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There and back again. Examining the development of employee commitment during a prolonged crisis



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ABSTRACT

To effectively function and adapt in crises, healthcare organizations rely on the skills and commitment of their workforce. Yet, our current understanding of how employees' workplace commitment is affected by and evolves throughout the course of a crisis remains limited. In this paper, we explore the commitment of hospital staff to an important workplace target, the COVID-19 crisis response, and show how this commitment develops over time. We report on an exploratory case study of hospital staff in a heavily hit region of the Netherlands. We conducted interviews with hospital executives, management, medical and support staff to uncover the issues hospitals faced in recruiting staff to provide COVID-19 care throughout the first and second wave of the crisis. Our findings suggest that while staff initially exhibited high levels of commitment to aiding in the crisis effort, staff were perceived to exhibit lower levels of commitment in the second wave, complicating the provision of COVID-19 care. We unveil three contributing factors to this shift, namely: competing demands, energy depletion and a lack of support and appreciation. Our findings suggest that while staff were initially willing to dedicate themselves and take responsibility for the crisis effort, as their other more stable commitments became more salient in the second wave, their willingness to dedicate limited resources to the crisis effort decreased. In our discussion, we examine the implications of our findings for the literature on workplace commitment, and advance our understanding of employee workplace commitment during crises.

1. Introduction

As the COVID-19 crisis continues, hospitals continuously need to adapt and rely on their workforce to respond to increasing demands and pressures. This poses serious challenges to hospital organizations worldwide that already struggled with significant resource constraints in terms of supply and staff shortages in key areas (Ang et al., 2013; Panagiotti et al., 2017) prior to the COVID-19 crisis. To respond to the increased demands, hospitals require even more of already limited staff, relying on their commitment and skills to support the crisis effort and treat patients at the frontline (Nembhard et al., 2020). When staff are highly committed they are willing to allocate effort and resources to the corresponding workplace target (Klein et al., 2012) and improved performance is expected (Klein, Lount, et al., 2020). However, emergent research shows that healthcare workers are struggling to maintain their

functioning as they continue to experience adverse psychological consequences (Lai et al., 2020; Pappa et al., 2021) and physical illness (Dzau et al., 2020) due to the crisis. We know that these strenuous conditions threaten organizations' abilities to remain responsive to the demands spurred by the COVID-19 crisis (Gifford et al., 2021; Lasater et al., 2021; Price et al., 2021), and may have an effect on staff's workplace commitments (Jain et al., 2013). Yet, it remains unclear how the ongoing situation has affected staff's commitment to the crisis response, in particular their willingness to provide COVID-19 care, and studies are lacking that investigate how employees' workplace commitments evolve over time (see Klein, Brinsfield, & Cooper, 2020 for a notable exception).

While initial studies highlight the exhaustion, stress and mental health of healthcare workers staff during the COVID-19 pandemic (Cahan et al., 2020; Dzau et al., 2020; Fleuren et al., 2021; Lai et al., 2020), studies on how these underlying issues affect staffs' commitment over

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time are lacking. Although earlier research on workplace commitment focused primarily on organizations as the target of commitment (van Rossenberg et al., 2018), more recent research has recognized that employees can be committed to various targets (Klein et al., 2014) including organizations, careers, projects, and specific organizational goals (Klein, Lount, et al., 2020). With the COVID-19 crisis spanning more than a year, the specific commitment to providing COVID-19 care and supporting the crisis response is crucial, but remains poorly understood. Research conducted during the pandemic indicates that professionals may show increased commitment to caring for COVID-19 patients (Zandi et al., 2020), but how this commitment evolves throughout the ongoing crisis remains unknown.

In the present study, we explore how commitment of healthcare workers has developed as the COVID-19 crisis has unfolded, working to uncover the underlying factors that may drive changes in commitment over the course of a prolonged crisis event and the implications for organizational crisis response. We question: *How does employee workplace commitment evolve over the course of a prolonged crisis event?* and *What are the underlying mechanisms driving any [perceived] changes in commitment?* As the current situation is unprecedented and poorly understood, this paper uses a qualitative, exploratory case-study approach to examine how the commitment of hospital based staff to the crisis effort [was perceived to] evolved through the first and second waves of the pandemic. Interviews were conducted with organizational staff responsible for providing COVID-19 care (i.e. medical specialists), supervising frontline staff, coordinating the crisis effort, and the staffing, redeployment and recruitment of frontline staff. Specifically, we employ an inductive grounded theory methodology (Strauss & Corbin, 1990), to expand upon existing theory by drawing directly from a rich, empirical context that allows us to investigate how the commitment of staff changed over the course of a prolonged crisis and why this occurred. Investigations of how crises affect employee commitment are scarce (see Markovits et al., 2014 and Meyer et al., 2018 for notable exceptions). As a result, this paper builds a base for future research to explore the issue of staff commitment during crises and offers insight into important underlying mechanisms driving commitment (see also Klein, Brinsfield, & Cooper, 2020).

2. Theory

2.1. Workplace commitment during crisis

Healthcare organizations rely heavily upon the dedication of their workforce to support organizational efforts to manage, respond to, and recover from threats. During the COVID-19 crisis, hospitals have had to rely on their staff to commit themselves to the crisis response and adapt quickly to an unknown disease and unprecedented crisis, organizing and working in new functional areas and roles, sometimes on a daily basis (Nembhard et al., 2020). Society as well has relied on healthcare workers' commitment to fighting the crisis and caring for patients affected by this disease. However, the duration and scope of the COVID-19 crisis raises unique challenges and puts healthcare workers under a heavy burden (Cahan et al., 2020; Dzau et al., 2020) that may affect their ability or willingness to commit to the crisis effort. Despite its importance, our current theorizing on workplace commitment does little to address how staff's commitment may be affected in more dynamic and competitive environments (Klein, Brinsfield, & Cooper, 2020) or during crises (Meyer & Morin, 2018). Scholars have therefore argued that we require new conceptualizations of employee commitment (Klein et al., 2012; 2020b) and the factors influencing employees' commitment to various and more temporary targets (van Rossenberg et al., 2018) such as crisis response.

2.1.1. Conceptualizing commitment

In this study we draw upon the unidimensional model of commitment presented by Klein et al. (2012) given its relevance and applicability to any workplace target. Commitment is defined as 'a volitional psychological

bond reflecting one's dedication to and responsibility for a target' (Klein et al., 2012, p. 146). In this conceptualization of commitment, commitment is a psychological state that can shift over time (Klein et al., 2014). Importantly, dedication and responsibility for a target plays a key role. Individuals are said to be committed when they willingly and voluntarily dedicate themselves and accept responsibility for a target (Klein et al., 2012; 2014). This differs from other and earlier models of commitment, where individuals are still considered committed even when they feel they have no choice (e.g. continuance commitment in Meyer & Allen's (1991) three-factor model). While Meyer & Allen's (1991) three factor model distinguished between three types of commitment, affective, normative and continuance, Klein et al.'s (2012) conceptualization focuses on volitional bonds only. When individuals have a high or strong commitment to a target, this has positive motivational effects, resulting in the dedication of resources toward the target and the willingness of individuals to make tradeoffs in support of the target (Klein et al., 2012), for example by dedicating limited time and energy to COVID-19 care provision. However, if individuals choose to forgo responsibility for the target, their commitment ceases. How commitment to various targets change overtime remains a point for future enquiry (van Rossenberg et al., 2018).

The central notion of responsibility is highly relevant in the context of healthcare, where the achievement of organizational goals and success of projects and work teams rely on the mutual responsibility of staff members dispersed across departments, professions, and even organizations (Gittell, 2000; Nugus et al., 2010). If staff choose not to, or choose to no longer be responsible for a certain target (i.e. to a change process, a multidisciplinary workgroup, an innovation project), this has repercussions for the achievement of important goals, projects and workgroups. In the current study, we utilize the unique context of COVID-19 to empirically explore how staff commitment to the crisis effort evolves over time, offering insights into the underlying factors that can support or undermine employees' workplace commitment to important organizational targets.

3. Methods

This study was reviewed by and granted ethical approval (*specific information removed for blinded peer review*). To report our methods and findings we follow the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

3.1. Case setting

We conducted our study in the Netherlands, a country that has had over 11 506 confirmed COVID-19 cases per 100 000 inhabitants (over 2 million confirmed cases in total) since the outbreak of the pandemic (data retrieved on October 01, 2021) (WHO, 2021). The country saw a rapid increase of infections and deaths in early spring 2020, particularly in the southern regions (CBS, 2020). As of October 2020, the country saw an ongoing surge of infections (WHO, 2021). In this study, we utilized data from an exploratory case study of hospital staff across all hospitals in one of the most heavily hit regions of the country, particularly during the first wave in spring 2020 (CBS, 2020). Hospitals included in the sample vary in size, ranging from one of the smallest of the country to one of the biggest of the country, in terms of number of available beds (297 compared to 980), patients treated and amount of staff. One of the case hospitals is an academic hospital, while the other four are general hospitals of which two are top-clinical centers. All included hospitals provide both inpatient and outpatient care, and have a 24-h emergency ward.

3.2. Sample

The scope of the present study included organizational members who all had a central role in coordinating and implementing crisis response and were responsible for ensuring the delivery of COVID-19 care in their

respective organizations. Access to participants was granted in collaboration with an internal liaison within each hospital. The research team requested a contact list from the liaisons that included representative individuals across all levels of the organization (executives, managers, frontline staff and support staff) who had been actively involved in the crisis response. From this initial list, we engaged in further snowball sampling to help diversify and expand our sample. Participation was voluntary and interviews were arranged directly with participants via email.

Our final sample included executives (hospital board members), management (senior and middle management and management with both professional and medical backgrounds), medical specialists across different specialty groups (e.g. internal medicine, emergency medicine), one intensive care (IC) nurse (who is also a nursing director), and support staff including those leading psychosocial support teams, and crisis team members. In total, we conducted 35 interviews across five hospitals (see Table 1 for a list of interviewees and cases). In two hospitals, we only received a limited contact list with two names (Hospital 4 and 5), as liaisons felt that they could not further burden staff with requests during the second wave of the crisis. In hospital 4, the authors utilized their professional network to add one additional interview with a medical specialist. Ultimately, across all hospitals, our sample allowed us to gain insights from a diverse sample of individuals working at different levels within the organization including the frontline by speaking with medical specialists (from internal medicine, psychiatry, emergency care and microbiology) and nursing directors including an IC nurse actively involved in providing patient care (see Table 1).

3.3. Data collection

Interviews were conducted by the two first authors (RG, FvdB) during the second wave of the COVID-19 crisis, in the period of September 2020 to January 2021, as part of a larger research project investigating hospitals' responses to the crisis. Interviews were conducted in both English and Dutch with both a native English (RG) and Dutch (FvdB) speaker present during interviews. Translations were performed by FvdB where necessary. Interviews were focused on understanding how hospital staff responded to, and were coping with, the ongoing crisis. We first asked interviewees to describe how the crisis began, their experience of the crisis response, and to reflect upon the challenges and successes of the first wave. Furthermore, we particularly asked how staff had been affected by, and were coping with, the crisis. We asked about organizational change, redeployments, task differentiation, and about the psychological and emotional effects of working in crisis response (e.g. How has your health and wellbeing at work been affected by COVID and the adaptations in your hospital; How are your staff currently coping?). We then asked interviewees to reflect on how the situation was in the period following the first wave, and to then comment on how the crisis response was unfolding in the second wave.

Interviewees were asked to reflect on similarities and differences between the first and second wave and were asked about the ability to staff COVID-19 departments and the wellbeing of staff in both waves. Finally, interviewees were also asked to consider how prepared they felt the organization was for future waves or crises, also considering the ability of staff to continue functioning over time. Our initial interview guide was updated to reflect emergent themes in our first interviews,

which included the lessening of staff commitment. In particular staff were asked about the willingness of staff, peers and their own experienced motivation (where relevant) to contribute to the crisis effort in both the first and second wave.

3.4. Analysis

We took an interpretive grounded theory approach to data analysis (Glaser & Strauss, 1967), analyzing interview transcripts to define emergent themes from the data. Our focus on workplace commitment was not determined from the outset, and rather evolved from the emergent themes found across interviews. Analysis was iterative from the first interview, and the first authors (RG, FvdB) engaged in constant discussion throughout the data collection and analysis period. Interview summaries were made immediately after each interview, and transcripts were analyzed as they were completed. Transcripts were put into Atlas.ti 8.0 for analysis. Throughout our analysis process, we constantly compared the data from different interviewees and organizations. This helped to continuously refine our focus and to probe in future interviews. For example, early on in the data collection, some interviewees remarked that staffing had become more difficult in the second wave and that healthcare workers were less willing to volunteer. Consequently, we incorporated a line of questioning that asked participants to reflect upon the willingness of staff to offer COVID-19 care.

In analyzing the transcripts, we began with a process of open coding. Open codes were created by both the first authors (RG, FvdB), and these authors worked in tandem to condense and combine codes and move into the second phase of axial coding (Strauss & Corbin, 1990). In this second phase we worked to find linkages between data points and began grouping the openly coded data into categories that formed the basis of our remaining coding (Allen, 2017). Our open codes indicated that in the first wave there was a clear goal (common enemy, collaboration) and a desire to help (commitment of staff, staff willingness to help) that brought positive emotions (pride in helping). However, we saw that as the crisis carried on, staff's energy was depleted due to ongoing mental and physical strain (staff tired of COVID-19, physical and mental strain, emotional burden) and a lack of recovery, competing demands put additional pressure on limited staff, and there was a feeling of being underappreciated (lack of appreciation). Because of this shift difficulties redeploying staff (who works on COVID-19 wards, who is responsible for COVID-19 care) emerged.

Through discussion of the emergent themes with the research group, the two coders then returned to the data and abstracted to a third level of theoretical coding (i.e. iterating between our findings and the literature to create our third order codes) (Glaser, 1998). At this stage we employed what other scholars may refer to as a 'pragmatic' approach to grounded theory, where we engaged with existing literature and concepts to refine our data and alongside attempts to derive novel themes rather than abstracting purely from a theoretical 'blank slate' (see Barbour, 2001). We then grouped together our axial codes from the first to the second wave. This allowed us to identify a shift from what appeared to be a stronger perception of commitment to the crisis effort (e.g. a strong desire to help, voluntary commitment) to lowered levels of commitment to the crisis effort (e.g. not wanting to perform COVID-19 care, doing so out of a sense of professional duty or moral obligation). We identified the contributing factors to this shift (e.g. competing demands, energy

Table 1
Sample description.

Staff function	Hospital 1 (H1)	Hospital 2 (H2)	Hospital 3 (H3)	Hospital 4 (H4)	Hospital 5 (H5)	Total
Executive	3	1			1	5
Management	5	4	4	1	1	15
Medical Staff	3	4	2	2		11
Support Staff	2	1	1			4
Total	13	10	7	3	2	35

depletion, lack of support) and considered further how these factors were interrelated.

In a final stage, we returned to the data to identify ways in which our findings relate to the literature on workplace commitment. We saw that there was a clear shift overtime in terms of the strength of commitment felt toward the crisis effort, expressed in a decreased willingness to provide and take responsibility for the provision of COVID-19 care. We then considered how this shift was uniquely driven by the context of crisis (as temporary) and how the identified factors may have uniquely and collectively contributed to such a shift (See Table 2 for a coding tree).

4. Results

We present our results below in two parts. First, we detail the findings regarding changes in the perceived commitment of frontline staff toward providing COVID-19 care. Second, we detail the three contributing

factors to these changes as indicated by our interviewees that include (1) competing demands, (2) energy depletion due to ongoing mental and physical strain, and (3) a lack of support and appreciation (e.g. not feeling valued). We then explore how this wavering commitment was perceived to affect, or potentially affect, the organization's ability to effectively staff for COVID-19 care. The abbreviations used at the end of each quote indicate which organization in Table 1 the interviewee belongs to (i.e. H1 regards Hospital 1, H2 regards Hospital 2 etc.).

4.1. Changing commitment

4.1.1. First wave, high level of commitment

4.1.1.1. *Shared responsibility.* In the first wave interviewees felt that there was a clear and strong sense of commitment of healthcare workers across all hospitals to provide care for COVID-19 patients. This was in

Table 2
Coding tree.

Shift in commitment first to second wave			
	First order codes	Second order codes	Third order codes
<i>First wave</i>	Common enemy	Shared responsibility	High level of commitment (COVID-19 care)
	Noses in the same direction		
	Clear focal point and goal	Emotional investment	
	Once in a lifetime event		
	Excitement of unknown		
	Proud to help	Dedication	
	Emotional connection to the crisis effort		
	Staff commitment		
	Desire and willingness to help		
	Staff volunteering		
<i>Second wave</i>	COVID-19 should be only in certain specialties	Lack of responsibility	Waning commitment (COVID-19 care)
	Everyone is tired of COVID-19		
	Staff want to focus on their own patients and care	Sense of obligation	
	Difficulty redeploying staff		
	Staff will provide care if needed		
	Professional responsibility to patients		
	Everyone is tired of COVID-19		
COVID-19 care is everyone's responsibility			
Contributing factors to shift in commitment			
First order codes	Second order codes	Third order codes	
Exhaustion staff	Physical strain	Energy depletion	
Physical illness			
Absenteeism due to illness	Mental strain		
Need for physical recovery			
Heavy emotional burden			
Uncertainty is high			
Unresolved trauma from first wave			
Hard to mentally detach			
No end in sight			
Absenteeism due to burnout symptoms	Lack of recovery		
Lack of recovery			
Hard to detach			
Strain of long working hours	Balancing regular and COVID-19 care	Competing demands	
Doing COVID-19 work on top of regular work			
Scaling up regular care difficult	Own priorities		
Patients transfer from other areas in second wave			
No common goal			
Commitment to own patients			
Intergroup tensions			
Protection of staff in own department			
No more gifts or applause			
Public not following regulations			
Aggression/frustration of patients and families			
Patients and visitors more demanding			
Staff doesn't feel valued by board	Lack of support and recognition by organization		
Importance of leadership visibility			
Lack of additional signs of appreciation			
Staff not thanked for their work in other departments	Financial support		
Staff appreciate recognition by the board			
Zorgbonus (care bonus)			
Financial reward would motivate			
Compensation for additional hours			

part due to a clear and central goal of providing crisis care, with everyone having clear priorities.

We've seen that we can work flexibly and people, if the priorities are made and the goal is quite clear and common, that you see that people are very motivated and able to, to act to [do] what is needed. Manager, H1.

Interviewees indicated that the majority of medical specialists worked easily and voluntarily as assistants to other clinicians in intensive, acute and COVID-19 care wards. This was seen as a deviation from normal practice where specialists tend to work in silos and with a clear hierarchy. Other healthcare workers also took on new roles and helped in the crisis response. Nurses were redeployed from outpatient clinics and surgical theatres to work in COVID-19 care. Residents took up COVID-19 care on the frontlines, acting as supervisors and attending on the COVID-19 wards. Management themselves (e.g. human resource managers, board members) were redeployed and repurposed (e.g. taking on new functions, working on crisis teams), working in new ways in new teams and for long hours. It was clear that the COVID-19 crisis was an 'all hands on deck' situation, and most staff were seen as willing to help.

I think in the first [wave of the] crisis, the organization, the action was quite good. I saw a lot of solidarity, a lot of people wanting to tackle the crisis. I saw a lot of people, especially among the professionals, but also the supporting departments, everybody wanted to help and wanted to do something. Medical Specialist, H4.

Yeah, you know, the personnel in the first wave, it just happened to everybody. So there everybody was willing to help. Everybody was willing to do work they didn't do before. There was really, how shall I call it, we were really a team. Everybody was prepared to do something else. Manager, H2.

This initial commitment enabled hospitals to be flexible and effectively respond to the ongoing crisis.

4.1.1.2. Emotional investment and dedication. Interviewees described staff as having an intrinsic drive to be involved and in the first wave interviewees told that the majority of staff were eager to aid the crisis effort. Many healthcare staff took pride in working on the frontlines, and even in departments that did not immediately have a role in crisis care, staff wanted to participate and help the crisis response, and were willing to take on new roles and functions to help. Interviewees gave various reasons for this, including the disease and situation being a unique event, particularly for those who have an interest in infectious diseases and acute medicine. For others, they wanted to be on the frontlines with their colleagues and help society to battle what was coming. After watching what had happened in Italy and China and seeing the crisis hit other regions, staff wanted to aid in the crisis effort in any way they could.

I think in the first wave, the great thing was that everyone, from orthopedic to eye doctor, all looked the same way, and did it together. [...] and I think in the first hit you had a It was new and we had the feeling that we have to do it together. Medical specialist, H2.

While some staff felt scared or anxious about stepping in, worrying about the possibility of infecting their loved ones or getting sick and dying themselves, interviewees told that in some cases, even these individuals eventually joined the crisis effort.

While some staff chose not to participate, for example due to health concerns, interviewees indicated that the overwhelming sense in the first wave was a strong desire to help out, to be involved, and a sense of teamwork and cohesion. It was because of this strong sense of commitment and togetherness that management felt they were able to effectively respond to the crisis in the first wave, in spite of the heavy burden it placed on the organization.

And what struck me is that you ... actually within a week we were fully on strength [...] That went very smoothly. And there were a few minor flaws here and there, but that really went well. And with combined strength and togetherness you see that a lot was accomplished in a very short time. Manager, H3.

Interviewees indicated that because staff were willing and committed to provide COVID-19 care and aid in the crisis response, it made it easier for organizations to remain responsive in the face of high uncertainty and to accomplish what they needed.

4.1.2. Second wave, waning commitment

In interviews it became clear that there was a significant shift perceived between the first wave (approx. March–June 2020) to the second wave of the crisis (beginning approx. September 2020) in terms of the atmosphere in the organization. As many interviewees told us, things felt differently the second time around.

4.1.2.1. Lack of responsibility. While in the beginning of the crisis (wave one) interviewees felt there was a strong sense of cohesion, motivation and commitment to aiding the crisis effort, as time went on the energy and willingness of staff to provide COVID-19 care was seen to decrease. Interviewees perceived this shift to be associated with decreased flexibility to staff COVID-19 departments. For example, many interviewees noted that it became increasingly difficult to staff for COVID-19 care the second time around.

The general nursing departments also has to deliver people again for COVID care, [but] It's troublesome ... And that's quite different than our first crisis. [In the first wave] everybody said "we can do this, together we fix it." Today its "pff please don't call, I don't want to. We can't." ... I have to go after this meeting to the central crisis team and tell them that we asked our nursing departments, "come and deliver 5 names" [but] I can't get them ... So that's quite troublesome and I think it's general [to all hospitals]. Manager, H1.

Uncertainty surrounding the length of the crisis and the spread of the disease remained high through the first peak, and as cases began rising again in autumn, organizations struggled to get staff to work on COVID-19 wards.

As the first wave wound down in the late spring of 2020, elective care (e.g. 'regular care') began to be scaled back up and staffs' commitment for COVID-19 care dwindled. After going back to regular care in their own departments and for their own patients, staff were reluctant to take responsibility for and return to COVID-19 care.

And people are not that ... It's not ... Not everyone ... 'heeft er begrip voor zegmaar' [is understanding of the situation]. And then I mean the public, but also for some nurses and some doctors, they think 'oh here we go again' and they're tired, but they also think, surgeons for example, they also think about their own. About their surgeries and they have to go on too and yeah. Medical specialist, H2.

When discussions regarding how to handle COVID-19 care in the second wave began, department managers tried to protect their staff, particularly where they had experienced a heavy burden in the first wave and some staff avoided working on COVID-19 wards altogether.

So people get a little tired of the COVID patient. When you only see the COVID patients, your personnel is getting a little tired afterwards. Medical Specialist, H4.

There were some differences across hospitals in terms of the availability of staff and the level of shortages in certain departments. For example, in H3, staffing was perceived to be less of a problem than in H1 and H2, however, across all organizations a clear shift in staffs' motivation from the first to the second wave could be observed.

4.1.2.2. Sense of obligation. While staff willingly volunteered in the first instance, in the second wave staff would rotate in COVID-19 care, albeit somewhat reluctantly.

Well, it's difficult to do this. There are still a lot of people who are still willing to do the COVID care. But it's harder than the first time. The first time it was easy to get the personnel because everybody wants to help. Manager, H2.

Interviewees found it difficult to answer if they felt that staff would be ready for another wave. There was a clear recognition that staff were

experiencing emotional, physical and mental burdens from the first wave and that securing staff dedication to COVID-19 care was becoming harder.

Inside our hospital not all the staff members wanted to go to this model again of the first wave and leave their own patients and go to work for the corona patients again. So that gave a lot of hassle and problems and we had weeks of trouble finding enough doctors who could take care of this ... After I think two or three weeks we found a model [each specially helping in COVID-19 care], which worked but it wasn't happily. So it's yeah, it's quite difficult. Executive, C5.

While there was an understanding that healthcare workers would continue to do their job regardless of the burdens placed on them, their motivation to do so was changing.

[In the first wave] there was a very community feeling in your organization. "We're going to fight this." There was one enemy and we are going to do this together. [Now] people are tired, they're really tired, and they don't want to do this again. But they realize we have to. We don't have a choice. ... If you work as a nurse, you will always be a nurse. It's like, it's a motivation from inside. And if it's going to happen again, a second wave, they will work as hard as they have to have to work in the first wave, but they're not enthusiastic. Manager, H1.

As the above quote indicates, even when they did not necessarily 'want to' staff would continue to support the crisis effort because of their professional dedication to helping patients. This points to the idea of a shifting underlying motivation, from an intrinsic desire to help (as seen in the first wave) to a moral imperative or sense of obligation, whereby individuals feel less willing to commit themselves to a target.

4.2. Factors undermining commitment

Interviewees highlighted several key issues that contributed to the lack of commitment of staff to provide COVID-19 care and the difficulties around redeployment and staffing in the second wave. While there were many influential factors and these varied somewhat between interviewees, we were able to identify three central factors as detailed by our interviewees that were consistent across interviewees. We detail these factors in the present section.

4.2.1. Competing demands

After the first wave had ended, organizations quickly picked up their normal functioning again since almost all regular care had been suspended. Going into the second wave this created tensions for staff, since hospitals decided to keep up regular care as much as possible. Many healthcare workers were then dealing with competing demands, as they had to balance the provision of regular care with the provision of COVID-19 care. Having to provide COVID-19 care during the second wave also conflicted with staff's sense of duty to care for their own (non COVID-19) patients, as they could not fully dedicate themselves to caring for their own patients.

4.2.1.1. Balancing regular and COVID-19-care. Interviewees often mentioned that the strong sense of commitment, in spite of the high uncertainty and the lack of information surrounding the disease, was partly the result of the fact that regular care had been suspended in the first wave. With most regular care suspended, normal functions and tasks of staff were stopped (e.g. elective surgeries, nursing in outpatient clinics, resident education) so staff had the ability and time to offer their help to COVID-19. This made it easier for the organization and staff to work toward a clear and shared goal, and created a shared feeling of bonding.

If you look at capacity then I think that we, especially during the first wave, ...we were able to deploy all the staff that became available to other wards and functions. And there was a high willingness to do so. - Manager, H3.

When the first wave began to taper off, professionals began to return to their normal tasks and work routines and hospitals scaled up regular

care to fulfill backlogs and avoid long waitlists. In some hospitals, departments scaled up to 110% capacity to handle a backlog through late spring and summer. This meant that in the period after the first wave, staff were still working under immense pressure and increased workloads, even with fewer COVID-19 patients.

The return to regular operations meant that professionals now had to cope with competing demands between their own departments, functions and patients on one hand and providing COVID-19 care on the other. Juggling these two priorities while still reeling from the first wave left staff feeling overwhelmed and less willing or able to provide COVID-19 care.

Yes [its harder in the second wave], because you still have your normal health care and people don't want to assist in the COVID care. They want to stay at their own departments. Manager, H5.

Yeah, the funny thing is that after we started again with normal care, it went away. So the feeling of collaboration, the feeling of working together against this disease ... And now in the second wave, it didn't come back. So that's a problem, actually, because in the second wave, the hospital decided to keep the normal care up and running as much as possible. So for many people, this extra work comes on top of the normal work. While, in the first wave, the normal work was ceased ... And we could fully concentrate on our work for this epidemic. And I think that generated a lot of more, a lot more collaboration than it does now. Now everybody tries to protect his own work. He still has to do that and working for the COVID pandemic that is now extra and is an extra burden actually. That's how it feels like. And it's much more difficult now to motivate my colleagues working for the COVID pandemic, because when we started to draw up a new schedule for the wards that we had to look after, and, with all these patients, we got all kinds of comments like: "our department doesn't want to help because we have an important care we have to take care of" and so on and so. Even though the director of the hospital stated that everybody should deliver about 20 percent of his total capacity to COVID care. Medical specialist, H1.

As a result, organizations had difficulty in getting enough staff for COVID-19 care and redeploying staff in the second wave.

4.2.1.2. Own priorities. Some interviewees indicated that professionals felt a sense of duty to their regular care and their own local patients rather than to COVID-19 patients, who in the second wave were often transferred from other regions. The fact that our case organizations were hit hard in the first wave and then were expected to take transfers from regions who had not been hit equally hard created some frustrations and put additional pressure on staff.

[In wave two] it took much more energy to get everybody aligned. And that's also because this province in this second peak, by itself, doesn't have the most problems. And in the Netherlands, we choose solidarity. So we take a lot of patients out of Rotterdam, Amsterdam. But there are a lot of people from here who don't like that kind of decision and they are planning and doing as much of their old work [as they can] so that prohibits good preparation. Executive, H1.

Staff continued to provide COVID-19 care, but felt a stronger sense of duty to their own patients and region that had been negatively affected throughout the first wave. Doctors in particular also felt a professional responsibility to care for their patients whose care had been continually postponed to support COVID-19 care.

4.2.2. Energy depletion

Throughout the duration of the crisis, staff members were faced with various environmental stressors. While they began the crisis effort with high levels of energy, overtime these stressors took their toll. Sources of stress were numerous, however interviews in the second wave highlight how the combination of enduring sources of stress (namely ongoing uncertainty, high work pressure, traumatic experiences of the first wave and lack of recovery) led to a sense of physical and mental strain which resulted in energy depletion. This in turn contributed to lower motivation

for performing crisis care, and was seen as a central challenge in the second wave, leading to reduced commitment and even turnover. The main challenge is personnel, you know, to keep personnel, good personnel and keep your personal, energetic, inspired, with energy. Because there's also, we saw it already in our questionnaire responses in June [and] I see it now also, there were many professionals who quit the job. And that's, well, that's a problem. I worry about this. Medical specialist, H4.

4.2.2.1. Mental strain. The continuation of uncertainty in the environment was expressed as a significant emotional stressor and a central factor in employees' declining commitment. In the beginning, there were high levels of uncertainty, particularly around disease pathology, treatment and spread, and staff were faced with an unknown disease and patient mortality on a daily basis. Interviewees indicated that not being able to save patients, particularly in the first wave when the disease was still unknown and protocols were only emerging, was particularly taxing for medical professionals who dedicate their lives to helping patients and for healthcare workers who were not used to dealing with critically ill patients.

It was quite tough because as a medical trainee, you were trained to ... you have certain medical cues and you tell if the patient is sick or not. But with COVID it was the weirdest thing I've ever seen. One moment they were doing quite OK and they said, "yeah I feel OK, I feel OK." And 3 h later they were in the ICU and no one ever saw it coming. So that was [difficult] in the first wave, the mental impact of the not knowing, and not knowing what the cause of the disease was and not knowing what treatment was best. Medical Specialist, H4.

While uncertainty in regards to disease protocols and treatments was reduced by the end of the first wave, in the second wave uncertainty intensified regarding the course and duration of the crisis. After enduring high levels of uncertainty for so long, in the second wave interviewees described a sense of discouragement and depletion. The feeling of uncertainty of the crisis duration, and being reliant on external factors such as public adherence to guidelines, made it hard to continue to work in unfamiliar, stressful conditions and circumstances. This feeling was described by interviewees as being exacerbated over time. Overall, interviews indicated that the longevity and continued uncertainty weighed on staff mentally, draining their energy. Due to the long duration and uncertainty of the end and trajectory of the crisis, it also became harder to find volunteers for shifts.

In the past, when we also had to fill shifts, when someone dropped out, then we often had that, then we put it on an App and within a few hours we had that arranged. Now we have to pull much more. People are tired and think this will all take a long time. Well, I think so too. And then the energy is also different. I notice that for sure. Medical specialist, H3.

On the other hand, where there was reduction of uncertainty, for example in knowing what to expect when facing COVID-19 patients, this also had depleting effects on some staff. Since staff had already experienced the intensity of working in COVID-19 care, in the second wave they became less eager to volunteer and were less willing to work in COVID wards. Interviewees told us that the reality of COVID-19 care lingered in the minds of professionals, particularly nurses who had not previously worked in trauma or intensive care. In the first wave, nurses and young doctors were faced with a lot of death and loss, sometimes losing multiple patients in a single shift. In the second wave, because of the images and memories of how difficult things were in the first wave (e.g. knowing what to expect), they were fearful and unwilling to work in such conditions again.

I think that may be now [overtired] but not the first time ... the first time you didn't know what to expect, what you [were] going to see. You went full of adrenaline, you went in, and that is really different now. We are now, say, still recovering [from] that period. IC nurse and manager, H3.

In addition, those who had to be redeployed out of their normal departments and that experienced role ambiguity and loss of their normal

peer group, were described as having a higher potential for cumulative stress and emotional and mental exhaustion after the first wave.

4.2.2.2. Physical strain. Beyond the mental strain of continued uncertainty and being faced with highly emotive work in the first wave, interviewees commented on the physical exhaustion of staff, in particular for nurses whose work takes a heavy physical toll, and a lack of recovery. During the first wave, staff pulled long hours and extra shifts, working in often unfamiliar roles and departments. In some cases, part-time work was temporarily cancelled, meaning that part-time workers took on full-time work and occasionally overtime hours. After the first wave, many staff who had been at the frontlines continued to work long hours. Even after the first wave slowed down, staff had been working hard to scale up elective care and deal with backlogs.

In some departments long and additional shifts carried on due to staff shortages and the need to scale up regular care. The willingness to provide COVID-19 care differed per person, with interviewees describing some being more easily willing to help out than others, yet staff's mindset was seen to have shifted from the first wave due to ongoing work pressures.

Yes, well the mindset in the second wave is very different from the first wave. You can see that they're being stretched too thin. That it's like: "oh, no, not again, as long as we don't go into 12-h shifts again." And others say "oh well let's go right back to 12-h shifts." It's all, yes you can see that they're being stretched too thin. Medical specialist, H3.

4.2.2.3. Lack of recovery. Over the summer period, hospitals had worked to provide recovery opportunities for staff. However, many interviewees reported that recovery was difficult due to the ongoing crisis and restrictions in the public sphere.

Most people stayed around home. So they didn't charge up as normally. They normally started after their vacations on [a] hundred percent, and now [they are] on eighty or seventy-five percent. Also there are colleagues who are getting a burnout. That's always the case ... And we were preparing for the second wave, we were making plans, we had some plans. But I think it's come too early and too quick. Too high. Also for personnel, I know I say it myself, at that time we all were not physically ready for a second wave. Support staff, H1.

The inability to properly recover coupled with the high intensity and mental and physical impact of the first wave, led to what interviewees perceived as a depletion in staff energy. These issues were all perceived to have had a profound (and cumulative) impact on staff's wellbeing, making them more reluctant to volunteer in the second wave.

And we see that the mental health is, well it's different than the first time. I mean ... the first time everybody went into the crisis and helped where they could. And we see that a lot of people are still tired and still need some time ... some of them are even traumatized. And so we have in this second wave to look more after our people than the first time. That sounds crazy because the first time it was much heavier. But we see that the people are really tired ... there were holidays but I mean, after such an experience, a holiday is not enough. It's not enough. - Manager, H2.

Overall, the initial strain -both mentally and physically-from the first wave, coupled with a lack of recovery, was seen to accumulate and deplete staff's energy resources, resulting in a decreased desire to work on the frontlines of COVID-19 care. While certain factors improved over time, such as the organization of care and redeployments and more information around disease treatment and protocols were available, the lingering effects of the first wave resulted in a sense of physical and mental fatigue. This shift was recognized for both frontline staff and management. However, the effects were perceived to be more severe for groups of nurses and residents who had played a central role at the frontlines.

Well, I think also we cannot do everything right. So there are people that, also in our team, that are not happy with what has happened. At that time it looked like they were happy enough. But when there's more time

to think it over, if we ask them now, they say, “no, not again. I can’t.” Because of physical experiences, it was hard to do all the care. Or because of mental, it was hard to see all those people. Medical specialist, H2.

The cumulative fatigue was exacerbated by the quick resurgence of COVID-19, as staff members barely had time to recover and reflect when the second wave began.

4.2.3. Support and appreciation

As staff kept up high workloads and sacrificed their own health and wellbeing to work long hours and respond to the crisis in the second wave, public support waned and appreciation for their continued efforts were perceived by some to be lacking. Interviewees commented that it became increasingly harder [for staff] to remain motivated (1) in the face of waning public support and (2) without feeling appreciated for their efforts. All interviewees highlighted the importance of organizational support and making staff feel valued, and interviewees in the majority of hospitals (H1, H2, H3) pointed to the need for more appreciation of staff within organizations, highlighting the need for more recognition of staff's efforts and financial support. These factors are detailed in the following sections.

4.2.3.1. Waning public support. Over the course of the crisis, staff described a major difference in public support and appreciation. During the first wave, staff were shown many signs of support and appreciation by the public. Local businesses brought many gifts, banners were hung opposite of the hospitals, and people clapped and cheered. This was a sharp contrast with the second wave where, while staff continued to work long hours, signs of public support were diminished.

Later on this created this feeling of pride for how we're all tackling this crisis together. With all the human resources and all the enthusiasm with which staff is doing this. And you also saw a lot of external applause, all sorts of gifts which were being sent to us. That's ... the applause has completely died down now. Nothing happens anymore. ... back then we got cakes and flowers and chocolates and Rituals ... [but that's] all gone, doesn't happen anymore. Manager, H3.

In addition to decreased signs of public support, staff also expressed a noticeable change among patients and families, telling that patients and their families became increasingly aggressive and frustrated. The sharp contrast of having overwhelming public support to a drop off in recognition while the work burden remained high, coupled with increasing impatience and aggression of patients and visitors made staff feel underappreciated for their continued efforts and placed a higher burden on them compared to the first wave. Some staff noted this also as having an effect on energy levels going into later waves.

In the first wave, I think what was really good was ... the sense of urgency that was really unanimous. So everybody had the same feeling ... “OK, we are going to do this together.” And that gave a lot of energy also. So that was very positive [...] and also in the general public, there was this feeling of applauding for care, et cetera. And that is really different in the second wave. So the feeling that what we do is very good, in the general public, that is really different. I think you see that people, ...can be very angry or impatient ... And that's not really helpful for the professionals. So also the understanding for, for example care that has to be postponed or whatever was very big in the first phase and it's completely disappeared in the second phase. Medical specialist, H1.

In the first wave staff were heralded as heroes and their work was recognized as important and outwardly appreciated. However, as the public perception of the crisis shifted overtime, and there was less understanding for the ongoing situation (e.g. postponements of care) and the public became frustrated with public health measures.

There is some fatigue among colleagues because it takes so long and we also see that a lot of people in the Netherlands don't take the measure so serious. Medical Specialist, H2.

As a result of this shifting public perception, healthcare staff experienced a clear shift into the second wave in terms of the appreciation for

their efforts, and some noted that this would only continue to get worse in future waves.

And also at the first wave, the public was very positive about health care and about the hospitals and everyone was a hero and it's gone now. But I think a third wave will make it even more difficult. Medical specialist, H2.

When reflecting on support, interviewees also highlighted a perceived lack of recognition from the government. The discussion of compensating healthcare workers for example started already during the first wave when the government announced healthcare personnel would receive a 1000 euro bonus. At first, this news was positively received by staff and created the expectation that they would be rewarded for their hard work. However, the fact that it took months before it was decided upon who would actually receive the bonus made that personnel still felt a lack of appreciation for their hard work both by the country and by their organizations.

Here in Holland in the first wave, they said, oh, well, everybody in health care gets a bonus of a thousand euros. Well, it took months before it was clear who would get it and when. And it was very, very disappointing for everybody in health care. They say something, but ‘what, when and how?’ And we didn't get that, they didn't get the answers to the questions they had. So those are all things that did not help to keep the spirits up. Manager, H2.

4.2.3.2. Lack of organizational support and recognition. Besides a shift in public support, a variety of other factors contributed to staff feeling underappreciated, revolving around the fact that staff felt they could be recognized more for the hard work they had done over a long period of time. These factors include staff having to work extra hours and experiencing high work burden without receiving satisfactory (financial) compensation, and staff not feeling recognized by their leadership and the government. Many interviewees commented that they were proud of their organizations and the handling of the crisis. However, during the second wave, interviewees suggested that signs of support and appreciation could be strengthened to help to motivate staff, and considering the longevity of the crisis.

Some interviewees highlighted that, after working hard and extra for so long, when they felt undervalued it made it hard for staff to maintain a high level of commitment to the crisis effort. More recognition from the leadership of the hospital was noted in particular as something that could boost morale.

A lot of colleagues of mine, I'm sure they would really appreciate some sign ... That the direction, the director is noticing that they are working hard, they're working extra, they're doing something on top of their normal work, some kind of situation. If it isn't money. Other than the emails that we get in which the board of directors states that they really appreciate the hard work. [...] Yeah, I think some of my colleagues are really looking for that. And I think it would really help if, for them, if a little bit more like that would be presented. Medical specialist, H1.

4.2.3.3. Financial support. Additionally, interviewees in H1, H2, and H4 informed us that staff expected more financial support because, as opposed to the first wave, COVID-19 related work had to be done on top of regular work. Since regular care was scaled back up, frontline staff often had to work extra hours or take on extra workload to be able to deliver both COVID-19 and regular care. To ensure a sufficient workforce during the remainder of the crisis, some interviewees felt that organizations should reward frontline staff, especially those with low salaries such as nurses, more for their hard work.

[In the first wave] there was more staff from the operating room, so in terms of the amount of people, it was enough. Now we don't have the amount of people because the operating rooms are still, six are running and only two are shut down since a few weeks into the second wave. So the people, the staff of the ICU and the operating room from the two operating rooms, have to work more hours. But still there's the fatigue. So

the ... fringe benefits, the terms of human resource for paying for extra hours. I think they should be more elaborate, more convenient ... [currently there are restrictions] because of the CAO [collective agreement] rules. But the CAO is meant to function in a normal world and not in a crisis. And I think because the strain on a fewer amount of people is now going on, I think you should look beyond those rules. It would be a gift. Medical Specialist, H2.

Overall, when the appreciation and support from society and the organization for their efforts dwindled, it thus became even more difficult for staff to maintain a strong desire to make sacrifices for the crisis effort, particularly after having dealt with an intensive first wave, and when facing competing demands in the work environment. As our interviewees indicated, more attention on the wellbeing of staff and organizational support is an essential part of sustaining staff's morale and motivation through future waves.

5. Discussion

In the present study we investigated two central questions: (1) How does employee workplace commitment evolve over the course of a prolonged crisis event? and (2) What are the underlying mechanisms driving any [perceived] changes in commitment? Our findings suggest that staff initially exhibited a strong desire to aid in the crisis effort, putting themselves on the frontlines and risking their own physical and mental health to care for patients (Dzau et al., 2020). Staff felt a sense of urgency and were 'prepared for battle', drawing upon their professionalism and intrinsic motivation to aid the crisis effort (McWilliams, 2020). They felt responsible for tackling the crisis and lined up to help the crisis response, and many staff felt an emotional connection and sense of pride in contributing. However, we find that, over time, staff's commitment to this specific target (i.e. providing COVID-19 care as part of the crisis response) decreased.

In the following sections, we elaborate on how our findings make two important contributions to the workplace commitment literature. First, we discuss how our findings unveil the underlying factors that contributed to staff's shift in commitment throughout the duration of the crisis (i.e. competing demands, energy depletion, and diminished public and organizational support), offering important insights into the potential antecedents and barriers for staff's workplace commitment (see Klein, Brinsfield, & Cooper, 2020). We theorize how these underlying factors both uniquely, and mutually, influenced individuals' commitment. Second, we elaborate on the influence of staff's other workplace commitments on their dedication to this particular target, offering important insights into the potential interactions between staff's multiple commitment targets (see also Klein, Brinsfield, & Cooper, 2020; van Rosenberg et al., 2018).

5.1. Shifting commitment: underlying factors

Our findings reveal three key factors that staff perceived to contribute to a shift in commitment throughout the course of the crisis: competing demands, energy depletion and lack of support and appreciation, whereby competing demands stands out as a central influential factor, with energy depletion and lack of support and appreciation further contributing to the lessening of staff commitment. While all of these factors together contributed to a lessening of commitment in the second wave, we believe that individually they created a unique response. In the following sections, we discuss each factor individually and highlight any relevant interrelationships.

5.1.1. Competing demands

In the present study, competing demands stand out as the central factor in the lessening of staff commitment. In the early days of the pandemic, normal operations were mostly suspended while hospitals pivoted to focus on providing COVID-19 care. This made it easy for staff to be redeployed and created a common goal within each hospital. As the

literature indicates, focusing on a shared goal and common interest (e.g. fighting against the pandemic) loosens the boundaries between groups (Alderfer, 1987; Kahn et al., 2018). This allows individuals to focus on collective concerns, concentrating collective commitment and effort in regards to the shared goal (Mitchell et al., 2011; Wang et al., 2005). As we see in our study, respondents indicated that in the first wave there was a collective sense of responsibility to the crisis effort ('COVID care is everyone's care') and individuals felt compelled to dedicate themselves. However, as organizations began rescaling regular work, commitment to this target waned.

The competing demands of staff (e.g. to their own patients and department and to COVID-19 care) posed a complicating factor and undermined the former sense of collective commitment to the crisis effort. Structurally, competing demands had clear consequences as individuals had to balance competing demands, often with limited resources in terms of time, staff, and energy. When regular care provision increased, individuals' sense of responsibility to their own patients and work domain was therefore perceived to act in competition with their sense of responsibility for providing COVID-19 care. To cope with the competing demands, some individuals therefore lessened their commitment to the crisis effort. This meant that individuals were less willing to make tradeoffs in favor of the crisis effort (e.g. working extra hours or shifts, sending staff members to work on COVID-19 wards, etc.) (Klein et al., 2012). As a result, in some organizations, it was decided that COVID-19 care should be the responsibility of particular specialties (e.g. internal medicine and pulmonology) to allow normal operations to return as much as possible. While this may free up staff in other departments to refocus on their own patients, as Klein et al. (2012) assert, commitment is based on dedication and responsibility to a particular target (e.g. COVID-19 care provision). Organizations that designate responsibility of COVID-19 care to specific departments may therefore consequently undermine the commitment that employees from other departments feel toward providing crisis care, complicating the ability to respond to increases in demand (e.g. during future peaks).

5.1.2. Energy depletion

Our findings indicate that energy depletion functions as both (1) an additive factor to the effects of competing demands, making it even harder for staff to split their energy and attention to multiple work tasks, and (2) a further result of competing demands as this introduces more stressors into the workplace environment. Exposure to workplace stressors are theorized to impact individuals' mental and physical health, and can produce strains which, with prolonged exposure, can negatively impact wellbeing resulting in mental and physical health problems (Ganster, 2008). Examples of stressors include lack of control over the environment, time constraints, lack of competence needed for tasks, high workloads and conflicting demands (Fletcher, Sindelar, & Yamaguchi, 2011; Ganster, 2008). While individual stressors may not have a strong impact on employees, cumulatively they have been shown to exert a powerful [negative] effect, and can cause fatigue (Wellens & Smith, 2006). In line with other models of stress (see Pearlin, Menaghan, Lieberman, & Mullan, 1981; 1999), we find it useful to think of stress as a process where events at earlier points in time may come to have effects later on (Pearlin, 1999). Stress and the effects of stress are therefore not 'merely discrete happenings' but are made up of multiple factors that can, cumulatively and over time, come to impact individuals functioning (Pearlin, 1999, p. 395). In our data we find that prolonged exposure to stressors, in particular uncertainty (which can be construed as a lack of control over environment), work pressure and time constraints and, eventually, the addition of new stressors such as conflicting demands depleted staffs energy, reducing their motivation and dedication to carrying on with crisis care.

Energy depletion may reduce individual motivation or restrict physical capacity (e.g. in the case of physical exhaustion or illness), and emotional exhaustion can increasingly limit employees ability to perform demanding work (Galletta et al., 2019). However, as highlighted by our

interviewees, healthcare workers tend to have high public-service motivation (i.e. “doing good for others”) (Andersen, 2009), which in professions with similar motivations, such as teachers, has been found to mitigate the effects of exhaustion on commitments that are altruistically (see Klein, Brinsfield, & Cooper, 2020) or more affectively motivated (Van Waeyenberg et al., 2020). Still, overtime, energy depletion may make it more difficult for staff to perform their functions and to maintain a high workload or work under stress, thereby negatively affecting wellbeing and increasing the likelihood of burnout (Kinman et al., 2020; Rathert et al., 2018) and potentially contributing to absenteeism or lower work performance. This aligns with research on conservation of resource theory (Hobfoll, 1989), which states that overtime as individuals' resources deplete they may compensate by disengaging with their work and reducing their workplace commitments (Thanacoody, Newman, & Fuchs, 2014; Wright & Hobfoll, 2004).

5.1.3. A lack of support and appreciation

Lastly, our study indicates that a perceived lack of support and recognition contribute to staffs lessening commitment overtime. When workers feel supported by their organization, they are likely to reciprocate with commitment to the organization or organizational goals (van Rossenberg et al., 2018) and can better handle competing demands (Yalabik et al., 2015). This reciprocity is even more essential in crises where uncertainty and job demands increase over prolonged periods. However, emergent research from the pandemic suggests that healthcare organizations are not providing adequate support and acknowledgement to healthcare workers as they face the harsh realities of this crisis (Cahan et al., 2020; Shanafelt et al., 2020). Our findings suggest that this lack of support was compounded over time, as workers felt a lack of appreciation and being valued by society more generally (beyond symbolic gestures such as food; e.g. via time off, shorter shifts, or additional financial support) as they continued to dedicate themselves to the crisis effort. Our interviews highlight that staff require both recognition (particularly from hospital leadership) and structural support (financial compensation, recovery time) to feel appreciated.

The simultaneous diminishing of public support and increase of patient and family demands made it so that healthcare workers felt frustrated and undervalued at a time where they were asked to make great personal sacrifices. As they continued to put their own health and the health of their families at risk, and coupled with the competing demands on their own personal and working lives, healthcare workers expressed less of a desire to continue working in COVID-19 care, and organizations experienced an increased difficulty in staffing. Showing employees that they are valued and appreciated can support employees' wellbeing and motivation by fulfilling a core need for relatedness (Ryan & Deci, 2000) and by helping medical professionals to avoid energy depleting job stress, which has been found to have a negative relationship with commitment (Zandi et al., 2020).

Meeting the basic needs of employees, for example by compensating them for their efforts during periods of adversity and making sure additional hours are paid, can help to signal appreciation and recognition of staff's hard work and work as a powerful motivational source, supporting commitment (Gao-Urhahn et al., 2016). When employees feel supported and appreciated (including structural support such as compensation) as has been noted in other studies, this can have significant effects on individuals' desire to help and willingly commit themselves (Battistelli et al., 2016; Eisenberger et al., 1990; O'Driscoll & Randall, 1999) to workplace targets. For example, a recent study by Mihalache and Mihalache (2021) demonstrated that organizational support can foster wellbeing by strengthening and supporting employees' affective commitment. However, when this support is perceived as lacking, as we found in the present study, it thereby may work to lessen or erode employees' commitment, as they feel less compelled to take responsibility for the target (Klein et al., 2012).

5.2. The salience of multiple commitments

Workers are known to typically hold simultaneous and high levels of commitment to numerous workplace targets or foci (Morin et al., 2011; Swart et al., 2014). However, the interactions between multiple targets remain undertheorized and studied (Klein et al., 2014). In the present study, we find that individuals' commitments to multiple targets played an influential role in determining their commitment to the crisis response. In particular, we find that individuals' willingness to dedicate themselves to new targets is (1) somewhat resource dependent and (2) influenced by the interaction between the new target and their existing commitments. First, we see in our study that when individuals' resources become more constrained, their willingness to make tradeoffs and direct resources to the crisis response dwindled. In the first wave, responding to the crisis was a salient target from which individuals gained positive affect, but as time carried on, commitment to this target became framed as having a depleting effect. In the first wave, individuals had more resources to give in terms of time and energy, and morale was high in the context of high public support. This meant that directing these resources to the crisis effort was less intensive. However, as individuals' energy depleted and the context became more demanding (e.g. aggressive patients, diminished public support), commitment to the crisis effort required more tradeoffs and individuals were consequently less willing to dedicate their energy and time to COVID care.

Second, and most saliently, as regular care was scaled back up, individuals were confronted with the need to make tradeoffs between multiple commitment targets, whereby the commitment toward their own work domain eventually took precedence over the temporary target. Depending on the salience of different targets, individual commitment toward them varies and can shift (van Rossenberg, 2018). Healthcare workers have been shown to have strong attachments to a specific work domain or specialty (Pratt et al., 2006) and feel a strong sense of ownership over the corresponding patient groups (Hewett et al., 2009). Therefore, commitment toward individuals' own work domain is likely to have taken precedence over the commitment toward caring for COVID-19 patients once regular care was scaled up after the first wave. This is clearly exhibited in the sense of competing demands interviewees described in the second wave, as professionals were asked to dedicate limited resources to COVID-19 care while also trying to balance the demands of their own workgroups and patients.

In this effect we can see that when individuals experienced a sense of competition between commitments that they were less willing to make tradeoffs in favor of the crisis response, and felt a responsibility to their more stable and longer term commitments (e.g. specialty group, regular care provision, patients from own region and specialty). This is a crucial point for organizations as the workplace becomes more dynamic and uncertain (Klein, Brinsfield, & Cooper, 2020) and organizations rely on the commitment of staff to achieve new goals or projects and deliver services (Yalabik et al., 2015). If individuals experience a competition between commitments (e.g. being committed to target A directly influences my ability to commit to target B) they are likely to direct their attention to the more entrenched and stable commitments. Future work may question how organizations can support employee commitment to new or more temporary targets, for example by bolstering its connection with the individuals longer-term and more stable commitments such as to their own profession or specialized work (van Rossenberg et al., 2018).

5.3. Limitations and future research

Our study was of an exploratory nature and requires additional research to parse out the findings presented here. Our diversity of interviewees helps to offer a broad picture of how commitment evolved throughout the first and second wave of the crisis, from individuals who

were both directly responsible for providing COVID-19 care as well as for staff and staffing of care. However, a first limitation concerns the lack of interviews with frontline staff, particularly nursing staff and residents, who were seen to be most heavily impacted by the crisis. While our findings offer a managerial perspective (how commitment of staff is perceived overtime, for example when trying to roster staff for COVID-19 care) and insights based on experiences of professionals working on the frontlines (e.g. medical specialists), future research is needed to bring forward the lived experience of other clinical and support staff. Additionally, while we focus here on the contributing factors to employees waning commitment more generally, future research that emphasizes the differences in experience and antecedents of commitment across individuals (e.g. across functions, groups) would offer a more nuanced insight into how organizations can help foster staff commitment.

Second, future research that examines the relationship between individuals' multiple commitments would help to expand upon the work here. For example, while we suggest that individuals' commitment to the crisis effort lessened when it was perceived to compete with their other, more stable commitments, it may be also that some individuals felt the crisis response was a part of their own longer-term commitments, such as their professional commitment or organizational commitment. Teasing out the multiple commitments individuals experience and their interrelationships would help to advance our understanding of workplace commitment in the modern workplace. It may also offer practical insights for organizations to help secure commitment of staff to relevant targets.

6. Conclusion

During periods of crisis, it is imperative that healthcare systems are able to sustain the healthcare workforce over an extended time. Our findings suggest that while staff initially demonstrated a desire to help and aid the crisis effort, as the crisis carried on staff commitment to providing crisis care also lessened. We draw upon rich empirical data to offer insights into why this switch occurred, unveiling three key contributing factors. Due to competing demands, energy depletion and a lack of support and appreciation, we see that over time, healthcare workers' commitment to providing COVID-19 care shifted, with individuals directing their attention to more stable and long-term commitment targets. This is due to a sense of competition between commitment targets and resource constraints. Such a switch can have negative implications for achievement of organizational goals and organizational performance, and may threaten the responsiveness of organizations through and after a crisis. These findings help to expand the current literature on workplace commitment and provide empirical evidence of the effect of context (i.e. crisis) on staff commitment. We believe that future research can build on our findings to further investigate the temporality of workplace commitment during crisis, and workers commitment to multiple and new workplace targets.

Author contributions

This paper has several authors, all who made significant contributions in the following areas: RG, conceptualization, investigation, methodology; formal analysis, writing-original draft preparation, writing-review and editing, funding acquisition. FvB, conceptualization, investigation, formal analysis, writing-original draft preparation, writing-review and editing. DW, writing-review and editing, funding acquisition, project administration, DR, writing-review and editing, funding acquisition, FZ, writing-review and editing, funding acquisition, LP, writing-review and editing, BF, writing-review and editing, funding acquisition. All authors have read and approved the final manuscript.

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Ethical approval

This study was reviewed by and granted ethical approval by the Faculty of Health and Life Sciences Research Ethics Committee at Maastricht University (FHML-REC/2020/110).

Informed consent statement

Informed consent was obtained from all subjects involved in the study.

Data availability statement

Data for this study can be requested from the corresponding author.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ssmqr.2022.100053>.

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