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Where Have All the Heroes Gone?

Resilience is defined as the ability and capacity to recover quickly from difficulties or adapt successfully in the face of adversity and social transformation (Barrios 2016; Hall and Lamont 2013; Mendenhall and Wooyoung Kim 2019; Panter-Brick 2014; Wu et al. 2013). The COVID-19 pandemic has prompted disaster conditions for public health care, and has radically intensified the need for adaptive practices of resilience in health care work. In the US, nowhere is this more evident than in intensive care units (ICUs), where there is constant pressure to adapt as surging patient loads, rapidly-changing protocols, and uneven supply of personal protective equipment are dramatically affecting the material conditions faced by all hospital staff.

Appeals that "we are all in this together," echoed among personalities from Donald Trump to the Duke and Duchess of Sussex to "Wonder Woman" star Gal Gadot, efface structural inequalities and the unevenness of resource security (Bowleg 2020; Fitzpatrick 2020; Guarnieri 2020). Often, these appeals connect a presumed sense of togetherness with the need for collective endurance and resilience. While the line of reasoning may be discontinuous from togetherness to resilience, healthcare administrators have often embraced it. Given the demands of for-profit medicine in the US and the extraordinary stress of the pandemic, promoting a culture of resilience is universally agreed to be a highly salient feature of health care work in the current moment. Yet, precisely what constitutes resilience and how it functions in public health remains poorly understood (Mulligan 2014, 2017).

Such vagaries only become magnified when "resilience" bleeds into "heroism," an iconic discourse that itself maintains that health care workers possess unique abilities to withstand and even overcome the challenges of a pandemic. The American Medical Association has emphasized this unique resilience capacity, and has noted that COVID-19 demands a specific culture of resilience to prevent burnout, trauma, and decreased performance capacity (Shanafelt et al. 2020). In this light, how do ICU workers connect idealized and actual resilience practices with their daily work in the context of societal discourse around "health care heroes"? Here, we analyze evidence from our ongoing qualitative study of health care workers at a major academic medical center ICU, and consider how it highlights the complex relationships between resilience, heroism, and labor during a public health crisis.

The tension of heroism

What might a closer look at heroism reveal, in terms of how health care workers interpret it and connect it to resilience practices? We ended each of our 52 semi-structured interviews to-date with a similar query: "What do you make of the dialogue around health care heroes? Do you see yourself as a hero?" We were struck by the responses, some that reject the figuration of the hero outright, some that accept it, and most which recalibrate it, suggesting the term's semantic capaciousness. A nurse retorts: "I hate that word . . . I'm not a hero . . . I still clean up the same amount of crap." A respiratory therapist says: "If anybody calls me a hero for doing my job, it's just sickening . . . it's empty. If you want to make a nice gesture, bring us more lunch or get us more help." A trainee physician remarks that the hero discourse "is a disservice to the sacrifice that people are making and the very, very strong effort that they're putting forth to do their best work every day in the face of a very terrible circumstance."

There is a profound disconnect here. Heroism acutely shapes the conversation around the work individuals across the country are doing in service of others for COVID-19. Yet this discourse fails to

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resonate with many of the individuals it targets. Why do our health institutions, the media and society require health care workers to be heroes, even as our informants distance themselves from this label? Their work exemplifies what the political theorist Nancy Fraser calls a "crisis of care" – a systemic strain on the social bonds that keep people alive (2016). Most of our informants consider the heroism discourse and feel, as Fraser suggests, that their affective labor is "taken for granted, treated as free and infinitely available 'gifts' which require no attention or replenishment" (31). Understanding how ICU workers in our institution interpret the concept of heroism points to how resilience is practiced.

Historical and philosophical framings of the hero concept throw light on how the notion has come to be understood in contemporary contexts. The term "hero" is often linked to virtues of extraordinary prowess; whether accorded to men or women, Greek myth underscored a bright line between heroes and gods (Lyons 2014). The linkage of public health workers to heroism stretches wide, from the humanism of Dr. Albert Schweitzer to the work of Florence Nightingale, or to the discoveries of Edward Jenner and John Snow. There are militaristic aspects of heroism: the courage to fight in spite of the fears of loss or death, being on the front line, taking a risk. There is also the theme of moral strength, exemplified by Albert Camus in his novel *The Plague* (1991). The character Rieux, speaking to another character, Rambert, observes that "There is no question of heroism in all this. It's a matter of common decency … in my case I know that it consists in doing my job" (1991:149).

Some of our informants reject the notion of heroism, while others illustrate its variability in relation to other dimensions of care in terms of ethics and endurance. Some reflect on it in ways that echo Rousseau's definition, shifting from deeds to morals and locating heroism in what Rousseau termed a "strength of the soul" (Kelly 1997:351). Some actively differentiate resilience from heroism: "ICU doctors are very resilient people … The hero thing? … I don't think most people here view themselves as heroes," notes a physician. Others may tolerate appeals to resilience but actively decry appeals to heroism. A COVID response leader puts it succinctly: "I find [heroism] nauseating and I find it uncomfortable."

Some respondents specifically note that *hero worship* in the context of the pandemic has limited appeal, and regard tokens of adulation such as lawn signs and discounted clothing as superficial (Carlyle 1993). This uncertainty about the balance between action, virtue, and regard pervades their responses. Is heroism defined by an innate quality that translates to super-human strength or capacity for empathy or honor? Is it defined by extraordinary action amidst calamity, as is the case for American renderings of soldiers in battle? Does a hero commit herself to selfless service? Do we only become heroes when we fulfill expectations of endurance, when we are "resilient enough to endure stuckedness," and move beyond the feeling of existential immobility (Hage 2009:97)? Must we demonstrate heroism in order to express resilience, amidst a prevailing sense of despair?

The work of heroism

One of our respondents notes: "To some extent this is our job, isn't it? Didn't we sign up for this?" Echoing Camus, this common response to the question about heroes tends to provoke sentiments of "I'm just doing my job." This affirms that the relevance of heroism is a key question in the story of pandemic labor, but it is not the only question. An equally critical set of questions would investigate for whom heroism is work, and the conditions of possibility for healthcare work to be visible as work. Put differently, the ideas and articulations of heroism are often as much about labor as they are about superhuman qualities. This work in hospitals is deeply gendered and racialized, and generic appeals to heroism may efface those important differences. We are struck by the fact that the only respondents in our study who embrace the hero label are service workers: housekeeping and environmental services staff, and supply chain workers. "I feel like a hero," an environmental services worker responds. "Every day I leave, I feel like a hero because I did something to make

somebody's day better or make them feel a little bit better." The worker is clear that heroism *for others* grounds their relation to the term. They clean hospital rooms, they explain, to offer care for the patient and to reduce the risks of infection among the clinical staff. If heroism is embraced by healthcare workers, it is done so in terms of relationality. Heroism is not simply an individuated quality; it is a quality that weaves workers into possibilities for care.

Yet, we are cautious in idealizing this close and careful working of the hero discourse into forms of labor that are the most invisible and lowest-paying in the hospital ecosystem. It must be interpreted in relation to the ways that the hero discourse may flatten critical differences in labor during the pandemic: how, for instance, ICU nurses report having worked continuously since the pandemic began, but have watched nurses from other units receive reassignments or paid time off; or noted how certain consultants and services have chosen not to enter a COVID-positive patient's room, instead using ICU nurses and physicians to perform specialized procedures beyond their usual scope of practice.

Heroism also may presume a unified socio-spatial uniformity of the hospital when in fact people work and inhabit that space in profoundly unequal terms. We conduct our interviews and record responses in a landscape marked by everyday material reminders of the work of heroism. The hospital administration hung a tall banner in the front of the hospital, a cartooned figure wearing a white coat, a red cape flowing behind her: "Heroes work here." A patriotic red, blue, and white sign stands in a yard: "Thank you, health care heroes." A white paper peeks through a grocery store's glass windows: "Hero Day! Show your ID for discount." Yet, the "here" in *Heroes Work Here* shores up the hospital as the critical location of COVID-19, acknowledging only half the story about spaces of resilience work. Many of our interviewees narrate COVID-19 as a specter that follows them outside of the hospital, demonstrating that hospitals are never islands (Street and Coleman 2012). An environmental services worker follows a detailed regime to dispose of work clothing on the porch of her house. A nurse ensures that when she arrives home, someone keeps her toddler away from her until she can shower. A resident aches to visit his family, but deems it too risky. Once outside the hospital, the hero may even register as a villain, as even a benign grocery store visit in clean scrubs leads to sharp stares and fear in the checkout line. Put simply, heroism is a fraught feature of the pandemic that ties clinics to communities.

While we continue to assess these themes, several preliminary observations are evident. The practices of resilience in the ICU may be hampered by discourses and expectations about what that work should be: asserting what resilience is definitively, rather than remaining open to its multiple possible forms. In extending forms of compensation for labor during the pandemic, some institutions are supporting the work of resilience both within and beyond the health care space. This is an ever more critical point as state and local public health institutions navigate the ongoing uncertainties of testing, the new logistics of vaccine distribution, and the burden of labor for health education that accompany both. By distilling it into a simple phrase "health care heroes," the complex array of work being done by public health workers, and the ways in which their identity is tied to this work, we diminish the ability of individuals and communities to process and frame their own narratives of resilience.

The future of heroism

As a dark winter confronts the globe, with waves of new cases and deaths reaching never before seen peaks, new viral variants threatening hard-won successes, daily increases in the numbers of infected health care providers, and the uncertain pace of vaccine distribution, we have noticed a sharp change: the hero discourse is disappearing, and workers are speaking back. Some express concerns about exhaustion and burnout; others say that this is not burnout at all, but rather the human toll of a system on the verge of collapse. The heroes are still here, working every day, harder than ever and possibly in even more fraught positions as the pandemic rails on, and their work continues to raise key questions.

How can scholars and public health leadership respond to crisis? What kind of logic of care is at stake under pandemic conditions (Mol 2008)? What can be done to protect the labor of that care (The Lancet 2020)?

The hero discourse is likely to miss how COVID-19 has transformed the foundations of public health that attract health care workers in the first place: human interaction, communication, and education. Rather than assuming that resilience is naturally abundant in all workers or even in some communities, or that it is practiced uniformly through heroics, or even that resilience in the pandemic context is simply an extension of resilience in other contexts, more qualitative research is needed to assess the emerging forms of resilience in the time of COVID-19.

Additionally, we believe it is imperative to frame COVID-19 as a problem of public health labor. This allows researchers to address how heroism and resilience share a foundation in the actual, daily work of public health. Discourses of super-human effort presume a mythic hero with infinite care potential. For public health workers, that supply is draining. Framing health care work as *work* can open up space to reflect critically on the terms of that work: how it should best be compensated in a context of extraordinary systemic strain, and how it is always in relation to other domains of labor such as care work at home with family. Healthcare workers, marked out as heroes to varying degrees, have hardly disappeared. They are waiting to be seen as workers, and it is time for a renewed discourse of recognition around their labor.

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