Hirsh & Lyons, 2010). Hirsh and Lyons (2010) also found that job authority increased perceptions of discrimination among white workers but decreased perceptions of racial discrimination among African American workers. A workplace with formalized screening processes (e.g., written applications) further reduced the likelihood that

workers perceived the existence of race discrimination (Hirsh & Lyons, 2010). Finally, the presence of nonwhite supervisors minimized perceptions about racial discrimination for all employees (Hirsh & Lyons, 2010). Based on their findings regarding supervisors, Hirsh and Lyons (2010) suggested that nonwhite supervisors may promote positive race relations and may indicate that employment practices are race-neutral such that workers are less likely to perceive discrimination.

Scholars have recently critiqued this socio-legal literature as focusing primarily on an individual's willingness to file grievances or pursue legal action (Poppe, 2019; Young & Billings, 2020), and have suggested more attention on structural reasons, including structural inequalities in the grievance or litigation process (Poppe, 2019) and the role of cultural capital (Young & Billings, 2020). Building on Bourdieu (1986), Lamont and Lareau define cultural capital as "the institutionalized, i.e., widely shared, high status cultural signals (attitudes, preferences, formal knowledge, behaviors, goods, and credentials) used for social and cultural exclusion" (Lamont & Lareau, 1988, p. 156). In a study of criminal justice among 108 students, Young and Billings (2020) found that students with high cultural capital had a greater sense of self-efficacy in police-citizen interactions. The present study contributes to a growing body of research on discrimination to help explain why healthcare workers – and more specifically long-term care facility staff – fail to report discrimination by patients (i.e., residents). It also extends legal consciousness theory by examining how workers understand experiences of discrimination in the context of conflicting rights (i.e., workers' rights and residents/patients' rights). Legal consciousness theory informs the research questions below by providing a framework for examining staff understandings and experiences of discrimination.

DESIGN AND METHODS

This study employed a qualitative comparative case study design (Meier, 2015; Mills, Durepos, & Wiebe, 2012) that compares three levels of staff in long-term care facilities to answer the following research questions: (1) How do long-term care facility staff from three occupational levels understand experiences of discrimination by residents?; and (2) Why do long-term care facility staff underreport experiences of discrimination by residents? Data includes in-depth semi-structured interviews (n = 80) of three levels of staff (floor staff, mid-management, and upper-management).

Participants and Design

This study used a combination of selective and snowball sampling procedures to recruit facility staff from three levels (n = 80) through a stratified purposive sample (e.g., Silver & Williams, 2018). Purposive sampling comprises a commonly-used approach in qualitative research to identify and select rich cases that provide depth on a particular phenomenon (Van Humbeeck, Dillen, Piers, & Van Den Noortgate, 2020). Here, the purposive sample included long-term care facility staff that were stratified among three levels (floor staff, mid-level management, and upper-management). I recruited participants from two long-term care facilities near an urban region in Michigan in the United States from flyers disseminated through staff email and posted in staff spaces (e.g., break rooms), through verbal announcements at staff meetings, and through snowball sampling from other participants. I focused on staff interviews at two facilities (as opposed to staff at numerous facilities in the region) because multiple interviews at two facilities provided greater richness and depth about how various levels of staff interpreted similar interactions between residents and staff. Including two facilities (versus one

facility) provided more data on upper-managers, given the smaller number of upper-managers at one facility. Both facilities are nonprofits and accept Medicaid and Medicare, have fewer than 110 beds, are continuing care retirement communities (CCRC), have resident councils but no family councils, and provide care outside a hospital. Both also received a minimum of 4 stars in the Centers for Medicare & Medicare Services' (CMS) quality measures (above average), a minimum of 4 stars for CMS's health inspection rating (above average), and 1 star in CMS's staffing rating (much below average). See Table 1b for a description of participants' race/ethnicity and gender by staff level and Appendix D for more details on how I accessed the two facilities.

I conducted 73 interviews face-to-face and 7 interviews by phone from August 2019 to March 2020. Phone interviews were particularly helpful for floor staff who often had multiple jobs and less flexibility for scheduling interviews. Seventy-nine of the 80 interviews were audio-recorded and transcribed by a professional transcriptionist. One participant preferred that I take written notes of their responses. Interview topics included educational/professional background, job duties, experiences of discrimination, and organizational practices and policies around discrimination. *See* Appendix A: Interview Protocol. These interviews were sometimes broken into shorter time frames to accommodate participants' schedules. Interviews lasted between 30 minutes and 2 hours and averaged approximately one hour. All participants received a $50 gift card. Upon conclusion of their interview, participants completed a short socio-demographic survey through Qualtrics about their age, race, gender, gender identity, and sexual orientation. To preserve confidentiality, participants used a participant identification number instead of their name.

Data Analysis

I coded all staff interviews using Dedoose (2020), a qualitative software program. After each interview, I wrote a brief memo that summarized key points, emerging themes, and identified similarities and differences from other interviews. As interviews were transcribed, I conducted line-by-line open coding to identify concepts and emergent themes that further informed subsequent interviews. Through this process of coding, I identified 22 codes to capture core themes about who the discrimination involved (e.g., discrimination between residents, discrimination between residents and staff), the type of discrimination described (e.g., race, sex), and descriptions of the interviewee's job (e.g., job duties, job challenges, education and professional background, sources of support).

To offset potential researcher bias, I assembled a data coding team of four research assistants to conduct another round of open coding before conducting axial coding. Research assistants were given the same list of 22 codes to recode a subset of the data to test for coding inter-rater reliability. The subset of data was randomly chosen in Dedoose to include 87 excerpts that research assistants would code with the codes provided. All coders received inter-reliability scores of 0.83 and 0.84 (very high agreement).

Next, the data coding team and I conducted axial coding. Axial coding explores relationships between the codes and organizes them into themes (Scott & Medaugh, 2017). We produced individual weekly memos and met weekly to discuss similarities and differences in the coding and to identify emergent themes and patterns. Earlier memos and discussions informed subsequent interviews. This process of coding revealed recurring themes regarding how different levels of staff understood discrimination between residents and staff and among staff. It also

helped identify emergent themes and patterns in how racial differences among staff shaped understandings of discrimination.

FINDINGS

Building on legal consciousness theory, the sections below present findings about (1) how staff at three levels understand experiences of discrimination by residents; and (2) why staff underreport experiences of discrimination by residents. Facility staff at all levels described rampant discrimination from residents. Some of the residents they served have cognitive impairment that limits executive functioning in a way that could facilitate discrimination. This circumstance posed unique challenges and opportunities for reframing discrimination among staff who are protected under anti-discrimination policies but also prohibited from denying care, especially to a resident whose health conditions may be contributing to unwanted verbal or physical harassment.

Sex and race-based discrimination and harassment emerged as some of the top challenges that floor-staff encountered at work. Nearly all interview participants recalled at least one instance of overt racial harassment toward an African American colleague, regardless of their staff level. One African American CNA recounted several circumstances in which residents referred to her as “nigger” or “monkey.” An African American nurse described how residents often mistook her for an aide: “I automatically was just, you know, this Black stereotype. Like oh, I must be the CNA because I was African-American.” Staff also described how residents inappropriately groped or attempted to grope them. One nurse manager described how a resident grabbed her and started rubbing his body on her when she had to change his briefs. Another resident told a cafeteria worker that he would “love to see that beautiful, luscious hair on his

body" and offered her $15,000 in gold if she removed her clothes. Staff also reported examples of residents refusing care based on their race or in some cases sex (when a resident refused care by a male CNA). Discrimination by residents created conflicting rights for staff who were protected under nondiscrimination laws but were also tasked with honoring residents' rights by providing their personal and medical care. Floor staff, mid-managers, and upper-managers employed varying approaches when constructing experiences of discrimination by residents that help explain underreporting.

Floor Staff

While most floor staff were well-aware of nondiscrimination policies that protected them, they often brushed aside these experiences as part of the job and thus centered residents' rights over their own, as expressed by one African American CNA:

> I tell the new CNAs that come…that you're going to be called names, you might get hit on, you might get spit on, but you've got to have a strong heart because at the end of the day, they need you. You can't retaliate or get upset because if you feel that way, then it's not the job for you.

Here, the CNA enumerated several verbal and physical indignities that her colleague could expect from residents. However, she never referred to this behavior as harassment, discrimination, unfair, or unjust. Her legal consciousness was shaped by a belief that residents should not be blamed for this behavior because it is an expected part of the job. Residents "need" the CNAs and this need eliminates blame for their behavior.

Even when floor staff viewed the harassment as discrimination, they rarely reported it, and only after the harassment became so frequent that it became unbearable. One white nursing manager explained how she learned about harassment toward floor staff:

> I had a newer nurse, and she was of color, and there was a resident that would call her names, call her racial slurs, but she never told anybody. Then it got to the point – Where one day she just, you know, after hearing it, hearing it, hearing it, hearing it, hearing it, she just couldn't take it, and she broke down, and that's where she presented it to the unit managers as discrimination.

This white manager continued to explain how disappointed she was that it took this CNA so long to report her experiences but expressed pride in her response in affirming the CNA's experience as discrimination once she learned about it. This manager made no mention of potential structural barriers shaping legal consciousness (Headworth, 2020; Hull, 2016) that this CNA might have encountered that could have impeded her ability to raise concerns about harassment with her white manager, including a long history of white women colluding with white men in racial and sexual violence toward Black women. Additionally, residents hold significant power over floor staff's livelihood, as one worker explained that if a resident files a complaint against a CNA–even if it is completely unwarranted–the facility must place that staff member on administrative leave during an investigation. The facility has discretion over whether or not to pay the staff member during this leave. The benefits of reporting discrimination (e.g., new resident assignment) may not outweigh the costs for floor staff barely making ends meet. Both of these examples also underscore the extensive emotional labor that Black floor staff employ after repeated experiences of mistreatment by residents because of their sex and/or race and why they

may “lump it” and fail to make a claim of discrimination until the harassment becomes unbearable.

Floor staff invoked several reasons that helped minimize or dismiss discrimination by residents and shaped their legal consciousness. Floor staff, especially CNAs, tended to accept that because they were employed in someone’s home vis-à-vis a facility, they had little recourse to resident harassment. Several CNAs underscored the importance of residents paying to live in the facility. As one CNA explained: “That’s their home. They pay to live here, so you have to be strong minded and overlook it.” Another CNA mirrored this sentiment: “They’re the resident, they’re paying, so we have to accommodate them. As soon as they walk in that door, we accommodate them.” The expectation to “accommodate” this behavior was motivated both by the way in which they framed the job environment (resident’s home) and that the residents paid to live there. Discrimination did not emerge as an injustice to be named but instead as a condition of the job. Given that many direct care workers and nurses are motivated by a sense of altruism (Ball et al., 2009; Gray et al., 2016, Rodriquez, 2014), some floor staff may fail to perceive experiences as discrimination but instead perceive their need to accommodate this behavior as an obligation of their caregiving duty in serving residents in long-term care. Like many family caregivers in Levitsky’s study (2008, 2014), floor staff’s legal consciousness may be framed more by moral responsibility than a sense of justice. Only when resident behavior impeded their ability to perform this role – and a disparity emerged between their perceived caregiving obligation and capacity to fulfill that obligation (Levitsky, 2008, 2014) – did floor staff complain to managers as illustrated in the example above.

Floor staff’s legal consciousness also privileged residents’ rights over their own by attributing harassment to cognitive impairment, even when they lacked knowledge about the

resident's cognitive status. For example, after a male resident groped a CNA's breasts, she explained that he "probably had dementia." It is important to note that the resident did not live in the dementia wing. Nor did his medical charts indicate he had dementia. Several managers subsequently acknowledged "that he knew exactly what he was doing." Here, the CNA avoided blaming the resident for engaging in sexual harassment by associating his behavior with a health condition. Invoking dementia allowed her to continue providing care to this resident and preserve his rights to personal care and avoid framing the experience as discrimination.

Mid-Managers

Mid- and upper-level managers more readily acknowledged the conflict between residents and staff but rarely framed the experience as discrimination and expressed varying levels of support for staff. On one end of the legal consciousness spectrum were managers who seemed paralyzed by the conflict as expressed through one nurse manager:

> It's so hard and conflicting because you want to make the resident feel safe and at home and comfortable but at the same time, you don't want the employee to feel neglected or discriminated against. I don't know. It's so hard.

The conflict between resident and worker rights presented significant challenges for this nurse manager. She was able to name resident behavior as discrimination but avoided attributing blame. Here, she conceptualized the discrimination as if it were happening to someone else (not her) and struggled to resolve these conflicting rights. The dilemma itself prevented her from moving beyond naming discrimination and suggests she might waver if a front-line worker presented her with a complaint of discrimination by a resident. This response is consistent with other research finding that workers fail to complain about discrimination because managers took

sides in supporting alleged perpetrators (EEOC, 2016; Marshall, 2005) or minimized experiences of discrimination (Xiao et al., 2021).

On the other end of the spectrum were managers who felt compelled to protect their staff as expressed through another mid-level manager:

> It's not something that could just be put on the backburner because that staff member may go home feeling disgusted, scared, unsafe, and never come back. And then the next thing you know, you can't get in touch with this person because she just feels like she's unsafe here.

Instead of viewing harassment by residents as discrimination, however, mid-managers framed it as a breach of workplace safety for their staff. This finding is consistent with other legal consciousness research on how dispute handlers (i.e., supervisors who receive discrimination complaints) frame discrimination complaints as "personality clashes" or "poor management" (Edelman, 2019; Edelman, Erlanger, & Lande, 1993) as opposed to viable legal claims. When complaint handlers frame discrimination complaints as managerial problems, they try to resolve the problem (Edelman & Cabrera, 2020; Edelman, Erlanger, & Lande, 1993). By recasting the experience as an organizational concern, however, complaint handlers strip legality, justice, and workers' rights to nondiscrimination from the process. Here, framing discrimination as an issue of workplace safety seemed to motivate some managers to take proactive steps to protect their workers, especially when it invoked concerns about staff turnover, but failed to recognize legal rights for workers.

Unless floor staff framed an experience as discrimination, mid-managers rarely invoked a sense of justice to "name" or characterize experiences as discrimination. This finding contradicts the finding of Hirsh and Lyons (2010) that white workers with more job authority would be more

likely to perceive the existence of race discrimination than those with less job authority. Hirsh and Lyons (2010) argued that increased job authority provided workers with a greater sense of entitlement that could translate to them identifying the existence of race discrimination in the workplace. Presumably, managers have more job authority than floor staff. However, the institutional context in which front-line healthcare workers–including long-term care workers–perform their tasks may be unique enough from other workers that they may have more job authority in some capacities than managers. While floor staff have many regulatory guidelines to follow and supervisors to whom they report, the nature of their work demands autonomy in their jobs that may provide a sense of authority – even if they are not supervisors exercising authority over other workers. Front line workers must often respond to urgent and basic needs of residents and patients whereas managers often have administrative responsibilities that may be less urgent than tasks on the floor.

Upper-Managers

Upper-level managers' legal consciousness varied from floor staff and mid-managers: upper managers avoided discrimination rhetoric but framed concerns about discrimination from residents in terms of general staff rights. For example, one administrator noted the following:

> Our staff have the right to refuse care on somebody, meaning that they cannot neglect that person, but they can say next time, I do not want to take care of this person and we have to be mindful of that.

Here, the administrator acknowledged a worker's right to "refuse care" when the instance does not involve resident neglect. However, the administrator avoided naming the worker's experience as discrimination or characterizing her right as the right to work in a space free from

discrimination. Moreover, the passive approach about being "mindful" (as opposed to taking action, including honoring a request) still gives significant deference to the resident. While the administrator initially acknowledges a worker's "right to refuse," the approach of being "mindful" undercuts the existence of that right, including a right to complain or "claim" discrimination. Whether intentional or not, by avoiding discrimination rhetoric, upper-level managers were able to avoid critical conversations about how staff rights (e.g., right to nondiscrimination) may trump residents' rights or customer preferences.

A Director of Nursing (DON) also invoked general rights rhetoric (the "employee has rights, too") when referencing sex discrimination toward a CNA. In this situation, a female resident did not want to be cared for by a female CNA whose gender presentation was more masculine than the other female CNAs. Here, the DON never referenced discrimination but more explicitly noted the presence of the employee's rights by which she as the DON must honor.

Sometimes upper-managers invoked rights language more implicitly, as illustrated by one DON:

> And we've had patients that have referred to–to Black individuals as the N word and I've told them, I said that behavior is never appropriate here. If you continue to do so–now, remember, these were alert and oriented patients. If you continue to use that type of verbiage, we'll have to look at seeking discharge for you. We have a no tolerance policy for that.

The "no tolerance policy" afforded staff the right to be free from discrimination. While the DON never used the word "rights" or "discrimination," by referencing a "no tolerance policy," he implied the existence of staff rights that could be violated by residents who breached this policy.

Larger social structures and cultural norms foregrounding person-centered care may also prompt upper-managers to avoid discrimination rhetoric while still invoking a general sense of injustice around staff rights. All of the upper-level managers interviewed were expected to draft and/or approve facility policies, including policies relating to discrimination and resident care. They were intimately familiar with these policies and their use of "rights" language and how specific rights carried a higher fear of litigation. Upper-managers described how a fear of litigation motivated some of their decisions and as one manager stated they "would never [want to] be accused of anything possibly like racism or discrimination." They were also deeply invested in person-centered care for the residents and ensuring that the facilities had high bed counts. Empty beds meant less pay for the facility, and unhappy residents could always move to another facility–thus creating more empty beds. By avoiding discrimination rhetoric, upper-managers may have found a middle-ground in which they could acknowledge staff rights without invoking liability concerns about discrimination or potential fall-out from angering a resident with a discrimination complaint.

DISCUSSION

Findings reveal rampant unreported instances of race and sex discrimination toward staff by residents and variations in legal consciousness among staff levels. Staff at all levels rarely invoked discrimination to describe interactions between residents and staff. Floor staff attributed experiences of discrimination to resident health and cognitive status or framed it as a condition of employment, which precluded floor staff from "naming" discrimination and "blaming" discriminatory behavior on residents. Floor staff had more resident contact than mid- and upper-managers and may have invoked these framings to allow them to continue to deliver personal

care to residents who engaged in discrimination toward them. Providing care to a difficult or even abusive resident requires a unique set of skills that may also help floor staff feel valued, which research has found to be an important motivation for direct care work (Bjerregaard, Haslam, Mewse, & Morton, 2017)–by shifting the explanation from racial bias to health condition. It may be easier to provide caregiving to someone exhibiting racism if a worker can frame it as a condition of a resident's health condition, as opposed to personal animus. By avoiding naming and blaming, floor staff never reached the claiming process that would result in a report or complaint of discrimination.

When managers discussed experiences of discrimination, they tended to focus on discrimination by floor staff that they supervised or oversaw as opposed to discrimination by residents that they personally experienced. Even mid-managers who had some contact with residents (e.g., social workers, nurse managers) still tended to focus on discrimination experiences as experiences that happen to floor staff (not them). Mid-management framed experiences around staff safety. The administrative responsibilities of mid-managers may shape their legal consciousness and facilitate framings around safety as opposed to discrimination. Mid-managers are responsible for ensuring that staff are adhering to the many federal and state regulations that govern long-term care facilities. Many of these regulations focus on safety. The centrality of safety may prime mid-managers for a safety framing more than a discrimination framing when interpreting these situations. Upper-management acknowledged staff rights without invoking discrimination rhetoric. While upper-managers more regularly acknowledged staff rights, by avoiding discrimination rhetoric, they provided space for more deference to residents' rights that could hinder discrimination complaints. Ultimately, managers' framings shaped how staff named, blamed, and claimed experiences of discrimination and help explain

why long-term care staff may be hesitant to report discrimination by residents. The discussion below provides additional context for these findings and concludes with proposed solutions at the micro, mezzo, and macro levels.

Formal caregiving is a challenging job. Direct care workers like CNAs are responsible for critically important tasks that are often physically demanding (e.g., physically lifting residents) and considered "dirty work" (e.g., toileting assistance). These tasks are difficult and often thankless. However, direct care workers have reported fulfillment in their jobs when they feel valued, a sense of belonging, and pride in their work (Bjerregaard, Haslam, Mewse, & Morton, 2017). Long-term care managers have reported altruistic motivations for their work (Ball et al., 2009, Rodriquez, 2014) that can drive a sense of satisfaction. Racism by residents would likely undercut a worker feeling valued, a sense of belonging, or pride in their work and expedite departure from that facility. Because sexism and racism are not limited to a particular type of facility or geographic region, women of color cannot escape racial bias from residents by seeking employment at another facility. Structural solutions are necessary to address discrimination and can and should occur through micro, mezzo, and macro-levels.

At the micro-level, front-line workers would benefit from tools that help understand how structural contexts shape interpersonal interactions, including discrimination. These micro-level tools, however, must be paired with mezzo and macro-level solutions to avoid placing the onus on eliminating discrimination solely on the individual. Metz and Hansen (2014) proposed a structural competency approach for addressing biases by healthcare providers that could be adapted to address discrimination toward providers (Popper-Giveon & Keshet, 2018). The structural competency approach explains how racism in interactions between healthcare providers and patients exist within larger social structural contexts that are shaped by providers'

race, ethnicity, stereotypes, and stigma (Metz and Hansen, 2014). Popper-Giveon and Keshet (2018) expanded on this approach to identify "tools" for providers experiencing bias from patients. They argue that understanding the social structural contexts that shape patients' biases (e.g., historical experiences, limited exposure to a diverse workforce, segregated housing experiences facilitated by redlining and restrictive covenants) provides a critical tool for helping providers navigate residents' biases by contextualizing them. Many of the front-line workers were already engaging in some form of structural competency approach. More experienced workers described how they mentored newer workers about the importance of placing sexist and racist comments from residents in these contexts (e.g., attributing discrimination to dementia, age, or historical experiences). However, more attention and support for this approach could help other front-line workers experiencing discrimination from residents. Nevertheless, the structural competency approach seems doomed to fail if the solution lies only with individual providers. Front-line workers must feel valued by their colleagues and supervisors and the larger organizational culture. Here, staff at all levels and at both facilities underscored the importance of working in a supportive environment that valued their contributions and experiences.

At the mezzo-level, facilities can support organizational policies that address biases and harassment based on sex and race. First and foremost, facilities can and should acknowledge the existence of this phenomena – this is particularly important for facilities with predominantly white leadership. In this study, one of the two facilities had a predominantly white management team and struggled to address racism by residents. Despite laws prohibiting facilities from honoring residents' racial preferences for caregivers, staff at all levels reported that they would defer to the resident. While several staff explained that deferring to residents would avoid abuse or mistreatment of staff, many staff framed deference to residents as a business imperative (e.g.,

need to please the customer). Facilities can develop agency policies such as Caregiver Preference Guidelines (Popper-Giveon & Keshet, 2018) that make clear that residents cannot request caregivers based on race. The law is somewhat still unsettled about whether or not facilities can permit residents to make caregiver preferences based on sex (Gold Waldman, 2018). Facilities will need to determine whether they should apply the same logic to gender preferences for caregivers that applies to racial preferences for caregivers by residents. However, a strong policy would prohibit sexual harassment by residents. Facilities should supplement these policies with staff trainings on how to support colleagues who have experienced racial and sexual harassment and identify multiple methods for reporting it.

At the macro-level, professional associations should issue guidelines and policy statements that address discrimination, including discriminatory requests for providers (Pope, 2018). While current state and federal laws prohibit race and sex discrimination by staff, policymakers could codify policies that address discrimination by residents, particularly given the ambiguity expressed by staff about how to address this issue. Residents exist as both customers and patients, and administrative guidance through the Centers for Medicare and Medicaid Services (CMS), which oversees nursing facilities receiving federal funding, could provide useful instruction. Additional funding and supports are further needed to strengthen the mental health of long-term care facility staff. Prior to COVID-19, a 2019 report found that the median operating margin of skilled nursing facilities in the United States dipped to -0.1% (Rutledge, Wocken, & Wilson, 2019). This report covers roughly the same time period as data collection for this study (August 2019 to March 2020). COVID-19 only exacerbated this issue as facilities had to very quickly pay for and acquire PPEs, incorporate facility improvements to keep residents and staff safe, and address massive gaps in staff support as workers became

infected and/or resigned for fear of infection. COVID-19 also exposed how long-term care staff are vastly devalued in the marketplace (Scales & Lepore, 2020) by revealing how many workers hold multiple jobs providing double or triple-duty caregiving roles (Van Houtven, DePasquale, & Coe, 2020). Increasing worker pay may not be enough to provide a sense of value that long-term care workers need. As policymakers engage in nursing home reform to address COVID-19 and its aftermath, new policies should address mental health supports for facilities, including those that address mental health consequences of discrimination that staff encounter from residents while performing their job.

CONCLUSION

This research has several limitations. First, while this case study included many diverse perspectives, only staff who voluntarily agreed to participate were included. Thus, the experiences of staff who did not sign-up for an interview are not represented in this data. Second, the sample of upper-level managers was small, and future research could focus specifically on the experiences of this staff level. Third, these findings are not generalizable; however, they instead provide rich description and theoretical explanation on how long-term care facility staff at various levels (floor staff, mid-level managers, upper-level managers) understand discrimination and how these understandings help explain underreporting. Fourth, the data gathered reflect responses in a pre-COVID world. The COVID-19 global pandemic has produced more federal and state policies that have increased scrutiny for resident and staff safety. Future research could build on these findings to identify how COVID-19 has shaped staff understandings and responses to discrimination, particularly among an already overburdened workforce.

Future research should also further explore the implications of race and gender (and the intersection of race and gender) in discrimination among nursing home staff. Stark gender and racial disparities exist among nursing home staff, which predominantly comprise women, particularly among front-line workers such as certified nursing assistants and nurses (PHI, 2018a). In Michigan, 94% of direct care workers are women (PHI, 2018a). Direct care workers in nursing homes are also disproportionately women of color. In Michigan, 43% of direct care workers in nursing homes are women of color (PHI, 2018b). Thirty-seven percent of direct care workers in Michigan identify as Black or African American (PHI, 2018b) while only 14% of Michigan's population identify as Black or African American (U.S. Census Bureau, 2019). While much of the front-line staff comprise women – and disproportionately represent women of color – leadership tends to be predominantly white (Bates, Amah, & Coffman, 2018), which could produce very diverse understandings and experiences of discrimination by other staff.

This research has several implications for theory, research, practice, and policy. First, it extends legal consciousness theory to examine how workers understand their rights when they conflict with other rights – here rights between residents (e.g., quality care, autonomy) and workers (e.g., nondiscrimination). It also provides new empirical data about an understudied but timely topic in healthcare and long-term care in particular: how staff understand discrimination by residents and why underreporting still persists. As nursing home reform continues to evolve throughout the United States – and throughout the world – in the wake of COVID-19, long-term care facilities, their staff, and policymakers have an opportunity to create new practices and policies that better support staff experiencing discrimination by residents and other staff. Amidst the COVID-19 pandemic, a global cultural awakening has occurred regarding race. Institutions are grappling with the consequences of centuries of racism, and many workplaces have begun

making efforts to improve their workplace culture to better support staff of color. This research provides important empirical evidence supporting these efforts, particularly for long-term care staff.

CHAPTER 4: Pray the Gay Away: Religious Exemptions and Cultural Discord in Caregiving for LGBTQ Residents in Long-Term Care Facilities

INTRODUCTION

Since LGBTQ advocates achieved marriage equality in 2015 (Obergefell, 2015), a renewed focus on religious liberty has emerged that pits religious rights against LGBTQ rights. Policymakers have passed new laws carving out exceptions for providers to deny services because of religious or moral beliefs (religious exemptions) – further fueling this debate. These laws have sparked significant public commentary on which rights prevail in this conflict (religious liberty or LGBTQ rights) from the media (Boorstein & Schmidt, 2021; Crary, 2021; Mattingly, 2020; Wolf, 2020) and legal scholars (Adenitire, 2020; Anderson & Girgis, 2017; Corvino, 2017; Hiegert, 2020; Singer, 2017; Thomas, 2018). This commentary has exploded against a backdrop of increasing public support for LGBTQ rights, including nondiscrimination protections for LGBTQ people (Jones et al., 2018). As of 2018, majorities in every state in the U.S. favor nondiscrimination protections for LGBTQ people (Jones et al., 2018). Still, nearly a quarter of respondents in a 2018 survey who favored LGBTQ nondiscrimination protections also supported religious exemptions allowing businesses to deny services to LGBTQ people (Jones et al., 2018). Such a position seems almost paradoxical but may be attributed to how individuals frame or understand religious exemptions.

Recent healthcare scholarship suggests that the sharp contrast between religious liberty and nondiscrimination demands a more nuanced examination. While much of the public rhetoric

and legal scholarship on religious exemptions has focused on addressing conflicting religious liberty and LGBTQ nondiscrimination rights, healthcare practitioners and scholars have mostly avoided this juxtaposition. Instead, healthcare scholarship focuses more on patient care and concerns that religious exemptions could produce negative health consequences for LGBTQ patients (Erstad, 2019; Raifman & Galea, 2018; Schuklenk & Smalling, 2016; Sofer, 2018; Stahl & Emanuel, 2017). Researchers have since documented the negative health impacts of religious exemptions on LGBTQ people and patient care (Blosnich et al., 2019; Grzanka et al., 2020; Raifman et al., 2018). The centrality of patient care in healthcare may help explain why healthcare providers avoid framing religious exemptions as a conflict between religious liberty and LGBTQ nondiscrimination and instead focus on religious exemptions as issues of patient care.

Healthcare has increasingly relied on teamwork for patient care (Barry et al., 2019; Keefe et al., 2020; Rucker & Windemuth, 2019), and a colleague who refuses to provide care based on religious or moral beliefs may disrupt that teamwork model of patient care. These disruptions may be more pronounced in residential healthcare facilities like long-term care facilities that provide 24-hour patient care. Perceptions about a potential disruption to patient care may vary among staff that have different levels of patient interactions. Direct care workers and other floor staff (e.g., nurses) with significantly more patient interactions may apply different views about patient care than mid-managers (e.g., nurse managers, social workers) with some patient interactions or upper-level managers (e.g., administrators, directors of nursing) with limited interactions. Staff at varying levels may apply different cultural frames – mental structures, or schema, that guide one's actions and help make sense of ideas and experiences (Cucchiara, 2020; Goffman, 1974) – to determine how to deliver patient care. When a colleague refuses to provide

patient care based on moral or religious beliefs, healthcare workers must reconcile what I call "cultural discord," or conflicts among cultural frames. Cultural frames help healthcare workers achieve social coherence (Tebbe, 2017) to harmonize cultural discord among conflicting frames (e.g., fairness, equality, religious liberty). Social coherence (Tebbe, 2017) involves the process that individuals use to reach a justifiable conclusion when a colleague refuses to provide care based on religious or moral beliefs.

Long-term care facilities represent a healthcare space that is particularly ripe for studying how healthcare workers understand religious exemptions, given the heightened centrality of patient care in this space. Patients receive 24-hour care in long-term care facilities. Patients become residents whose homes include healthcare facilities. Given the level of care that many residents require, long-term care facilities also operate under a complex network of laws and regulations that center patient care. Long-term care facilities also rely heavily on healthcare workers who have regular and repeated contact with residents to deliver patient care. Within this context, however, workers also enjoy various employment rights, including religious liberty. Staff understandings and responses to religious exemptions are particularly timely for study, given the recent frenzy of policies introduced to expand or curtail religious exemptions. Long-term care staff could and have exerted religious exemptions to deny caregiving to LGBTQ+ older adults (Justice in Aging, 2015). In long-term care, residents are dependent on the staff who serve them for basic everyday tasks like using the toilet or dressing as well as facilitating social connections and support with other residents. Denying care to LGBTQ+ older adult residents, particularly based on staff members' personal religious beliefs, could have negative physical and mental health implications for LGBTQ+ residents and diminish their quality of care. To better

understand this process of social coherence in healthcare—and specifically in long-term care facilities—this study asks the following two questions:

1. How do long-term care facility staff respond when colleagues refuse care to LGBTQ residents because of individual religious or moral beliefs?
2. Why do long-term care facility staff who support nondiscrimination principles for LGBTQ people also support religious exemptions among staff?

The Rise of Religious Exemptions

After the United States Supreme Court granted marriage equality for same-sex couples in 2015 (Obergefell, 2015), anti-LGBTQ groups rapidly shifted their messaging to emphasize a new minority status that needed liberty protections (Wilson & Djupe, 2020). Policymakers responded by passing a slew of new federal and state policies with religious exemptions that pitted LGBTQ rights against religious liberty (e.g., Alabama, 2017, Arkansas, 2021, Illinois, 2017, Mississippi, 2016, Tennessee, 2016). Religious exemptions allow individuals and organizations to avoid delivering business services (e.g., catering, hotel accommodations), child welfare services (e.g., foster care placement), and healthcare services because of moral or religious beliefs. While religious exemptions existed prior to marriage equality, religious exemptions after *Obergefell* focused more heavily on healthcare. Five states (Alabama [2017], Arkansas [2021], Illinois [2017], Mississippi [2016], and Tennessee [2016]) passed laws after *Obergefell* that permit medical professionals to decline services to LGBTQ clients. In 2018, the United States Department of Health and Human Services (HHS) announced a new Conscience and Religious Freedom Division in its HHS Office for Civil Rights (U.S. DHHS, 2018), which has received criticism, along with religious exemptions in healthcare more generally, from public

health and medical scholars (Raifman & Galea, 2018; Schuklenk & Smalling, 2016; Stahl & Emanuel, 2017), nurses (Sofer, 2018) and pharmacists (Erstad, 2019) as negatively impacting LGBTQ patients.

As laws and policies with religious exemptions have grown, an emerging body of scholarship about religious exemptions has developed, particularly in legal studies. Scholars have presented arguments supporting religious exemptions (Adenitire, 2020; Anderson & Girgis, 2017; Koppelman, 2006) and opposing religious exemptions (Corvino, 2017; Hiegert, 2020; Feldblum, 2006; Singer, 2017; Thomas, 2018) and have questioned how religious exemptions falsely pit LGBTQ rights against religious liberty (Koppelman, 2020). Several studies grounded in psychology have also examined mental health of LGBTQ residents in states that passed these laws. Raifman and colleagues (2018) found that laws in 12 states permitting denial of services to same-sex couples for religious or moral reasons were associated with a 46% increase in sexual minority adults experiencing mental distress. Grzanka and colleagues (2020) conducted an exploratory study on Tennessee residents' perceptions about a state law allowing counselors and therapists to deny services to a client based on "sincerely held principles." They found significant associations between this legislation and perceptions of mental health care, willingness to seek services, and psychological distress (Grzanka et al., 2020). In a study of 4,911 sexual minority individuals across 21 states in the U.S., Blosnich and colleagues (2019) found sexual minorities in Indiana (the only state in the sample that passed a law with religious exemptions) exhibited significantly more unhealthy days (self-reported mental and physical health that is not good) under the Behavioral Risk Factor Surveillance System than heterosexual adults in Indiana. A 2018 Report by the Public Religion Research Institute (PRRI) found that 57% of Americans oppose allowing a small business owner to refuse products or services to gay

or lesbian people if providing them violated their religious beliefs (Jones et al., 2018). About one in three (36%) Americans supported religious exemptions for business owners (Jones et al., 2018). Curiously, this report also found that 23% of respondents who favored LGBTQ nondiscrimination protections also supported religious exemptions allowing business owners to deny services to LGBTQ people (Jones et al., 2018). Such a position seems almost paradoxical but may be attributed to how individuals frame or understand religious exemptions. The present study provides new data to untangle this paradox.

Long-Term Care Facilities

Long-term care facilities in the United States (often colloquially called nursing homes) provide residents skilled nursing care, rehabilitation services due to injury or disability, or regular health-related care because of a mental or physical condition (Requirements for Nursing Facilities, 42 U.S.C. § 1396r, 2020; Requirements for Long Term Care Facilities, 42 C.F.R. § 483, 2020). Seventy percent of long-term care facilities operate as for-profit businesses, 24% operate as nonprofit organizations, and 6% operate as government facilities (CMS, 2015). Over 95% of approximately 15,000 long-term care facilities that exist in the United States receive government funding through Medicare and/or Medicaid programs (Kusmaul, Bern-Klug, & Bonifas, 2017). Long-term care facilities receiving government funding must adhere to a bevy of regulations outlined in federal and state law (e.g., Nursing Home Reform Act, 2010). To ensure compliance, long-term care facilities employ managers who can provide care oversight and comply with administrative paperwork and electronic database system requirements. Front-line long-term care workers like certified nursing assistants (CNAs) and nurses usually provide care to older adults who have complex medical needs (Zimmerman et al., 2014), including assistance

with ADLs (e.g., bathing, grooming, dressing, eating, using a toilet), IADLs (e.g., meal preparation, shopping, using a phone, taking medication), psycho-social care, and overall care management. CNAs spend more time than any other nursing staff assisting residents (PHI, 2015).

In the last few decades, a cultural shift has produced a new emphasis on de-institutionalization of nursing homes and a focus on person-centered care (Zimmerman et al., 2014; Kusmaul & Tucker, 2020). In fact, one key objective of the Affordable Care Act included the adoption of a more community-based and person-centered long-term care system (Hawes et al., 2012; Kietzman, 2012; Patient Protection and Affordable Care Act, 2010). The devastating impact of COVID-19 on long-term care facilities, residents, and its staff has ushered new calls for reform and person-centered care in this space (American Geriatrics Society, 2020; Morley, Kusmaul & Berg-Weger, 2021). Long-term care facility staff immersed in an environment that emphasizes person-centered care may foreground this principle when making decisions about the care they provide and the support they provide to their colleagues seeking assistance for resident care, including for LGBTQ residents.

While the number of individuals residing in long-term care facilities in the United States is declining (CMS, 2015), LGB older adults have a higher percent chance of moving to a nursing home compared to heterosexual older adults (Singleton, Gassoumis, & Enguidanos, 2021). This disparity may be explained by negative health consequences of cumulative discrimination and internalized stigma among LGBTQ older adults (Emlet et al., 2017; Fredriksen-Goldsen, 2009; Hoy-Ellis, 2017; Lyons et al., 2019) and the smaller likelihood of having living children who could help compared to heterosexual adults (Singleton, Gassoumis, & Enguidanos, 2021). One study found that LGBTQ older adults are four times less likely to have children as their non-

LGBTQ peers (Espinoza, 2011), whereas a more recent study found the number closer to two times less likely to have children (Singleton, Gassoumis, & Enguidanos, 2021). Rejection from biological family has prompted many LGBTQ older adults to rely on families of choice (Lowers, 2017; MetLife Mature Market Institute, 2010). This social, historical, and economic context creates unique challenges and needs among LGBTQ residents that staff may be especially motivated to meet to ensure culturally responsive care to this community.

Long-term care facility floor staff, managers, and administrators must balance the needs and rights of all the residents along with needs and rights of the staff who work there. Religious exemptions can present a conflict in long-term care when a staff member refuses to provide services to an LGBTQ resident because of the staff member's religious or moral beliefs. LGBTQ advocates have expressed concern that the recent flurry of policies with religious exemptions could result in substandard care and decreased services for LGBTQ people (INCLO, 2015; Movement Advancement Project, Public Rights/Private Conscience Project and SAGE, 2017). Yet, research on religious exemptions is limited, and there are no data on how healthcare staff understand and respond to religious exemptions in providing care to LGBTQ people. One study in Wales found that over 16% of long-term care workers and managers had difficulty reconciling their religious views with their interest in accepting LGB people, and over 40% did not share their religious views (opposing LGBTQ people) so that they could accept LGB people (Willis, Raithby, Maegusuku-Hewett, & Miles, 2017). However, no data examine how staff respond to colleagues who assert religious exemptions to care, which is particularly important given the growing emphasis on team-oriented approaches to healthcare (Barry et al., 2019; Keefe et al., 2020; Rucker & Windemuth, 2019).

Social Coherence and Cultural Frames

To help answer the two research questions, I turn to two theoretical approaches: social coherence (Tebbe, 2017) and cultural frames (Cucchiara, 2020; Goffman, 1974). Amidst the recent rise of religious exemptions, socio-legal scholar Nelson Tebbe (2017) introduced an approach called social coherence to provide a framework for resolving disputes between religious freedom and equal rights for LGBTQ people. Social coherence involves a process of reflection, in which an individual resolves conflicts between religious liberty and equality by appealing to social context to make moral and political judgments coherent. In describing social coherence, Tebbe (2017) invokes political philosopher John Rawls's (1971) notion of "reflective equilibrium," (p. 26), which involves finding ways to harmonize conflicting principles to reach a justifiable conclusion. As a socio-legal scholar, Tebbe (2017) proposes social coherence as an instructive conceptual framework for courts and policymakers to employ when adjudicating conflicts between religious liberty and equality. However, social coherence also presents a framework for understanding the process of reflection that staff employ when a colleague asserts a religious exemption to care that extends beyond a dichotomous paradigm of religious liberty and equality.

While Tebbe (2017) describes social coherence as a reflective process, I argue that social coherence can also include an outcome that one reaches through this reflective process. Thus, if someone experiences cultural discord among cultural frames, their reflective process to reconcile this conflict can produce social coherence as a resolution. This approach to social coherence parallels scholarly conversations about "justice" that present justice as a process (Warner, Meerts-Brandsma, & Rose, 2019; Williams, 2020) and/or an outcome (Bansal, 2017; Falavigna, Ippoliti, & Manello, 2019).

Tebbe (2017) identifies four principles that "manage tensions between religion and equality" (p. 14), including avoiding harm to others, fairness to others, freedom of association, and government nonendorsement of religion. Tebbe (2017) invokes these principles with court judges and policymakers in mind (i.e., how can the government pass laws that avoid harm to others while protecting freedom of association). Tebbe (2017) justifies use of these four principles by noting that they are rooted in constitutional law and thus easily accessible to court judges and policymakers bound to uphold the U.S. Constitution.

Some of these principles also have relevance in healthcare, too. For example, several healthcare scholars have opined that religious exemptions violate core tenets for healthcare practitioners to avoid harm to others (e.g., patients) (Raifman & Galea, 2018) and fairness (e.g., avoiding discrimination based on health condition or social characteristics) (Stahl, 2017). Tebbe's other two legal principles (freedom of association and government nonendorsement) are part of a cultural narrative (i.e., cultural frames) of individual rights for many Americans (Bernstein et al., 2020; Garlington, 2014). Long-term care staff may invoke these principles when navigating religious exemptions.

Cultural frames include the mental structures, or schema, that guide one's actions and help make sense of ideas and experiences (Cucchiara, 2020; Goffman, 1974) and construct "strategies of action" (Swidler, 1986, 2003). For example, in Cucchiara's (2020) study of parenting education, parents used cultural frames that viewed force as sometimes necessary and effective whereas instructors used cultural frames that discouraged all forms of force. The social context in which one is invoking the cultural frame matters, and individuals may be more likely to adopt cultural frames supported by others they respect in this social context (Harding, 2010). The opinions of professional associations and coworkers (including views about religious

exemptions) may shape one's support and use of a cultural frame in any given situation and may serve as yet another cultural frame to resolve conflicts between nondiscrimination and religious exemptions.

Different levels of staff may rely on different cultural frames to understand and respond to religious exemptions invoked by fellow staff. Job duties and responsibilities, education, and training vary among floor staff, mid-managers, and upper-managers in long-term care facilities. Direct care workers (CNAs) provide the bulk of in-person caregiving of nursing facility residents yet have minimal training and educational requirements and no professional associations. Floor nurses (LPNs and RNs) provide in-person caregiving but have additional training and educational requirements and access to professional associations. Mid-managers in long-term care facilities tend to be nurses and occasionally social workers who have similar educational and training backgrounds and access to professional associations as floor nurses but additional job responsibilities related to management (e.g., administrative paperwork, compliance). Upper-managers often have increased education and training requirements and access to professional associations, and additional job responsibilities related to managing the facility itself compared to floor staff and mid-managers. The diversity of these experiences among floor staff and managers may prompt them to invoke different cultural frames from one another that shape how they understand and respond to religious exemptions presented at work. The present study contributes much-needed empirical data examining how healthcare providers, specifically in long-term care staff at three levels (floor staff, mid-management, upper-management), understand religious exemptions and how they reconcile conflicting cultural frames when colleagues assert religious exemptions to providing care to LGBTQ residents.

DESIGN AND METHODS

This study employs a qualitative comparative case study design (Meier, 2015; Mills, Durepos, & Wiebe, 2012) that compares three levels of staff in long-term care facilities to answer the following research questions: (1) How do long-term care facility staff respond when colleagues refuse care to LGBTQ residents because of individual religious or moral beliefs?; and (2) Why do long-term care facility staff who support nondiscrimination for LGBTQ people also support religious exemptions among staff? Data includes in-depth semi-structured interviews (n = 90) of three levels of staff (floor staff, mid-management, and upper-level management).

Participants and Design

This study used a combination of selective and snowball sampling procedures to recruit facility staff from three levels (n = 90) through a stratified purposive sample (e.g., Silver & Williams, 2018). Purposive sampling comprises a commonly-used approach in qualitative research to identify and select rich cases that provide depth on a particular phenomenon (Van Humbeeck, Dillen, Piers, & Van Den Noortgate, 2020). Here, the purposive sample included long-term care facility staff that were stratified among three levels (floor staff, mid-level management, and upper-management). I recruited participants from two long-term care facilities near an urban region in Michigan in the United States from flyers disseminated through staff email and posted in staff spaces (e.g., break rooms), through verbal announcements at staff meetings, and through snowball sampling from other participants. Both facilities are nonprofits and accept Medicaid and Medicare, have fewer than 110 beds, are continuing care retirement communities (CCRC), have resident councils but no family councils, and provide care outside a hospital. Both also received a minimum of 4 stars in the Centers for Medicare & Medicare

Services' (CMS) quality measures (above average), minimum of 4 stars for CMS's health inspection rating (above average), and 1 star in CMS's staffing rating (much below average). Because only a handful of upper-managers work in a facility, I also recruited upper-managers from other nonprofit facilities throughout Michigan to increase the sample size of this group. I recruited additional upper-managers by attending state-wide conferences for long-term care facility staff, including one that specifically focuses on upper-managers (*see* Appendix C: Additional Description about Upper-Level Staff). See Table 1c for a description of participants' race/ethnicity and gender by staff level and Appendix D for further description about how I accessed the two facilities.

I conducted 78 interviews face-to-face and 12 interviews by phone from August 2019 to March 2020. Phone interviews were particularly helpful for floor staff who often had multiple jobs and less flexibility for scheduling interviews and for upper-managers in facilities scattered throughout Michigan. Eighty-nine of the 90 interviews were audio-recorded and transcribed by a professional transcriptionist. One participant preferred that I take written notes of their responses. Interview topics included educational/professional background, job duties, religious beliefs, experiences of conflicts arising at work because of religious or moral beliefs, and organizational practices and policies (e.g., Can you think of any challenges that staff may have for providing care to LGBTQ residents?; Can you think of an example when a colleague struggled to provide care to an LGBTQ resident because of moral or religious beliefs?). *See* Appendix A: Interview Protocol.

I also included two hypothetical scenarios about conflicts arising at work because of religious or moral beliefs because few participants were able to recount actual experiences in which colleagues refused care to LGBTQ residents because of religious or moral beliefs. Instead,

much of the data about how they would navigate religious exemptions stems from their responses to these hypothetical scenarios in the future. One scenario involved a religious staff member who refused to allow a same-sex couple to participate in social activities with other residents because of her religious belief in marriage equality. Another scenario asked how they would respond if a colleague at their facility refused to provide care to a gay resident because of the staff member's religious or moral beliefs. These scenarios represent real situations as reported from research reports and scholarly articles (e.g. Caceres et al., 2020; Heyman & Davies, 2006; Kusmaul & Tucker, 2020; Wolfenson, 2017), including Justice in Aging's 2015 *Stories from the Field* report about the experiences of residents and staff in long-term care, particularly LGBTQ+ residents, and informal conversations with staff in long-term care facilities that I had at statewide and national conferences and individual meetings with long-term care staff (prior to data collection). Hypothetical scenarios are often used in qualitative research to probe beliefs about controversial issues that are important to understand but may be infrequent in occurrence (e.g., Callahan & Zukowski, 2019; Takla et al., 2021). Researchers have used hypothetical scenarios to examine discrimination (Brettell, 2011; Shanaah, 2020) and individual beliefs (Herek, Widaman, & Capitanio, 2005) and behavior (O'Conor et al., 2018) about transgender women and men in public bathrooms (Callahan & Zukowski, 2019), support for transgender youth (Walzer, Fagley, Shahidullah, 2020), euthanasia and end-of-life care (Takla et al., 2021), and perceptions about trade-offs between public health and economic measures during the COVID-19 pandemic (Reed, Gonzalez, & Johnson, 2020). *See* Appendix B: Additional Description about Hypothetical Cases.

Interviews were sometimes broken into shorter time frames to accommodate participants' schedules. Interviews lasted between 30 minutes and 2 hours and averaged approximately one

hour. All participants received a $50 gift card. Upon conclusion of their interview, participants completed a short socio-demographic survey through Qualtrics about age, race, gender, gender identity, sexual orientation, religiosity, and religious belief. To preserve confidentiality, participants used a participant identification number instead of their name.

Data Analysis

I coded all staff interviews using Dedoose (2020), a qualitative software program. After each interview, I wrote a brief memo that summarized key points, emerging themes, and identified similarities and differences from other interviews. As interviews were transcribed, I conducted line-by-line open coding to identify concepts and emergent themes that further informed subsequent interviews. Through this process of coding, I identified 15 codes to capture core themes about participants' jobs (e.g., job duties, job challenges, educational and professional background, sources of support), organizational policies (e.g., participants' knowledge of policies and how they informed their work), rights (any time participants used the word "rights"), religion (e.g., religious discrimination, denial of care because of religion), and team (e.g., examples of staff relying on other colleagues for tasks, references to teamwork).

To offset potential researcher bias, I assembled a data coding team of four research assistants to conduct another round of open coding before conducting axial coding. Research assistants were given the same list of 15 codes to recode a subset of the data to test for coding inter-rater reliability. The subset of data was randomly chosen in Dedoose to include 87 excerpts that research assistants would code with the codes provided. All coders received inter-reliability scores of 0.83 and 0.84 (very high agreement). The data coding team and I conducted a second round of coding that included more in-depth coding for the excerpts pulled from the scenarios

and for religious discrimination. This process generated 5 additional codes about the scenarios and discrimination excerpts involving religious exemptions (e.g., support for staff denying care, opposition to staff denying care, interpersonal response [i.e., conversation with staff member], macro response [i.e., reference to policies, laws, regulations], discussion about reporting denial of care).

Next, the data coding team and I conducted axial coding. Axial coding explores relationships between the codes and organizes them into themes. We produced individual weekly memos and met weekly to discuss similarities and differences in the coding and identify emergent themes and patterns, as is part of the process during axial coding (Scott & Medaugh, 2017). Earlier memos and discussions informed subsequent interviews. This process of coding revealed recurring themes regarding how different levels of staff navigated situations in which colleagues denied care to LGBTQ residents because of individual religious or moral beliefs.

FINDINGS

Staff invoked varying cultural frames when engaging in social coherence about religious exemptions. Cultural frames included staff rights, fairness, resident safety, religion, job obligations, and laws and policies. Staff raised religion, fairness, and resident safety and comfort as a justification to both deny and accommodate a colleague refusing care. Table 3 identifies how different staff levels invoked various cultural frames. The findings section below first describes how staff identified each of these cultural frames to help resolve cultural discord and then concludes with a comparison among staff levels.

Staff Rights

Several staff incorporated a rights framing to justify their decision to accommodate a colleague denying care to an LGBTQ resident because as one LPN noted "that's one of their rights, also." One CNA drew a distinction between religious rights and general denial of care.

> I wouldn't have them serve him [an LGBTQ resident], because I feel like – because even with certain religions, like they can't eat – like they can't touch pork and stuff like that, so I feel like if it's religion based, then I feel like we should go by religion. Now with your wants and the things that you want, we can't – you know, we can't be okay with that. But if it's a religious thing, I feel like we should take it more serious.

For this CNA, a colleague could not merely refuse care to an LGBTQ resident because of general dislike or personal preference. But once they invoked religion, that colleague had rights that the facility and its staff (including her) had to acknowledge. This CNA did not subsequently express concern about the resident's right to care, which may have been, in part, because she was willing to switch with her colleague and provide the care the resident needed.

One manager also invoked staff rights to justify refusing care based on religion:

> In my past experience, if someone has a religious belief, you really can't interfere with that. You could talk to them and explain to them that by being employed here they are expected to care for, you know, all races, all genders, all religions, but when someone brings the, you know, it's against my religion, you really can't force them into doing that.

This manager subsequently explained that she had an experience at a prior job as an assistant director of nursing where she fielded numerous complaints about a CNA who read the Bible throughout her shifts. Other staff complained that this was unfair because they could not bring books or magazines to read throughout their shifts. However, when she reported these complaints to the Director of Nursing (DON), the DON told her that the facility could not

preclude this staff member from reading the Bible during shifts because it would interfere with her religious rights. None of the other managers expressed concern that denying care was permissible because of individual religious rights. Nor did they share experiences where concerns about individual religious rights of staff had surfaced when questions about their job performance emerged. This particular manager's framing was shaped by her own experience – and particularly another supervisor who expressed concerns about religious infringement. It is worth noting, however, that these situations are distinct. A colleague refusing care to a resident is not analogous to a staff member reading during their shift. This manager's account never noted that staff complained that their colleague's Bible reading was interfering with resident care. Instead, it centered on concerns about fairness. Nevertheless, the experience shaped this manager's perception of the salience of staff religious rights and how it framed her understanding of religious exemptions for resident care. Perhaps, because she lacked other experiences with colleagues exerting religious liberty, this manager invoked this experience as a cultural frame to understand how she should respond if a colleague asserted a religious exemption to caregiving.

Fairness

Many staff expressed concerns that denying care was "not fair" or "not right." For some staff, fairness provided a cultural framing that they employed to both justify accommodation and discourage religious exemptions among colleagues as one CNA's statement captures below:

> I don't have the right to impose what I believe on you or anybody else. So I would say well, I'll take over and do the activities with John, but I would kind of pull her to the side and say that that's not right, that's not fair for you, you know? It's not.

This CNA invoked a cultural frame that imposing beliefs on others was problematic. For her, refusing care because of a religious belief was "not right" and "not fair" but imposing her sense of moral beliefs on her colleague was also wrong. She navigated this tension by accommodating her colleague and taking over the resident's care while engaging in a dialogue where she could share her beliefs. Sharing her beliefs did not violate her sense of fairness, whereas acting on individual moral beliefs (e.g., refusing care) did.

Other staff invoked fairness framings to justify refusing to accommodate a colleague who wanted to deny care.

> What the hell are you talking about? What is wrong with this resident? I mean, he's still a person. He still enjoys doing activities. Why wouldn't you do them with him? He's no different than anybody else. That's just not fair.

This CNA's comments reflected moral indignation for a colleague who refused to care for an LGBTQ resident because of religious or moral reasons. For her, fairness equates to equality. The LGBTQ resident was "no different than anybody else" and it was his sameness that demanded equal treatment by her colleague. For this CNA, her cultural framing of sameness is what motivated her to oppose religious exemptions for caregiving.

Another CNA invoked a fairness framing that centered sameness and resident empathy to oppose religious exemptions.

> I'd have to bite my lip at first, but I don't know, I don't think that's right anyway, no matter what, because that – everybody deserves the same care. They don't want to be here in the first place. I mean, nobody wants to be in a place like this… Yeah, they shouldn't be able to refuse.... I don't think that's right.

This CNA saw fairness as demanding equal care. For her, none of the residents wanted to be in a long-term care facility, which equalized them. She foregrounded their status as resident over their sexual orientation or gender identity and over her colleague's religious beliefs. Their status as a resident resigned to live in a long-term care facility trumped a colleague's individual beliefs and demanded a sense of equality among the residents.

Managers rarely invoked fairness framings in their discussion. One mid-manager, however, noted that if a staff refused care because of religious beliefs, she would "need to talk to them" and tell them that "maybe this isn't the place for you… because everybody is welcome. I mean who are you that you can dictate how somebody can be and act and think? What makes you think that?" This manager invoked a similar framing as several CNAs that focused on inclusion. She concluded with a condemnation of this colleague that builds on her view of fairness as inclusion.

Job Obligation

While staff at all levels expressed disapproval about a colleague denying care as abdication of their job duties, floor staff invoked this framing much more frequently but in diverse ways. Some staff blended frames about fairness and job obligations. One CNA emphasized the humanity of the resident along with the importance of performing the work.

> You can't judge that person on who they are, you know, you have to get the job done, regardless of who they are. They're a human being. They need assistance just like you would if you was older.

Another CNA foregrounded respect as a component of the job and how denying care would compromise that component of the job.

> I'm here to serve everybody and treat everybody with respect, so if you can't do that then I feel like you should find another job, because you're not going to complete your job. That's what you're here for.

For some CNAs, receipt of payment formed the basis of this mandatory job duty.

> Well, you've got a job to do, and this is part of your job, so I understand your religion, but this – your religion is not what pays your bills. Your job does. And this is part of your job, and this is what you need to do, and if you don't want to do it, then you can find you another job.

For her, denial of care would suggest payment for services not rendered as well as jeopardize financial well-being. Many direct care workers work multiple jobs and live paycheck to paycheck (Baughman, Stanley, & Smith, 2020; PHI, 2015) and cannot afford to lose a paycheck for failing to perform their jobs.

Staff identified the importance of centering residents as a component of the job, as exhibited by one CNA:

> This is your job, so you're imposing your religious beliefs on John now. You know, you're – Whatever the issue is, that's kind of too bad, because this is the field that you're in and that's your job. So you can't pick your residents. Your residents however, can pick you, but you can't pick your residents.

For this CNA, providing care to residents – even residents you did not like – was a necessary condition of the job. She accepted that an unequal dynamic exists between residents and staff and that this dynamic was part of the job. Here, inequality was permissible – resident preferences were permissible, but staff preferences were not.

Another CNA took a more diplomatic approach that foregrounded teamwork as a component of the job.

> We all are a team player up in here … but … sometimes we have to get out of our character of what our religion is because even though it might be our religion, we still have a job.

Long-term care staff rely heavily on each other to ensure quality care for residents. Direct care workers depend on floor nurses to provide medications and some direct ADL care, and floor nurses rely on CNAs to provide assistance with ADL caregiving tasks like toileting, bathing, teeth brushing, and dressing. As one CNA noted "you signed up as a caregiver….so bathing them. Changing their diaper. All the dirty stuff. It doesn't matter what religion you have." CNAs also help transport residents throughout the facility and have much more interaction with residents on a day-to-day basis. CNAs rely on each other to help with lifting residents and other caregiving tasks when a two-person assist is required. Team approaches have grown in healthcare, including long-term care (Barry et al., 2019; Keefe et al., 2020; Rucker & Windemuth, 2019) and have become an important part of the job in many facilities. While some CNAs were sympathetic to a colleague whose religious beliefs challenged her caregiving abilities, many concluded that the job takes precedence and invoked a frame around job obligations to navigate this situation.

Managers also invoked the job obligation framing and noted that if a staff member refused to provide care to an LGBTQ resident because of religious or moral reasons, they would remind them about their job duties to the resident. One nurse manager noted that staff could have biases but must not act on them. For her, denying care amounted to acting on a bias.

> I guess you can have any personal bias you want. Keep your mouth shut. You signed up to take care of people. You didn't ask what sex they were, what religion, what color, whatever. That's what you signed up for. If you don't feel like you can do your job, I will find -- feel free to leave.

This nurse manager invoked a job obligations frame to employ a more pragmatic approach. She recognized that some of her staff would likely have biases toward some of the residents based on race, sex, or sexual orientation. However, if they acted on those biases by providing substandard care, or denying care, their actions contravened their work obligations as a caregiver, and she would ask them to leave.

One mid-manager described an interactional approach that would coach the staff refusing care about the consequences of denying an assigned task.

> I'd have to sit down with him and say this is your job, these are the residents, no matter who they are. I'm sorry they don't belong with your beliefs. But we're here for the greater good of the resident and if you don't think that you can do your assigned task, then maybe this place isn't for you.

Unlike the previous manager, this mid-manager took a more stepwise approach when invoking a job obligations cultural frame that involved a conversation to help the worker understand why denying care violated the facility's objective to provide resident care. But if the worker refused to comply, this mid-manager suggested she would be terminated.

When asked about a staff member asserting a religious exemption to care, a Director of Nursing underscored how denying care to LGBTQ residents amounted to unprofessional conduct and thus could not be tolerated.

> You may not like everybody, but I would expect that they would care for them and they would be – treat them with dignity and respect no matter what, no matter what their personal beliefs are, and if they can't do that, then they would be addressed, because I mean, that's professionalism.

For her, unprofessional conduct, including denying residents respect, violated their job duties as a caregiver. She was the only participant to reference professionalism when invoking a job obligations frame, which may be influenced by her increased access to professional associations and expectations as a Director of Nursing to comply with professional conduct standards (as a registered nurse and Director of Nursing). Here, professionalism informed the cultural frame she invoked when addressing religious exemptions to caregiving.

Resident Safety and Comfort

Resident safety and comfort emerged as another frame that some staff, particularly managers, employed when navigating religious exemptions. One CNA associated denial of care to contributing to poor health for LGBTQ residents. She expressed concern for LGBTQ residents that have to "keep it bottled up and don't come out," and attributed suicide rates in the LGBTQ community to being unable to disclose one's sexual orientation or gender identity. Her concerns align with research supporting suicide attempts, ideation, and future risk of suicide for LGBTQ individuals (Ferlatte et al., 2018; Rimes et al., 2019; Salway et al., 2019)

Managers invoked resident safety as a frame to accommodate staff wanting to refuse care. One nurse manager acknowledged that she would permit another staff member to switch residents to avoid caring for an LGBTQ resident to avoid being "rude" and "hindering care" for the resident such that they may be "scared" by interactions with a caregiver whose religious or

moral beliefs oppose care for LGBTQ residents. Several mid- and upper-level managers stressed the importance of resident comfort and invoked that framing to both accommodate and to deny accommodating staff who refused care to an LGBTQ resident. For example, one nurse manager noted that he "would do what [he] would have to do to switch that person out because at the end of the day [he] wants the resident to be comfortable." For him, accommodating the staff member precluded a negative interaction with an LGBTQ resident that could make the resident uncomfortable. Similarly, a Director of Nursing invoked resident comfort as a frame to justify why she would accommodate a staff member who did not want to provide care to an LGBTQ resident based on religious belief.

> I probably would move him because I feel like if that's what he truly believes, he may make the patient feel uncomfortable when providing care, and I wouldn't want the patient to be uncomfortable at all. So I probably would accommodate just to make sure that that patient remains comfortable when getting care.

Both resident safety and resident comfort were linked to the space in which the care was delivered and shifted the strategy of action that managers pursued. Long-term care staff deliver care to residents in an institutionalized setting. The residents live where they are receiving care. That fact mattered for many managers in helping them frame how to navigate religious exemptions and their strategy of action. When managers invoked a resident safety or comfort frame that incorporated "home," they were much less deferential to staff wanting to deny care. For example, one nursing manager invoked this framing to explain why she would not accommodate a staff member denying care.

> But most importantly, we have to understand where we are and when we're here, we're in their homes. I can't stress that enough, to just make them feel as comfortable as the

> residents can be and try to, as much as we can, keep those personal feelings kind of separate.

Another nursing manager emphasized that residents deserve respect because staff are providing care in their home.

> This is their home. We're in their home. So we have to respect them and no matter what their beliefs are, whether it's religion.

Denying care because of religion amounted to disrespecting the resident, particularly because the care occurred in the resident's home. Even though caregiving occurred in a place of business, that place of business also served as the primary residence for the resident. When managers used the resident safety and comfort frame to invoke the salience of care in their "home," managers refused to accommodate staff with religious exemptions. Residents pay the facility to provide care in their home – a home that exists within an institutionalized setting. Managers were keenly aware that residents had choices in where they could live, and as one Administrator noted "can leave at any point." Upper-managers strategized with mid-managers about available beds (i.e., spaces for paying customers) and followed up with residents who expressed dissatisfaction with the facility and a desire to leave. While "home" was associated with resident safety and care, when managers invoked it in this cultural frame, it changed their strategy of action from accommodating staff with religious exemptions to refusing to accommodate staff. When residents decide to make a particular facility their "home," they become an ongoing income stream for the facility. This business consideration may have contributed to why some managers' strategies shifted when they invoked "home" in this cultural frame.

Policies, Laws, and Regulations

None of the floor staff invoked policies when discussing their responses to a colleague refusing care to an LGBTQ resident. However, mid- and upper-managers regularly referred to facility policies, laws, or state regulations when explaining why they could not accommodate this staff member. Upper-level managers specifically cited nondiscrimination policies. For example, one Administrator explained that she could not permit a staff to refuse care.

> We at least have policies that we don't discriminate. So it's not up to you what you're comfortable with. You might be comfortable at another job somewhere, or in a different position.

A Director of Nursing stated that she "would be concerned about that [denying care], because in health care, you can't discriminate." The Administrator cited the facility's nondiscrimination policy, whereas the Director of Nursing cited a more general policy of nondiscrimination in the profession. However, both invoked specific nondiscrimination language to frame concerns about policy violations from staff refusal to provide care to an LGBTQ resident.

Mid-managers invoked general policies or rules that would preclude such staff behavior – without naming discrimination. For example, one nurse manager referenced both her facility's policy and state license as a reason why she could not allow a staff to deny care to an LGBTQ resident.

> We can't refuse to take care of anybody, under the facility's policy and our license, it is not our right to refuse anyone because of [a staff member's] religious beliefs. And if she feels like she cannot do that, then maybe she should work elsewhere that would practice her way of religion to fit her needs better.

For her, and others, it was unnecessary to identify a specific policy or regulation. Another nurse manager noted that he would also "go back to the policy, which does not allow for that [refusal

of care].” Even managers who were unfamiliar with facility policy expressed a general belief that facility culture and unwritten policies would preclude allowing staff to deny care because of personal religious beliefs, as expressed by a social worker.

> We accept everyone, so you might have to – I don’t know what the policies are on that. I don’t believe there are any, you know, you – this is what it is and if it’s a comfort level, maybe this isn’t the place for you to work.

Another nursing manager noted that the facility has “zero tolerance” that would prevent staff from denying care to LGBTQ residents because of their religious beliefs. For this nursing manager (and the social worker above), the facility culture “is what it is” and has “zero tolerance” for denying care to residents because of their sexual orientation or gender identity. Neither of these workers could cite specific facility policies but instead invoked unwritten policies that expressed a culture of inclusion at the facility.

Other managers invoked facility mission statements. One nurse manager stated that the staff member “needs some respectful accountability in regards to who she’s serving and the responsibility to the facility…[and its] mission statement.” He subsequently noted that the facility’s mission statement describes how the facility serves older adults “of all faiths” and “diverse environments.” Mission statements provided another mezzo-level framing to justify actions that opposed religious exemptions in caregiving.

Other managers invoked laws and regulations and noted that denial of care is “against the law” and “unlawful.” One rehabilitation manager expressed concern that denying care because of religious belief would violate “the idea of separation of church and state.” Interestingly enough, this manager worked in a faith-based facility. While her faith-based facility identified core Christian values in its mission, she invoked cultural frames that disapproved of disparate

treatment of LGBTQ residents and violating larger governmental principles of separating church and state.

Staff framings about policies, laws, and regulations presented a sharp contrast between floor staff and managers. Here, managers invoked mezzo-level framings that centered facility policies and culture and macro-level framings that centered legal principals or laws. Mid-managers and upper-managers also contrasted in whether or not they specifically invoked discrimination policies. Upper-managers referred to discrimination policies, whereas mid-managers did not.

Religion

Floor staff invoked religion as a frame to both deny and to accommodate staff refusing to care for LGBTQ residents because of personal religious or moral beliefs. One CNA acknowledged that she would accommodate a staff member who wanted to switch residents because "I respect your religion [and] ain't knocking nobody." However, several floor staff invoked religious views of inclusion to explain why staff should not deny care to LGBTQ residents because of religion. One CNA stated that "it's in my religion to love everyone." Another CNA stated that denying care because of religion is "not very Christian-like" and added that "God loves everybody [regardless] of whether that person is gay or not." One floor nurse invoked a religious frame by expressing a more cynical view of a colleague invoking a religious exemption.

> I would pull her to the side and say it's unacceptable, because you bathing that person, it doesn't matter about if they're gay or not. Like I mean, I feel like people are just so one-

sided because it's like even if I say it's against your religion, there's a lot of things that's against your religion. You cannot pick and choose which one you want to – you know?

For this CNA, religious exemptions presented a space where inconsistent religious beliefs and practices emerge. This framing resonates with some LGBTQ rhetoric that religious exemptions present a convenient excuse to exercise bias against LGBTQ people by selectively identifying some religious dogma to follow while ignoring other dogma (Griffen, 2015; Gruberg et al., 2018; LoMaglio, 2019).

None of the upper-managers invoked religion as a frame, and only one mid-manager invoked religion. This nurse manager did not support LGBTQ rights but invoked religion as a way to persuade a colleague with similar beliefs to provide care to an LGBTQ resident.

I would kind of explain to them that being gay is a sin, but your taking care of them is not causing you to be gay. So you're not sinning.

This manager was not compelled by fairness, facility policies about inclusion, staff job obligations, or resident care. Instead, she invoked her personal religious beliefs about sin as a frame to both make sense of religious exemptions and determine her strategy of action (e.g., coach a colleague with similar religious views to provide care). This approach was particularly surprising, given that much of the rhetoric around religious exemptions focuses on individual staff religious rights. For her, individual religious rights did not matter. Instead, she invoked religion to help her colleague understand how she could continue to provide care while still holding her religious belief. While her framing includes language that could harm LGBTQ residents if they heard it, the irony of her framing is that it could also help this staff member provide better care to LGBTQ residents. This same nursing manager subsequently emphasized the centrality of resident care when noting that "we are providing care for the resident…it's all

about her." Here, her experience managing people in a patient-centered environment, coupled with her religious beliefs, facilitated a framing that encouraged resident care without challenging the individual staff member's religious views about LGBTQ individuals.

Comparisons among Staff Levels

Staff at all three levels invoked many of the same cultural frames to resolve cultural discord around religious exemptions. These cultural frames helped staff engage in the process of social coherence and achieve a resolution. However, two cultural frames differed among floor staff and mid-and upper-managers: job obligations and laws and policies. Floor staff much more readily invoked job obligations as a cultural frame to explain why they would refuse to accommodate religious exemptions in caregiving. Floor staff explained this cultural frame as including specific caregiving tasks, respect for residents, contractual obligations (services for pay), and teamwork. When staff invoked religious exemptions to avoid care, it presented cultural discord that centered less on tensions between equality and religious liberty but more on job responsibilities and religious liberty. For many floor staff who invoked this cultural frame, the process of social coherence was simple, and they rarely struggled with their strategy of action: They could not support co-workers who shirked their caregiving responsibilities. Floor staff are already overburdened with an abundance of tasks in a very demanding environment that are challenging to meet (Travers et al., 2020). Refusing to allow staff to opt-out of their caregiving duties because of religious belief benefits overworked staff who (as noted by several floor staff) "need assistance" and "are paid to work," which helps underpaid floor staff "pay the bills."

When managers invoked job obligation frames, they took a more interactional approach that included conversation and discussion with staff insisting on religious exemptions before

denying the accommodation. Managers also more readily turned to laws and policies as a cultural frame compared to floor staff. Whereas mid-managers cited general policies (e.g., zero-tolerance, policies of inclusion), upper-managers cited specific policies (e.g., facility nondiscrimination policies) as cultural frames to navigate cultural discord regarding religious exemptions. When managers used law and policies as a cultural frame during this process of social coherence, they identified a strategy of action that opposed religious exemptions. Even when managers failed to cite specific policies, the invocation of policies as a cultural frame made the process of social coherence easy and left little room for cultural discord.

Staff at all three levels invoked cultural frames of fairness, resident safety and comfort, and religion to both support and oppose religious exemptions for caregiving. Floor staff who supported LGBTQ rights nonetheless accommodated staff who invoked religious exemptions to deny care to LGBTQ residents. While this tension created cultural discord for staff, they did not frame this discord between equality and religious liberty but instead around issues that centered patient care. For example, one CNA noted that while religious exemptions were unfair, she would accommodate a staff member with religious exemptions because she did not believe it was fair to impose her beliefs on her colleague. By switching residents, she was not compromising resident care (and possibly preserving it). Her cultural frame of fairness became the frame that she used for social coherence to resolve this cultural discord. Similarly, managers invoked cultural frames of resident safety and comfort to justify accommodating staff with religious exemptions by emphasizing how accommodating staff would protect residents.

DISCUSSION

Overall, staff employed a variety of cultural frames to achieve social coherence regarding religious exemptions in resident care, including staff rights, fairness, resident safety and comfort, religion, job obligations, and laws and policies. These frames helped staff achieve social coherence and/or identify their strategy of action (Swidler, 1986, 2003) as to whether to grant a colleague's refusal to provide care. The use of various cultural frames beyond religious liberty and equality contrasts with the dominant narrative that religious exemptions present a conflict between two rights (religious liberty and LGBTQ nondiscrimination). The data here, however, suggests that healthcare staff – and particularly long-term care staff – adopt a more nuanced approach that invokes a variety of cultural frames that mostly center patient care. The centrality of patient care helps explain the paradox of mutual support for nondiscrimination protections and religious exemptions found in the PRRI 2018 study described above: that nearly a quarter of survey respondents who favor LGBTQ nondiscrimination protections also support religious exemptions that allow businesses to deny services to LGBTQ people (Jones et al., 2018). By focusing on patient care, long-term care staff shifted the focus away from dichotomous cultural frames of religious liberty and equality and instead focused on how religious exemptions would shape resident care.

Social Coherence and Cultural Discord

Scholars in socio-legal studies (Tebbe, 2017; Feldblum, 2006) and political science (Rhodebeck, Gainous, & Gray, 2019) have framed religious exemptions as tensions between equality (LGBTQ rights) and morality (religious freedom). Much of this literature focuses on religious exemptions for businesses and public accommodations. While most of the debate around religious exemptions has centered around conflicts between equality and religious liberty,

long term care facility staff did not echo that tension. Healthcare scholars provide some insights as to why healthcare providers may not view religious exemptions as a tension between equality and religious liberty. Healthcare scholars responding to the most recent spate of religious exemption laws have cited other values when religious exemptions are applied to healthcare workers, including patient care (Raifman & Galea, 2018; Fry-Bowers, 2020; Stahl, 2017), which staff at all levels discussed here. Without advocating a position, Fry-Bowers (2020) cites arguments by the American Medical Association (AMA), the American Nurses Association (ANA), and the American Academy of Nursing (AAN) that "the freedom to act according to belief is not without limits" (p. 123). She further quotes from a 2018 joint letter from the ANA and AAN to the U.S. Department of Health and Human Services that "the primacy of the patient in nursing practice is paramount, and the moral and ethical considerations of the nurse should never, under any circumstance, result in the inability of the patient to receive quality, medically necessary, and compassionate care" (p. 1). Cultural norms, values, and professional duties in healthcare may shape how staff understand religious exemptions in long-term care in ways that are different from a purely non-healthcare-related business.

Several staff who supported LGBTQ rights also reported that they would accommodate a colleague who denied care to an LGBTQ resident because of their religion. This finding supports recent research that nearly one-quarter of survey respondents in the American Values Atlas support both LGBTQ nondiscrimination laws and religious exemptions (Jones et al., 2018). Data here helps explain why staff can hold these seemingly contradictory positions. One key similarity emerged in all of the situations where staff supported both LGBTQ rights and religious exemptions: all of the staff members who accommodated religious exemptions underscored that LGBTQ residents still would receive quality care by switching residents for caregiving duties.

Swapping residents was not uncommon for the floor staff, and staff at all levels noted that they often accommodated resident preferences for individual caregivers that had nothing to do with positionalities like race, sex, or sexual orientation. Staff also swapped residents when residents made inappropriate comments to particular caregivers, which was also not uncommon. This permissive environment of resident swapping created a space for many staff to more easily reconcile cultural discord by accommodating religious exemptions. It is possible that staff may have been less accommodating of religious exemptions if care for an LGBTQ resident was not so readily available by substitution. Given participants' emphasis on patient-centered care, it seems likely that at least some of the staff who accommodated religious exemptions may not be so accommodating if the religious exemption compromised or delayed care to an LGBTQ resident. Further research is needed to examine this possibility. Additional research could also examine the application of this phenomenon (supporting both nondiscrimination principles and religious exemptions) to non-healthcare contexts to explain why individuals may hold these contradictory positions. For example, additional research could examine whether individuals who support LGBTQ rights and religious exemptions for public accommodations do so because of an assumption that the denied customer can still receive similar public accommodations elsewhere. While this "separate but equal" frame is troubling, it could nonetheless explain the paradox of supporting both LGBTQ nondiscrimination laws and religious exemptions.

Limitations and Future Directions

This research has several limitations. First, while this case study included many diverse perspectives, only staff who voluntarily agreed to participate were included. Thus, the experiences of staff who did not sign-up for an interview are not represented in these data.

Second, these findings are not generalizable. While producing generalizable data was never the goal of this qualitative project, it is important to clarify to avoid misapplications of these data. Instead, this study provides much-needed empirical data with rich description on how long-term care facility staff at various levels (floor staff, mid-level managers, upper-level managers) understand and respond to religious exemptions. Future quantitative research could build off this study to produce generalizable data about beliefs about religious exemptions by healthcare providers.

Third, the data gathered reflect responses in a pre-COVID world. The COVID-19 global pandemic has produced more federal and state policies that have increased scrutiny for resident and staff safety, which could shape how staff respond to healthcare providers, including staff in long-term care, denying care. Future research could build on these findings to identify how COVID-19 has shaped staff understandings and responses to religious exemptions, particularly among an already overburdened workforce.

Fourth, few participants were able to recount actual experiences in which colleagues refused care to LGBTQ residents because of religious or moral beliefs. Instead, much of the data about how they would navigate religious exemptions stems from their responses to hypothetical scenarios in the future. This challenge often arises in qualitative research when probing beliefs about controversial issues that are important to document but that participants may have not yet encountered. Researchers have employed hypothetical scenarios to study discrimination (Brettell, 2011; Shanaah, 2020) and individual beliefs about AIDS (Herek, Widaman, & Capitanio, 2005) and/or to examine behavior that has not yet occurred (Callahan & Zukowksi, 2019; O'Conor et al., 2018). Using hypothetical scenarios has limitations, given that they involve factual situations that have not yet happened. Participants' responses reflect presumed behavior,

attitudes, or thoughts, and not actual behavior based on real-life situations. Because scenarios are hypothetical, respondents may also provide answers about their idealized responses – what they hope they would do in a given situation – as opposed to what they would actually do. While imperfect, hypothetical scenarios, however, are a useful tool to build a body of empirical data in areas that are controversial or infrequent but important to document and study. Future research is needed, however, to further explore how service providers in long-term care facilities and other healthcare domains respond when colleagues refuse to provide care because of religious or moral belief. Given the use of teams among healthcare staff and service delivery (Miller et al., 2018; Pype et al., 2018; Rydenfault et al., 2017), that data will help further examine the impact of religious and moral exemptions on healthcare providers and recipients.

Finally, this paper did not discuss implications of race and gender (and the intersections within) as it relates to how staff understand and navigate religious exemptions to caregiving for LGBTQ+ residents. In this project, race and gender stereotypes about commitment to care and work ethics were intertwined with concerns about being understaffed. These issues further intersected with perceptions about fairness and gender as it relates to LGBTQ+ rights. Individual faith, which is also intertwined with race and gender, further shaped how staff understood and responded to religious exemptions by other colleagues. These complex dynamics will be further explored in a subsequent paper, which will pull from a separate body of theoretical and empirical scholarship.

CONCLUSION

Overall, this study provides important contributions on a timely topic. Religious exemptions have grown with increasing frequency across the United States in the past few years.

While public support for LGBTQ rights has grown significantly such that majorities in every state support equal rights for LGBTQ people (Jones et al., 2018), still a quarter of supporters for LGBTQ rights support religious exemptions for services. Religious exemptions present cultural discord for healthcare providers, including long-term care staff, that they must resolve – often in real-time when navigating care for a resident or patient. Despite their salience in healthcare and policy, very little empirical data exists on religious exemptions. This study provides timely data on how long-term care staff navigate religious exemptions and why they can support both LGBTQ rights and religious exemptions that deny care to LGBTQ individuals.

This research also has implications for theory. This study provides one of the first applications of Tebbe's (2017) social coherence conceptual framework by using cultural sociology to explain the process of social coherence for long-term care staff. The study's introduction of cultural discord also provides a new theoretical tool that subsequent scholars can use for understanding how conflicting cultural frames shape behavior, attitudes, and beliefs. Social coherence and cultural discord are useful theoretical constructs that other researchers can invoke and build on to help explain social processes for navigating conflicting cultural frames in areas outside of religious exemptions.

The cultural frames and social coherence processes that staff employed also have implications for policy and practice. Much of the discussion around religious exemptions has centered on a tension between equality and religious liberty. These data underscore that the tension for many healthcare staff moves beyond these frames. This finding suggests advocates employ new approaches to address cultural discord regarding religious exemptions in healthcare. Moreover, these data suggest that employers and advocates should not assume that religious healthcare providers will support religious exemptions. While research has found that particular

religions are more or less supportive of religious exemptions (Jones et al., 2018), the examples from these data suggest that religious healthcare providers may employ cultural frames that transcend the dichotomy between religious liberty and equality. It is important that policymakers, advocates, and employers engaged in long-term care understand these cultural frames.

CHAPTER 5: CONCLUSION

Conflicting rights present an understudied but important and timely topic. Long-term care facilities provide a space ripe for examining conflicting rights. The findings from this dissertation illuminate ways that facility staff understand and respond to conflicting rights for residents (e.g., safety and autonomy) and conflicting rights between staff and residents (e.g., nondiscrimination, religious liberty, autonomy). Instead of framing these rights in terms of political ideology (e.g., liberal, conservative, Democrat, Republican), however, staff understood and responded to these understandings as an extension of patient care. When concerns about conflicting rights arose regarding resident autonomy and safety (e.g., medical decision-making), discrimination, and religious exemptions, none of the staff invoked larger polarizing political narratives (e.g., "right to die" or "death with dignity," "racial justice," "white supremacy culture," "rape culture"). Staff resolved conflicting rights by determining their role as a staff member providing care to a resident with significant health needs. While facility staff reached diverse conclusions, which were sometimes shaped by their staffing level (e.g., floor staff, mid-management, upper management), they ultimately resolved conflicting rights in ways that centered patient care over political persuasion. This overarching finding presents an important contribution to a larger conversation about conflicting rights and the increasing polarization of the United States and has implications for theory, social work practice, and social policy. Patient care trumped political preference in ways that allowed staff to transcend the dominant narrative that juxtaposes liberals/Democrats and conservatives /Republicans. The sections below provide a summary of the findings from each empirical chapter, theoretical implications of this research,

social work practice and social policy implications of this research, and limitations and future directions.

Summary of Findings

Chapter 2 presents findings on how long-term care facility staff understand and respond to conflicting rights for residents regarding safety and autonomy. Facility staff identified three areas that presented conflicting rights for residents regarding autonomy and safety: (1) fall prevention; (2) food intake; and (3) medication management. Staff often invoked interprofessional team approaches across staff hierarchies, especially among floor staff and mid-level managers, particularly in the context of fall prevention and food. Medication management, however, presented a different response among staff. Staff reported diminished discretion in this context, even though guidance was still somewhat vague on how to navigate conflicting rights in this space. While many of those conflicting goals remain here (e.g., administrators are more concerned with liability), the necessity for team approaches for resolving conflicting rights, especially in a healthcare-related space like a long-term care facility, often created a space of collaboration instead of conflict.

Chapter 3 presents findings about how staff understand experiences of discrimination by residents and why they may not report it. Facility staff at all levels described rampant race and sex-based discrimination from residents. Discrimination by residents created conflicting rights for staff who were protected under nondiscrimination laws but were also tasked with honoring residents' rights by providing their personal and medical care. Floor staff attributed experiences of discrimination to resident health and cognitive status or framed it as a condition of employment, which precluded floor staff from "naming" discrimination and "blaming"

discriminatory behavior on residents. Mid-management framed experiences around staff safety. Upper-management acknowledged staff rights without invoking discrimination rhetoric. Ultimately, facility staff's framings shaped how they named, blamed, and claimed experiences of discrimination and helped to explain why underreporting still persists.

Chapter 4 presents findings on how long-term care facility staff reconcile conflicting rights and cultural discord when colleagues refuse to provide care to LGBTQ residents. Overall, staff invoked a variety of cultural frames to achieve social coherence regarding religious exemptions in resident care, including staff rights, fairness, resident safety and comfort, religion, job obligations, and laws and policies. These frames helped staff navigate religious exemptions and determine how to respond when a colleague refuses to provide resident care. The use of various cultural frames beyond religious liberty and equality contrasts the dominant narrative that religious exemptions present a conflict between two rights (religious liberty and LGBTQ nondiscrimination). The data here, however, suggests that healthcare staff – and particularly long-term care staff – adopt a more nuanced approach that invokes a variety of cultural frames that mostly center patient care. The centrality of patient care helps explain why facility staff who support nondiscrimination principles for LGBTQ people may also support religious exemptions among staff.

Theoretical Implications

Chapter 2 extends street-level-bureaucracy theory to include managers at mid- and upper-level. One key principle of street-level bureaucracy is that front-line staff and managers are in conflict given varying goals (Lipsky, 2010). Street-level bureaucracy theory has thus focused heavily on traditional front-line workers like government caseworkers as "street-level

bureaucrats" who are engaging in policy interpretation and implementation from the ground-up. Street-level bureaucracy theory has predominantly treated these front-line government workers as distinct from managers because their interests focus more on those of individual clients than the organization (e.g., liability). While many of those conflicting goals remain (e.g., administrators are more concerned with liability), the necessity for team approaches for resolving conflicting rights, especially in a healthcare-related space like a long-term care facility, often created a space of collaboration instead of conflict where front-line workers and managers often collaborated to maximize patient care. Applying street-level-bureaucracy theory to healthcare spaces underscores the complexities of on-the-ground policy interpretation and implementation and how street-level bureaucrats may exist beyond a traditional front-line paradigm to sometimes include managers. This study also contributes to the growing body of street-level bureaucracy literature examining whether increasing managerialism reduces discretion. Here, front-line staff working with substantial oversight still exercised significant discretion on the ground when navigating conflicting rights, except when legal documentation surfaced (e.g., healthcare power of attorney). These findings suggest new theoretical extensions of street-level bureaucracy theory, particularly in healthcare.

Chapter 3 builds on legal consciousness literature by posing a new area of examination: conflicting rights – and specifically how individuals understand workplace discrimination when their nondiscrimination rights may conflict with the rights of those they serve. Legal consciousness theory presents a framework for understanding how individuals invoke legal concepts to understand their day-to-day experiences (Ewick & Silbey, 1998; Hirsh & Lyons, 2010; Hoffmann, 2003). Legal consciousness literature has examined why individuals "lump it" or choose to do nothing (Felstiner, 1974; Morrill & Edelman, 2021; Poppe, 2019) when they fail

to name, blame, or claim an experience as a legal issue. Legal consciousness literature has attributed underreporting to individual fears or concerns about retaliation, reputational damage, perception of competence or contribution as a team player (EEOC, 2016; Kaiser & Miller, 2003; Kaiser, Dyrenforth, & Hagiwara, 2006). Recent critiques of this literature (Poppe, 2019; Young & Billings, 2020) suggest more attention on structural reasons for why people "lump" potential legal claims. By applying legal consciousness theory to conflicting rights, this study helps understand nuances of how healthcare staff experience discrimination and illuminates structural reasons, including structural inequities between patients and front-line care providers, as to why underreporting still persists.

Chapter 4 extends Tebbe's (2017) conceptual framework of social coherence by using cultural frames from sociology to explain how long-term care staff navigate religious exemptions. Social coherence provides a framework to describe the process that individuals invoke to reconcile disputes between religious freedom and equal rights for LGBTQ people (Tebbe, 2017), and how they reframe these concepts altogether. I argue that social coherence also includes the resolution that individuals reach when they reconcile these conflicts. This study, thus, extends social coherence theory to an outcome and underscores how the process itself is inextricably intertwined with the outcome such that social coherence is both a process and an outcome that one can achieve through the process. This research further introduces the concept of cultural discord to explain how staff engage in social coherence when cultural frames conflict (e.g., fairness versus religious liberty). While sociologists have extensively studied cultural frames, cultural discord provides a new tool for identifying and examining how individuals navigate and invoke conflicting cultural frames in their everyday lives. Social coherence and cultural discord present theoretical concepts that scholars can further engage,

particularly researchers interested in understanding the process of reflection that individuals invoke to navigate conflicting rights beyond religious liberty and nondiscrimination.

Social Work Practice and Social Policy Implications

This research has several implications for social work practice and social policy. Chapter 2 presents data about conflicting residents' rights for safety and autonomy in three areas: fall prevention, food intake, and medication management. The findings in Chapter 2 underscore the importance of interprofessional teams that cross staff hierarchical boundaries and team meetings that include staff from different professions and staffing levels. Team meetings provide an optimal structure for information dissemination and discussion about conflicting rights but only when all participants (including front-line staff like CNAs) are equal contributors. Nursing home reform that seeks to improve conditions for workers and residents should include more support (e.g., financial and training) to facilitate team approaches to caregiving that cross professional and staff hierarchies.

Findings from Chapter 3 on discrimination by residents suggest that workers need more support when subjected to discrimination. Healthcare workers are particularly vulnerable to discrimination by patients because of an increasing focus in healthcare on patient-centered care and rising corporatization of healthcare that treats patients as paying customers. Facilities could better support staff with written organizational policies and education that address biases and harassment based on sex and race by residents. Professional associations and policymakers could develop guidelines and policy statements that address discrimination by residents, including discriminatory requests for providers.

Findings from Chapter 4 on religious exemptions suggest that policymakers, advocates, and practitioners should adopt a more nuanced approach to religious exemptions than the dominant narrative, which underscores a tension between equality and religious liberty. Data from this dissertation underscore that the tension for many healthcare staff moves beyond these frames. Moreover, these data suggest that employers and advocates should not assume that religious healthcare providers will support religious exemptions. While research has found that particular religions are more or less supportive of religious exemptions (Jones et al., 2018), the examples from these data suggest that religious healthcare providers may employ cultural frames that transcend the dichotomy between religious liberty and equality. It is important that policymakers, advocates, and employers engaged in long-term care understand these cultural frames.

All three empirical studies also revealed that non-social work staff (e.g., nurses, physical therapists, nurse managers) sought guidance from social workers when conflicting rights arose. Staff expected social workers to apply their expertise in interpersonal dynamics when conflicting rights arose with residents or between residents and staff. While social work training prepares social workers well for navigating complex interpersonal dynamics, social workers may benefit from more targeted training on mediating conflicting rights in their practice. This finding underscores the importance of incorporating education, resources, and tools for social workers to better prepare them to navigate conflicting rights. This finding also reveals the salience of social workers on interprofessional teams and suggests that organizations and healthcare institutions like long-term care facilities would benefit from social workers on their staff. Some states mandate that long-term care facilities employ at least one social worker if they have a certain number of residents. However, regulations do not always require that the designated social

worker have actual training or education as a social worker. These data suggest that social work training may be particularly helpful for individuals employed in this role, regardless of whether or not current regulations require it, particularly given the level of training social workers receive navigating complex interpersonal dynamics that could provide at least a bedrock of tools for navigating conflicting rights.

Limitations and Future Directions

This study has several limitations that suggest future directions. First, while this case study included many diverse perspectives, only staff who voluntarily agreed to participate were included. Thus, the experiences of staff who did not sign-up for an interview or participate in team meetings are not represented in these data. Some staff may have avoided an interview if they were concerned about being perceived as biased (e.g., against LGBTQ residents because of their personal religious beliefs) or were concerned about divulging caregiving experiences that may have been contrary to regulatory guidelines or facility practice. As such, these data may exclude additional ways that staff with these concerns navigated conflicting rights.

Second, these findings are not generalizable. While producing generalizable data was never the goal of this qualitative project, it is important to clarify to avoid misapplications of these data. Instead, this study provides much-needed empirical data with rich description on how long-term care facility staff at various levels (floor staff, mid-level managers, upper-level managers) understand and respond to conflicting rights. Future quantitative research could build off this study to produce generalizable data about the types of conflicting rights that emerge and attitudes and experiences about various conflicting rights among healthcare providers.

Third, the data gathered reflect responses in a pre-COVID world. The COVID-19 global pandemic has produced more federal and state policies that have increased scrutiny for resident and staff safety. Future research could build on these findings to identify how COVID-19 has shaped staff understandings and responses to conflicting rights, particularly among an already overburdened workforce.

Finally, regarding Chapter 4, few participants were able to recount actual experiences in which colleagues refused care to LGBTQ residents because of religious or moral beliefs. Instead, much of the data about how they would navigate religious exemptions stems from their responses to hypothetical scenarios in the future. This challenge often arises in research when probing beliefs about controversial issues that are important to study but that participants may have not yet encountered. Researchers have employed hypothetical scenarios to study discrimination (Brettell, 2011; Shanaah, 2020) and individual beliefs about AIDS (Herek, Widaman, & Capitanio, 2005) and/or to examine behavior that has not yet occurred (Callahan & Zukowksi, 2019; O'Conor et al., 2018). While imperfect, hypothetical scenarios are a useful tool to build a body of empirical data in these areas. Future research is needed, however, to further explore how service providers in long-term care facilities and other healthcare domains respond when colleagues refuse to provide care because of religious or moral belief. Given the use of teams among healthcare staff and service delivery (Miller et al., 2018; Pype et al., 2018; Rydenfault et al., 2017), that data will help further examine the impact of religious and moral exemptions on healthcare providers and recipients.

TABLES

Table 1a: Participants' Race / Ethnicity and Gender by Staff Level and Facility (n=80)

	Overall (*n* = 80)	**Independent Facility** (*n* = 43)	**Corporate Facility** (*n* = 37)
FRONT-LINE WORKERS (*n* = 41)			
Race / Ethnicity			
Black	28	24	10
White	12	2	3
Latinx	1	1	-
Filipino	-	-	1
Middle Eastern / Arab	-	-	-
Gender			
Female	37	24	13
Male	4	3	1
MID-LEVEL MANAGERS (*n* = 33)			
Race / Ethnicity			
Black	7	5	2
White	24	7	17
Latinx	1	-	-
Filipino	-	-	-
Middle Eastern / Arab	1	1	-
Gender			
Female	30	12	18
Male	3	1	2
UPPER-LEVEL MANAGERS (*n* = 6)			
Race / Ethnicity			
Black	2	2	-
White	4	1	3
Latinx	-	-	-
Filipino	-	-	-
Middle Eastern / Arab	-		-
Gender			
Female	4	2	2
Male	2	1	1

Table 1b: Participants' Race / Ethnicity and Gender by Staff Level (n=80)

	Overall (*n* = 80)	**Facility 1** (*n* = 43)	**Facility 2** (*n* = 37)
FRONT-LINE WORKERS (*n* = 41)			
Race / Ethnicity			
Black	28	24	10
White	12	2	3
Latinx	1	1	-
Filipino	-	-	1
Middle Eastern / Arab	-	-	-
Gender			
Female	37	24	13
Male	4	3	1
MID-LEVEL MANAGERS (*n* = 33)			
Race / Ethnicity			
Black	7	5	2
White	24	7	17
Latinx	1	-	-
Filipino	-	-	-
Middle Eastern / Arab	1	1	-
Gender			
Female	30	12	18
Male	3	1	2
UPPER-LEVEL MANAGERS (*n* = 6)			
Race / Ethnicity			
Black	2	2	-
White	4	1	3
Latinx	-	-	-
Filipino	-	-	-
Middle Eastern / Arab	-		-
Gender			
Female	4	2	2
Male	2	1	1

Table 1c: Participants' Race / Ethnicity and Gender by Staff Level (*n* = 90)

	Overall (*n* = 90)	**Facility 1** (*n* = 43)	**Facility 2** (*n* = 37)	**Additional Upper-Managers** (*n* = 10)
FRONT-LINE WORKERS (*n* = 41)				
Race / Ethnicity				
Black	28	24	10	-
White	12	2	3	-
Latinx	1	1	-	-
Filipino	-	-	1	-
Middle Eastern / Arab	-	-	-	-
Gender				
Female	37	24	13	-
Male	4	3	1	-
MID-LEVEL MANAGERS (*n* = 33)				
Race / Ethnicity				
Black	7	5	2	-
White	24	7	17	-
Latinx	1	-	-	-
Filipino	-	-	-	-
Middle Eastern / Arab	1	1	-	-
Gender				
Female	30	12	18	-
Male	3	1	2	-
UPPER-LEVEL MANAGERS (*n* = 16)				
Race / Ethnicity				
Black	4	2	-	2
White	12	1	3	8
Latinx	-	-	-	-
Filipino	-	-	-	-
Middle Eastern / Arab	-		-	-
Gender				
Female	13	2	2	9
Male	3	1	1	1

Table 2: Discretion by Staff Level and Conflicting Right

	Discretion Freedom to act / interpret policies Professional experience
Floor Staff (e.g., CNAs, LPNs)	
Fall Prevention	***High***: Significant floor experience in assessing and preventing falls
Food Intake	***High***: Significant floor experience feeding residents
Medication Management	***Low to High***: Limited experience managing medication but significant experience comforting residents in pain
Mid-Managers (e.g., RNs, nurse managers, social workers)	
Fall Prevention	***High***: Significant experience in assessing and preventing falls through documentation and education
Food Intake	***High***: Significant experience in assessing and evaluating food/diet needs through documentation and education
Medication Management	***Moderate to High***: Some RNs had significant experience managing medication. Other managers had some experience assessing and evaluating pain.
Upper-Managers (e.g., DONs, Administrators)	
Fall Prevention	***High***: Upper-level position and authority
Food Intake	***High***: Upper-level position and authority
Medication Management	***High***: Upper-level position and authority

Table 3: Cultural Frames Invoked by Staff Level

		Staff Level		
Purpose	**Cultural Frame**	**Floor Staff**	**Mid-Manager**	**Upper-Manager**
To Accommodate Religious Exemptions	Staff Rights	Yes	Yes	Yes
	Fairness	Yes	Rarely	Rarely
	Resident Safety and Comfort	Rarely	Rarely	Yes
	Religion	Yes	No	No
To Reject Religious Exemptions	Fairness	Yes	Rarely	Rarely
	Resident Safety and Comfort	Rarely	Yes	Yes
	Job Obligations	Yes	Rarely	Rarely
	Laws, Policies, Regulations	No	Yes	Yes
	Religion	Yes	Rarely	No

APPENDIX A

Interview Protocol

The interview protocol reflects a list of semi-structured interview questions that were developed after meetings and feedback from my dissertation committee and several researchers and community members in nursing and social work, including one researcher who works closely with direct care workers such as certified nursing assistants. I further refined questions after pilot testing them with and incorporating feedback from five mid- and upper-level managers and direct care workers at Michigan nursing facilities (through conferences and word-of-mouth).

Interview Protocol for Direct Care Workers, Middle Level Staff (e.g. registered nurses, SWs), and Upper-Level Managers (e.g. DONs, Administrators)

<u>Pre-Interview Demographic Questionnaire</u>

1. Today's Date:
2. Participant Identification Number (PIN) (for confidentiality purposes):
3. Please enter your date of birth (MM/DD/YYYY)
4. What is your current age?
5. How would you identify your race and/or ethnicity?

6. How would you describe your socioeconomic class status? (e.g. middle-class, upper middle-class, working-class, etc)
7. What is your current job title(s)?
8. Are you currently enrolled in school? [yes/no]
    a. [Skip pattern—If yes:] Please identify the certification(s) / degrees you are pursuing
9. Would you identify or describe yourself as religious or spiritual? [yes/no]
    a. [Skip pattern—If yes:] How would you describe your religious affiliation or spiritual beliefs?
10. Do you regularly attend religious or spiritual services? [yes/no]
    a. [Skip pattern—If yes:] Please identify how frequently you attend services.
11. How would you describe your gender (e.g. female)?
12. How would you describe your sexual orientation (e.g. heterosexual, lesbian, bisexual, gay)?
13. Is there anything else you would like me to know before the interview?

I. Opening Questions about Background and Job:

1. When did you first start working at <name of organization>?
2. Tell me about what drew you to your job? The nursing / social work profession? Long term care?
    a. Tell me about your educational background.
    b. Are you a member of any professional associations or work-related groups? If so, what are they?

c. [Autonomy]: Does your job require any professional licensing / credentialing? If so, what are the requirements?

d. MID and UPPER LEVEL: Have you ever worked as a direct care worker?

3. What does your role entail? Describe an average day.

a. [Team Meetings]: Do you attend team meetings for your job? What jobs are represented on the teams? How do you participate in these team meeting?

b. [Other work meetings] Do you attend any other kinds of work meetings? Tell me about them. [e.g. For what? Who else attends these meetings? What's your role?]

c. What are the biggest sources of support in your job?

d. What are the biggest challenges in your job?

e. MID AND UPPER-LEVEL WORKERS: What are the key differences in your job as social worker/nurse and manager?

f. MID AND UPPER-LEVEL WORKERS: Do you see your job as more social work/nursing or management?

II. Specific Policy / Practice

1. The Residents' Bill of Rights is a section of the Nursing Home Reform Act that outlines various rights for nursing home residents, including quality of life, right to be fully informed and participate in one's care, right to privacy and confidentiality, right to dignity, freedom, and respect, right to visitors, and the right to make independent choices—some of which can conflict at any given time. Can you think of an example when you were not sure how to respond to an issue that arose under the Residents' Bill of Rights?

a. What happened?

b. How did it get resolved?

    i. At what level [meaning how did various workers resolve it (e.g. direct care workers, social workers/registered nurses, directors of nursing]?

    ii. What did you turn to for guidance to help you resolve this conflict? How did these things help you resolve the conflict? [probe whether the resolution emerged from a team discussion, religion]

    iii. What challenges did you encounter in resolving the conflict? [probe individual and organizational barriers e.g. resources, organizational hierarchy/lack of professional status, religious belief]

        a. NOTE: For upper-level workers (e.g. DONs), probe the role of professional identity as a nurse/SW v. manager

ALTERNATE VERSION FOR DIRECT CARE WORKERS

1. Long-term care facilities are heavily regulated. More so than nuclear facilities. This means that there are many opportunities for regulations to conflict and provide confusing (if any) guidance for people on the ground. I am especially interested in how direct care workers problem-solve when rules about patients' rights conflict – or provide little to no guidance. Can you think of an example when you were not sure how to respond to an issue that arose because rules about patients' rights conflicted or were too vague? [Probing topics: quality of life, right to be fully informed and

participate in one's care, right to privacy and confidentiality, right to dignity, freedom, and respect, right to visitors, and the right to make independent choices]

a. What happened?
b. How did it get resolved?
    i. At what level [meaning how did various workers resolve it (e.g. direct care workers, social workers/registered nurses, directors of nursing]?
    ii. What did you turn to for guidance to help you resolve this conflict? How did these things help you resolve the conflict? [probe whether the resolution emerged from a team discussion, religion]
    iii. What challenges did you encounter in resolving the conflict? [probe individual and organizational barriers e.g. resources, organizational hierarchy/lack of professional status, religious belief]

2. Your organization has a nondiscrimination policy that prohibits discrimination against residents and staff. Can you think of an example when it was unclear how to respond to an issue that arose under the organization's nondiscrimination policy?
    a. How did it get resolved?
        i. At what level [meaning how did various workers resolve it (e.g. direct care workers, social workers/registered nurses, directors of nursing]?
        ii. What did you turn to for guidance to help you resolve this conflict? How did these things help you resolve the conflict? [probe whether the resolution emerged from a team discussion, religion]

iii. What challenges did you encounter in resolving the conflict? [probe individual and organizational barriers e.g. resources, organizational hierarchy/lack of professional status, religious belief]

a. NOTE: For upper-level workers (e.g. DONs), probe the role of professional identity as a nurse/SW v. manager

III. Creative Problem-Solving / Discretion

There are many situations that arise at work where it is not clear what policies or rules might apply. Sometimes, it is also hard to figure out how a particular policy or rule might apply in a given circumstance. Some people respond by engaging in creative problem-solving that can lead to new practice and policy at an organization. I am interested in learning about how organizational policy and practice decisions are made when these challenges arise in the context of LGBT residents and staff.

1. Can you think of a time when it was unclear what to do about an issue because policies, regulations, or your professional obligations about resident care conflicted?
    a. What happened?
    b. How did it get resolved?
        i. At what level [meaning how did various workers resolve it (e.g. direct care workers, social workers/registered nurses, directors of nursing]??
        ii. What did you turn to for guidance to help you resolve this conflict? How did these help you resolve the conflict? [probe whether the resolution emerged from a team discussion, religion]

iii. What challenges did you encounter in resolving the conflict? [probe individual and organizational barriers e.g. resources, organizational hierarchy/lack of professional status, religious belief]

- NOTE: For upper-level workers (e.g. DONs), probe the role of professional identity as a nurse/SW v. manager

2. Can you think of any challenges that arose at work with LGBT residents when it was unclear how to respond?
    a. What happened?
    b. How did it get resolved?
        i. At what level [meaning how did various workers resolve it (e.g. direct care workers, social workers/registered nurses, directors of nursing]??
        ii. What did you turn to for guidance to help you resolve this conflict? How did these help you resolve the conflict? [probe whether the resolution emerged from a team discussion, religion]
        iii. What challenges did you encounter in resolving the conflict? [probe individual and organizational barriers e.g. resources, organizational hierarchy/lack of professional status, religious belief]
            - NOTE: For upper-level workers (e.g. DONs), probe the role of professional identity as a nurse/SW v. manager

3. Can you think of any challenges that arose at work with LGBT staff when it was unclear how to respond?

a. What happened?

b. How did it get resolved?

   i. At what level [meaning how did various workers resolve it (e.g. direct care workers, social workers/registered nurses, directors of nursing]??

   ii. What did you turn to for guidance to help you resolve this conflict? How did these help you resolve the conflict? [probe whether the resolution emerged from a team discussion, religion]

   iii. What challenges did you encounter in resolving the conflict? [probe individual and organizational barriers e.g. resources, organizational hierarchy/lack of professional status, religious belief]

   - NOTE: For upper-level workers (e.g. DONs), probe the role of professional identity as a nurse/SW v. manager

IV. Micro Decisions Rising to Organizational Policy

1. Some people see policy and practice as the same thing, whereas others see them as very different things. What is an organization policy to you? How does it differ from an organizational practice?
2. Can you think of any examples when practice decisions on the ground rose to become organizational policy? What happened?

   a. How did this information get shared? (e.g. training, written document, word of mouth)

   b. UPPER LEVEL: What factors do you consider in whether or not to adopt new policy?

c. UPPER LEVEL: What are some of the biggest obstacles in adopting new policy?

d. UPPER LEVEL: What are some of the biggest facilitators in adopting new policy? [alternative wording: What factors best facilitate new policy?

3. Can you think of situations when staff creatively solved a problem / issue on the ground that did *not* become organizational policy? [i.e. did not become a written policy for all staff to follow in a similar dilemma]

    a. What happened? [or did not happen]

    b. Why do you think some practice decisions become organizational practice and some do not? Why do you think some practice decisions become organizational policy and some do not?

V. Scenarios

Next, I'll present you with some hypothetical scenarios drawn from real-life situations at other facilities and will ask you questions about how you would respond to the situation. There are four of them, and we'll go through them one at a time.

Scenario 1: Decision-making regarding Conflicting Gender Norms and Rights (residents' rights and nondiscrimination against LGBT residents) regarding a more Technical Decision (roommate assignment)

Scenario 1

Velma is an 81-year-old transgender woman who will soon be entering a long-term care facility. When she was born, her birth certificate identified her as a man. However, 20 years ago, she began transitioning her gender and now considers herself a woman.

1. How should the facility decide the gender of the roommate?
2. What other factors should the facility consider in assigning her roommate?
3. What would you use to help guide your decision here? (e.g. organizational practice or policy, religious doctrine, particular values, NH regulations)
4. If you made this decision in your job, how would this, if at all, become organizational policy?

Scenario 2: Decision-making regarding Conflicting Gender Norms and Rights (residents' rights and nondiscrimination against LGBT staff) when Caregiving – in particular bathing

Scenario 2

Rhonda is a transgender woman working as a nursing assistant at a long-term care facility. One of her jobs includes bathing some of the residents. One of the new female residents asked to be bathed only by another woman and asked that Rhonda not bathe her. How should the facility respond?

1. What would you use to help guide your decision here? (e.g. organizational practice or policy, religious doctrine, particular values, NH regulations)

2. If you made this decision in your job, how would this, if at all, become organizational practice or policy?
3. Can you think of an example when a resident expressing a preference for a particular worker for bathing?
    a. If so, what happened?
    b. How did this situation get resolved?
4. How would the decision be different if Rhonda was Black, and the new female resident requested that someone who was white bathe her? Would you need to use different things to help guide your decision?
5. How would the decision be different if Rhonda was a man? Would you need to use different things to help guide your decision?

Scenario 3: Decision-making when Religious Exemptions Arise for LGBT Care

Scenario 3

[Scenario 3a]:

Jessica works at a nursing facility. She created and facilitates Guiding Light, a religious group for other residents at the facility. When Edna and Betty, two new residents recently moved to the facility, Jessica invited them to Guiding Light. Edna and Betty were eager to meet new friends at the facility and decided to attend. After their first group meeting, they made jokes about being an "old married couple." After the meeting, Jessica came up to them and asked them not to return to

the group. She explained that gay marriage was against her religion—and that of several other residents in the group. Edna and Betty complained to the facility. What should the facility do?

1. What would you use to help guide your decision here? (e.g. organizational practice or policy, religious doctrine, particular values, NH regulations)
2. If you made this decision in your job, how would this, if at all, become organizational practice or policy?
3. Can you think of an example when residents or other staff expressed religious concerns about other LGBT residents or staff?
    a. What happened?
    b. How did this situation get resolved?

Scenario 3 Follow-Up Questions [Scenario 3b]:

Now, let's change the scenario. Let's say that Jessica is refusing to provide care to LGBT residents because of her religious or moral beliefs (e.g. as a nurse, CNA, social worker).

1. What should the facility do?
2. How would you respond if a colleague at the facility refused to provide care to a gay resident because of the staff member's religious or moral beliefs?
3. What would you use to help guide your decision here? (e.g. organizational practice or policy, religious doctrine, particular values, NH regulations)

Scenario 4: Decision-making when Conflicts between LGBT rights and Patient Rights are complicated by Dementia.

Scenario 4

Gary lives in a care facility with multiple levels of care. He is gay. Recently Gary complained to facility staff that another resident, Robert, was bullying him. Gary alleges that Robert repeatedly calls him derogatory names and acts disgusted when around him. What should the facility do?

1. What would you use to help guide your decision here? (e.g. organizational practice or policy, religious doctrine, particular values, NH regulations)
2. What helps you make a decision when two people have different interpretations of the same event?
3. How would this change, if at all, if Gary was facility staff—instead of another resident (e.g. possible harassment by a resident or LGBT staff)
4. How would this change, if at all, if Robert had dementia?
5. How do these kinds of decisions become organizational practice or policy?

<u>Closing Questions</u>

1. Is there anything that I haven't asked about that you think I should know?
2. Do you have any questions for me?

APPENDIX B

Additional Description about Hypothetical Cases

The interview protocol includes four hypothetical scenarios, including one scenario with a modified factual pattern (Scenario 3). I incorporated scenarios that represented real situations as reported from research reports and scholarly articles (e.g. Heyman & Davies, 2006; Kusmaul & Tucker, 2020), including Justice in Aging's 2015 *Stories from the Field* report about the experiences of residents and staff in long-term care, particularly LGBTQ+ residents, and informal conversations with staff in long-term care facilities that I had at statewide and national conferences and individual meetings with long-term care staff (prior to data collection). Chapter 4 incorporates data from Scenario 3a and 3b. Data from Scenarios 1, 2, and 4 will be incorporated in subsequent papers – outside of this dissertation.

Scenario 1 focuses on decision-making regarding conflicting gender norms and rights (e.g. residents' rights and nondiscrimination against LGBT residents) regarding a technical decision (roommate assignment). I incorporated this scenario into the interview protocol because it represents a widespread concern raised by long-term care staff, residents, and visitors (i.e. friends and family) interested in culturally responsive care for LGBTQ+ residents. I also used this scenario because it provides an example of a seemingly quick technical decision about roommate selection that could have complex repercussions for staff, visitors, and residents. I

hoped this would illuminate staff understandings and meaning-making regarding conflicting rights as it pertains to residents, autonomy, and gender.

Scenario 2 focuses on decision-making regarding conflicting gender norms and rights when caregiving. In particular, this scenario examines staff understandings and meaning-making regarding conflicting rights regarding resident autonomy, decision-making, personal care, and staff rights to nondiscrimination. The area of bathing is particularly useful to probe because of gender norms regarding body representation and because it invokes a gray area of law regarding sex discrimination, bona fide occupational qualifications (which allow for some type of sex discrimination), and patient rights. Scenario 2 provides a good contrast to Scenario 1 because it looks more complex and less explicitly bureaucratic than roommate selection. However, different workers may still frame them as both bureaucratic/administrative decisions.

Scenario 3 (Scenarios 3a and 3b) focuses on decision-making when staff encounter potential conflicts between religious rights and LGBTQ+ rights. Scenario 3 initially includes a scenario (Scenario 3a) involving a staff member who excludes a resident in social activities based on her personal religious belief and the religious beliefs of other residents. After the interview participants provided their responses to this scenario, I modified the scenario (Scenario 3b) to include a staff member who refused to provide care to LGBTQ+ residents because of her religious or moral beliefs. Here, I wanted to probe staff understandings and meaning-making about potential conflicts regarding rights when the colleague's responsibilities included direct care in contrast to facilitating social activities. While both types of interaction involve caregiving and support, direct care may spark a different response when a staff member invokes religious exemptions.

Scenario 4 focuses on decision-making when conflicts between LGBTQ+ rights and

patient care are complicated by dementia. This scenario represents a complex situation of competing rights that practitioners in the field have repeatedly raised in state and national conferences as well as informally with me in my previous jobs. There seems to be a lot of concern/anxiety among some practitioners and upper-level managers about what they should do in this situation, and there is no clear answer from the law. As such, I expected staff to have a diversity of responses that would reveal a range of creative problem-solving responses.

APPENDIX C

Additional Description about Upper-Level Staff

The participant sample included three groups of upper-level managers (e.g. Directors of Nursing, Administrators) (n = 16). I obtained this sample through a purposive sampling approach, which comprises a commonly used approach in qualitative research to identify and select rich cases that provide depth on a particular phenomenon (Van Humbeeck, Dillen, Piers, & Van Den Noortgate, 2020). One group included three upper-level managers from Facility 1, which represented two Administrators and one Director of Nursing. A second group included three upper-level managers from Facility 2, which represented one Administrator and two Directors of Nursing. Facility 1 and Facility 2 were similar in that both facilities are nonprofits and accept Medicaid and Medicare, have fewer than 110 beds, are continuing care retirement communities (CCRC), have resident councils but no family councils, and provide care outside a hospital. Both also received a minimum of 4 stars in the Centers for Medicare & Medicare Services' (CMS) quality measures (above average), minimum of 4 stars for CMS's health inspection rating (above average), and 1 star in CMS's staffing rating (much below average). Facility 1 comprised an independent facility, which was not affiliated with any other facilities. Facility 2 was affiliated with a larger corporation that had other facilities throughout Michigan.

I conducted all interviews with front-line workers and mid-level managers at Facilities 1 and 2. By interviewing all three levels of staff at these two facilities, I was able to gather a more complete picture of how staff experiences and understandings varied at these facilities. However, because each facility had a much smaller pool of upper-level managers to interview, I expanded my data to a third group, which included upper-level managers from other facilities in Michigan. By interviewing upper-level managers at other facilities and increasing my sample sizes, I was able to draw more robust comparisons among staff levels.

I recruited this third group (n =10) primarily from state and national conferences and a snowball sampling approach that afforded me access to upper-level managers like Administrators and Directors of Nursing in Michigan long-term care facilities. Given the challenge of accessing this smaller sample (compared to front-line workers and mid-managers) and hard-to reach sample, I included upper-level managers at any nonprofit long-term care facility in Michigan and did not attempt to only include those who worked in facilities with similar CMS ratings as Facilities 1 and 2. Of the ten upper-level managers in group 3, nine worked in a facility with fewer than 110 beds (similar to Facilities 1 and 2). All ten participants worked at facilities that accept Medicaid and Medicare and have resident councils (similar to Facilities 1 and 2). Seven facilities received a minimum of 4 stars in the Centers for Medicare & Medicare Services' (CMS) quality measures (above average) (similar to Facilities 1 and 2). Six facilities received a minimum of 4 stars for CMS's health inspection rating (above average) (similar to Facilities 1 and 2). However, unlike Facilities 1 and 2, only one of the facilities had a CMS score of 2 (below average) and none had a 1 star staff rating (like Facilities 1 and 2).

APPENDIX D

Additional Description about Accessing the Two Facilities

To identify the two comparative facilities (Facility 1 and Facility 2), I reviewed data on over 400 nursing facilities in Michigan from the Centers for Medicare & Medicare Services' (CMS)'s Nursing Home Compare website (2021), which is accessible on Medicare.gov. This website includes ratings from 1-5 stars about each facility on the information below. One star equates to much below average. Two stars equates to below average. Three stars equates to average. Four stars equates to above average. Five stars equates to much above average. Data on CMS's Nursing Home Compare website included the following information:

1. **Overall rating**: based on a nursing home's performance on 3 sources: health inspections, staffing, and quality of resident care measures.
2. **Health inspection rating**: based on each nursing home's current health inspection and 2 prior inspections as well as findings from the most recent 3 years of complaint inspections and 3 years of infection control inspections.
3. **Staffing**: based on registered nurse (RN) hours per resident per day and total nurse staffing (including RN, licensed practical nurse (LPN), and nurse aid) hours per resident per day.

4. **Quality of resident care**: based on data from a select set of clinical data measures. For long-term care, the rating reflects the quality of care delivered to long-term residents, and whose typical goal is to maintain or attain their highest possible well-being while residing in the facility, including the number of hospitalizations per 1,000 long-stay resident days, number of outpatient emergency department visits per 1,000 long-stay resident days, percentage of long-stay residents who got an antipsychotic medication, percentage of long-stay residents experiencing one or more falls with major injury, percentage of long-stay high-risk residents with pressure ulcers, percentage of long-stay residents with a urinary tract infection, percentage of long-stay residents who have or had a catheter inserted and left in their bladder, percentage of long-stay residents whose need for help with daily activities increased, percentage of long-stay residents who needed and got a flu shot for the current flu season, percentage of long-stay residents who needed and got a vaccine to prevent pneumonia, percentage of long-stay residents who were physically restrained, percentage of long-stay low-risk residents who lose control of their bowels or bladder, percentage of long-stay residents who lose too much weight, percentage of long-stay residents who have symptoms of depression, percentage of long-stay residents who got an antianxiety or hypnotic medication.

The website also identifies the number of certified beds in a facility, whether it participates in Medicare and/or Medicaid, whether it has a resident and/or family council, whether it is located within a hospital, whether it is in a continuing care retirement community, and the ownership type (e.g., nonprofit corporation, for-profit corporation, county facility).

After comparing the above data for various facilities in Michigan, I subsequently identified approximately ten potential facilities in Michigan that had a reputation for supporting culturally responsive care for LGBTQ+ older adults. I acquired this information informally through community leaders in the aging network (e.g. Area Agencies on Aging), local LGBTQ+ organizations (e.g. SAGE Metro Detroit) and LGBTQ+ older adults. I specifically chose facilities that were LGBTQ+ supportive for two reasons. First, I was particularly interested in examining individual staff responses to religious exemptions in caregiving when an organization has expressed support for LGBTQ+ older adults at a mezzo level (e.g. via nondiscrimination policies, staff trainings). Religious exemptions often arise in the context of LGBTQ+ caregiving. Facility 1 was non-secular, whereas Facility 2 was secular. While both were supportive of LGBTQ+ older adults, I also wanted to compare facilities based on religion. Ultimately, the data revealed no difference on this measure, which may have been because both facilities had strong support for LGBTQ+ older adults on an organizational level (e.g. nondiscrimination policies, trainings).

Second, given my background as an attorney and nonprofit executive with LGBTQ+ organizations, I assumed I would have significant difficulty gaining access to facilities that did not support LGBTQ+ organizations. Many organizations that fail to provide culturally responsive care to LGBTQ+ older adults appear neutral on paper – meaning that their websites and corporate documents are silent about support or lack thereof for LGBTQ+ older adults. Thus, I affirmatively chose to gather data from facilities that affirmatively and outwardly expressed support for LGBTQ+ older adults by having written nondiscrimination policies that expressly include sexual orientation and gender identity and that have had an LGBTQ+ culturally responsive training in the past two years.

Once I identified two potential facilities, I reached out to community members and colleagues that I knew who had relationships at these two facilities. These community members and colleagues facilitated introductions with facility organizational leadership. I subsequently sent emails to organizational leaders at both facilities describing my project. I also physically met with staff at both facilities. Each facility then engaged in an internal process of approval. Both facilities subsequently agreed to participate in this project.

APPENDIX E

Salience of Race, Gender, and Intersectionality in this Project

Long-term care facilities are predominantly staffed by women, particularly among front-line workers such as certified nursing assistants and nurses (PHI, 2018a). In Michigan, 94% of direct care workers are women (PHI, 2018a). Direct care workers in nursing homes are also disproportionately women of color. In Michigan, 43% of direct care workers in nursing homes are women of color (PHI, 2018b). Thirty-seven percent of direct care workers in Michigan identify as Black or African American (PHI, 2018b) while only 14% of Michigan's population identify as Black or African American (U.S. Census Bureau, 2019). While much of the front-line staff comprise women – and disproportionately represent women of color – leadership tends to be predominantly white (Bates, Amah, & Coffman, 2018).

Both Facility 1 and Facility 2 mirrored the above data regarding race and gender among front-line workers. Front-line workers at both facilities were overwhelmingly women, and women of color were overrepresented (compared to the general population) in this staffing level. Facility 1, however, included more women of color in leadership roles than Facility 2. In Facility 1, 41% of the mid-level managers identified as Black compared to only 10% in Facility 2. This trend continued in upper management. In Facility 1, two of three upper-managers identified as Black, whereas all three upper-managers identified as white at Facility 2. The implications of

race and gender (and the intersection of race and gender) were most apparent in Chapter 3. When a majority of the staff at all levels identified as Black (as was the case for Facility 1), race discrimination by other staff was much less salient. Instead, staff focused more on experiences of race and/or sex discrimination by residents (who were often white) and LGBTQ+ discrimination by staff and/or residents. In contrast, at Facility 2 where very few women of color were represented in mid- or upper-level management roles, race discrimination was much more salient. White staff complained that Black staff invoked race to circumvent rules whereas Black staff complained of overt and subtle race discrimination by staff (and residents). Staff of all races also complained about sex discrimination by residents at Facility 2. Chapter 3 only addresses race discrimination by residents and thus subsequent papers will further examine the salience of race and gender as it pertains to discrimination by staff. However, data about discrimination from residents underscored the complex ways in which women of color experienced discrimination and how they navigated that discrimination. African American women described being oversexualized and fetishized in ways that are consistent with scholarship on sexual abuse toward Black women (Holmes, 2016; Silvestrini, 2020).

Chapter 2 focuses on how staff navigate conflicting rights regarding safety and autonomy for residents. While the salience of race and gender may seem less obvious in this chapter (as compared to Chapter 3 regarding discrimination), gender and race persisted as important contexts for staff understandings and responses. Gender and race norms drive perceptions about acceptable work behavior, which influenced some of how the staff I interviewed responded. This finding was further complicated by uneven racial composition of staff at various levels, particularly in Facility 2 – and further shaped by diverse perceptions by white and Black staff about how race shaped perceptions about commitment to care and work ethics. These complex

dynamics will be further explored in a subsequent paper, which will pull from a separate body of theoretical and empirical scholarship for framing.

Chapter 4 focuses on how staff understand and navigate religious exemptions to caregiving for LGBTQ+ residents. Like Chapter 2, race and gender stereotypes about commitment to care and work ethics intertwined with concerns about being understaffed. These issues further intersected with perceptions about fairness and gender as it relates to LGBTQ+ rights. Individual faith, which is also intertwined with race and gender, further shaped how staff understood and responded to religious exemptions by other colleagues. As with Chapter 2, these complex dynamics will be further explored in a subsequent paper, which will pull from a separate body of theoretical and empirical scholarship for framing.

APPENDIX F

Reflexivity

Reflexivity is an important or "core" (Rankl, Johnson, & Vindrola-Padros, 2021) part of qualitative research (Day, 2012; Gabriel, 2015; Probst, 2015). While multiple definitions exist regarding reflexive research (Day, 2012), a key component of reflexivity is the act of reflecting on oneself as the researcher and how one's "self-location" (Rankle, Johnson, & Vindrola-Padros, 2021) regarding gender, class, ethnicity, and other social locations or positionalities, and one's interests, assumptions, and life experiences shape how a researcher approaches participants in a study and the knowledge produced. Jacobson and Mustafa (2019) developed a Social Identity Map as a reflexivity tool for researchers to identify and reflect on their social identities or positionalities. The map involves three tiers: identification of social identities (Tier 1), how these positions impact our life (Tier 2), and details that may be tied to the particularities of our social identity (Tier 3) (Jacobson & Mustafa, 2019).

Denzin and Lincoln observed that qualitative researchers wrestle with a "triple crisis of representation, legitimation, and praxis" (2000: 17). Reflexivity allows researchers to tackle these three issues. Reflexivity regarding representation examines a researcher's place in the social world and one's underlying assumptions about knowledge (Day, 2012). Reflexivity regarding legitimation examines what is considered legitimate knowledge and how power,

identity, and positionality shape knowledge development (Day, 2012). Reflexivity regarding praxis examines how one can apply reflexive techniques into practice to produce good research (Day, 2012).

As a researcher, my intersecting positionalities, particularly regarding race, gender, and class were particularly salient during this project. As a cis white woman (Tier 1), I was most similar in these positionalities to mid- and upper-level managers in facilities in ways that could have shaped rapport among participants in diverse ways (Tiers 2 and 3). These intersecting positionalities may have made it easier for other white women in mid- and upper-level management to feel more comfortable discussing their concerns about race with another white person. This dynamic seemed most significant at Facility 2 where there was a larger racial disparity between front-line workers and management and where very few mid- and upper-level managers were women of color. Several white women managers shared with me their perceptions that some of the Black CNAs that worked at their facility were invoking race to avoid discipline at work. These white participants were each careful to note that they eschewed racism while simultaneously demonstrating comfort in complaining about Black staff. They may have assumed that my racial privilege as a white woman provided a shared sense of racial understanding and/or apprehension about being called racist after complaining about Black staff.

In contrast, as a white woman, I likely had less rapport with some of the Black staff I interviewed and/or observed through staff meetings, who may have felt that I could not or would not be able to relate to or understand their experiences. Some participants may have chosen different language / wording or omitted sharing particular experiences altogether. Because I gained access to the facilities through upper-level managers / leadership, women of color CNAs who felt unsupported by white leadership may have also been less forthcoming about some of

their experiences with mid- and upper managers if they feared a lack of confidentiality. While I tried my best to assure confidentiality, my race and gender (white woman) may have created barriers, given that some had conflict with white women in leadership at the facility where they worked.

Some of the participants I interviewed were also aware of my work experience in the community, in particular, my work in the LGBTQ+ community. This may have helped or hindered knowledge development and rapport building. Three Black lesbian staff who were not out at work confirmed that they felt comfortable to share their experiences as Black lesbians at their facility with me, in part, because they trusted me, given my work with communities of color and LGBTQ+ organizations (and intersections within). However, other staff may have felt stifled to freely share less supportive views about serving LGBTQ+ older adults, if they were aware of my past work experience.

Reflexivity also requires reflection about how my positionalities shaped knowledge produced. Research (quantitative, qualitative, and mixed methods research) requires many data interpretations. A larger spotlight shines on interpretations for qualitative research, given concerns about legitimation and validity, which is, in part, one reason why reflexivity is so important (Day, 2012). I concluded my data collection one day before nursing facilities excluded visitors due to COVID-19. While I engaged in some data interpretation prior to the conclusion of my data collection, given the iterative nature of this project, much data analysis and interpretation occurred during COVID-19. During this time, staff shortages skyrocketed, particularly among direct care workers, who were already underpaid and overworked prior to the pandemic. Growing racial inequities in COVID-19 hospitalizations and mortality rates also left a vacuum for many facilities in front-line workers, given a prior reliance on women of color to

serve in these roles. COVID-19 required many women of color to increase caregiving at home – for family and friends with COVID-19 and/or provide support during the grieving process after a death. The digital divide further exacerbated caregiving roles for many women of color who were previously serving as direct care workers but now had to secure computer hardware and broadband internet to support children in their virtual learning. While I experienced loss and elevated stress from the pandemic, too, my positionalities as a white, middle-class woman with stable income (and technology and reliable internet) afforded me privileges to survive—and in some ways to thrive—during the pandemic. Given that my income did not require in-person labor, I was able to transition and maintain virtual employment throughout the entire pandemic and continue working on my dissertation project, including data analysis and interpretation, when many of the staff I interviewed could not earn income from working remotely. The digital divide became much more visible during COVID-19 when I was engaging in much of my data analysis and underscored how important it was that I provided both in-person and phone interviews for participants, particularly direct care workers. It also heightened my awareness of the multiple caregiving responsibilities of many of the direct care workers participants in this project, which may have shaped some of their responses, particularly the frustrations with feeling unsupported by colleagues and/or supervisors with race or class privilege. The murder of George Floyd and increasing attention on Black Lives Matter also sharpened my focus on race while engaging in data interpretation. I also participated in several multi-week antiracist trainings and workshops and discussion groups that provided space to further reflect on the impact of my positionalities and more carefully consider how to tackle the "triple crisis of representation, legitimation, and praxis" (Denzin & Lincoln, 2000: 17). I incorporated some of these reflections throughout the dissertation. However, they also formed the foundation for several papers that I

began developing outside this dissertation, which will further address the salience of race, gender and intersectionality in this project using different research questions and conceptual and theoretical scholarship (*See* Appendix E).

As expressed above, my representation as a cis white woman likely shaped rapport with my participants (both white women and women of color) in diverse ways as well as data analysis and interpretation. Triangulating data was helpful, particularly as I worked alongside a research team of five to seven research assistants with diverse positionalities – albeit all at the same university. Legitimation (Day, 2012; Denzin & Lincoln, 2000) became important in this project as I incorporated very different types of data and knowledge from participants. Interviews provided an opportunity to build rapport more so than group staff meetings that allowed me to validate knowledge provided by participants. However, staff meetings allowed me to consider more invisible or latent forms of knowledge generation (e.g. facial expressions, microaggressions) exhibited in meetings. For example, at one CNA meeting, two white mid-managers presented evolving facility policies that were being updated to address resident concerns about soiled laundry. During this conversation, one of the white mid-managers attributed the problem to inattentive or late CNAs, which sparked several negative facial expressions from Black CNAs. In prior conversations I had with several Black CNAs at this facility, they had expressed concern that they were being penalized differently from white CNAs and labeled as bad employees. When they were late because of unreliable transportation, they reported being labeled as undependable or branded as bad employees. They added that they observed white CNAs who were late for other reasons who were not penalized. They attributed this difference to the fact that some of the white CNAs who lived closer did not depend on unreliable public transportation and thus had reasons for being late that were more relatable to

white mid-managers (i.e. got rear-ended, sick child). These facial expressions (and the microaggression comment) produced legitimate knowledge, particularly when combined with other data such as individual interviews with the staff at these meetings.

Moreover, I considered the staff I interviewed (regardless of level of staff) as experts in their experiences. I was the interloper that was temporarily visiting their space and learning from them. My advanced graduate degrees became meaningless in interactions, particularly with front-line workers, who were particularly focused on direct practice experience and serving the daily needs of the residents. I will note that one of the upper-level managers was particularly impressed with my academic trajectory and past work experience as an attorney. I think that my professional background enhanced my rapport with him in ways that may have made him feel as if his knowledge was more legitimate (given that he also had several graduate degrees). But even in my interactions with him, I considered him the expert. My degrees were equally meaningless in my interpersonal conversations as I aimed to underscore his role as expert.

I further aimed to engage in reflexive praxis (Day, 2012; Denzin & Lincoln, 2000) by intentionally building rapport with participants during participant and non-participant observation and interviews. I repeatedly considered and reconsidered how my intersecting positionalities shaped interactions and how I should respond accordingly to further build rapport. For example, as a white woman, many of the Black participants referenced experiences of race that were unique to them as Black women. They described them to me as an outsider looking in (e.g. “As a Black woman, I experience this all the time….” “Let me explain what I mean by X” [referencing experiences of racism]). I deferred heavily to participants as experts of knowledge who had information that I needed to understand about how staff navigate conflicting rights in long-term care facilities. Even when I had heard similar stories or definitions from other

participants, I approached each participant's story as new and useful data that I probed for more details, which often evoked additional details about experiences of racism or racial disparities that were unfamiliar to my lived experiences. As a member of the LGBTQ+ community, however, I had some insider knowledge that I was able to employ to build rapport with several participants who described their experiences being LGBTQ+ formal caregivers in long-term care. For example, my positionalities (SOGI - sexual orientation and gender identity) and experiences in the LGBTQ+ community heightened SOGI visibility of some of the LGBTQ+ participants (e.g. sometimes more colloquially referred to as "gaydar"). I occasionally shared personal details about my own work or personal life to build rapport, which prompted several LGBTQ+ participants to disclose their own experiences being LGBTQ+ at their long-term care facility that I may not have otherwise been able to access. Finally, I engaged in significant memo-writing while collecting and analyzing data to ensure reflexive praxis. Reflexive praxis is a challenging process – but an important process in qualitative research – and one that I hope to continue to refine along my academic journey.

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