

"We are not heroes"

The flipside of the hero narrative amidst the COVID19-pandemic: A Danish hospital ethnography

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Published in:
Journal of Advanced Nursing

DOI:
[10.1111/jan.14811](https://doi.org/10.1111/jan.14811)

Publication date:
2021

Document Version
Peer reviewed version

Citation for published version (APA):
Halberg, N., Jensen, P. S., & Larsen, T. S. (2021). "We are not heroes": The flipside of the hero narrative amidst the COVID19-pandemic: A Danish hospital ethnography. *Journal of Advanced Nursing*, 77(5), 2429-2436.
<https://doi.org/10.1111/jan.14811>

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Title "We are not heroes" - The flipside of the hero narrative amidst the COVID19-pandemic: A Danish hospital ethnography

Abstract

Aim: To explore how the media and socially established hero narrative affected the nursing staff who worked in the frontline during the first round of the COVID19-pandemic.

Background: During the COVID19-pandemic, both media, politicians and the public have supported and cheered on the frontline healthcare workers around the world. We have found the hero narrative to be potentially problematic for both nurses and other healthcare workers. This paper presents an analysis and discussion of the consequences of being proclaimed a hero.

Design: Hospital ethnography including fieldwork and focus groups.

Method: Empirical data was collected in a newly opened COVID19-ward in a university hospital in the urban site of Copenhagen, Denmark. Fieldwork was performed from April until the ward closed in the end of May 2020. Succeeding focus group interviews with nursing staff who worked in the COVID19-ward were conducted in June 2020. The data were abductively analyzed.

Results: The nursing staff rejected the hero narrative in ways that show how the hero narrative leads to predefined characteristics, ideas of being invincible and self-sacrificing, knowingly and willingly working within risk, transcending duties and embodying a boundless identity. Being proclaimed as a hero inhibits important discussions of rights and boundaries.

Conclusion: The hero narrative strips the responsibility of the politicians and imposes it onto the hospitals and the *individual heroic health care worker*.

Impact: It is our agenda to show how the hero narrative detaches the connection between the politicians, society and healthcare system despite being a political apparatus. When reassessing contingency plan, it is important to incorporate the experiences from the health care workers and include their rights and boundaries. Finally, we urge the media to cover a long-lasting pandemic without having the hero narrative as the reigning filter.

Keywords: COVID19, hero narrative, frontline, hospital ethnography, health care workers, nursing

1. INTRODUCTION

During a focus group, nurses discussed how they felt about being proclaimed heroes during the COVID19-pandemic: *"One nurse explains: 'I do not feel like a hero at all. This is something we have all had to survive'. The interviewer asked: 'What is a hero? What does that entail?' and the nurses continued: 'Heroes go through fire for others' 'and sacrifice themselves'. We continued the discussion, and another nurse explained: 'Yes, I also get irritated when people call us heroes. It is a lack of recognition of the fact that we are also human, and this has been tough'"* (Nurses, focus group)

During the first months of the pandemic, both media, politicians and the public have supported and cheered on the frontline healthcare workers around the world. The rhetoric has been rich and filled with terms of 'war', 'frontline', 'battle' and 'heroes'. Based on a hospital ethnography in a COVID19-ward including fieldwork and follow-up focus group interviews, we have found the hero narrative to be problematic for both nurses and other healthcare workers. This paper presents an analysis and discussion of the consequences for a healthcare worker of being proclaimed a hero.

1.1. Background

The World Health Organization declared the spreading of COVID19 a pandemic on the 11th of March 2020. The first positive COVID19-patient in Denmark was identified on the 27th of February 2020 (Nielsen and Dieperink 2020). At that time, visual changes began to appear in local hospitals, e.g. by implementing test wards and making new protocols for receiving and registering patients with COVID19. On the 21st of March, a COVID19-ward opened in a university hospital in the urban site of Copenhagen, Denmark. Within a short time, this regular ward was altered into a ward capable of receiving patients from the intensive care units to continue the care and rehabilitation for patients with COVID19. Besides changes in both the materials and physical surroundings, the ward's nursing staff included nurses specialized within other specialties. Consequently, the nurses had limited time to upgrade their qualifications to care for patients with severe respiratory symptoms before the first patients arrived at the new COVID19-ward. The nurses, allocated to

the COVID19-ward, had to face not only a new virus, they also had to care for server ill patients in new surroundings together with new colleagues whom all had to change their life around new work schedules. During our two months of field study, we continuously noted how the media and socially established hero narrative affected how the nurses related to the work in the COVID19- ward. To understand and explore our observations, we conducted focus group interviews with the nursing staff after the ward had been closed due to reduced patients with COVID19. In this paper, we examine the hero narrative in relation to the implications for the nurses.

1.2 Hero narrative

We understand narratives as performative speech-acts that are given a social reality that did not exist prior. These widely accepted speech-acts are performative because they construct identities (Brown 2006). The heroic narrative is a media and socially established narrative about health care workers during the pandemic, which becomes identity-constructing. A collective identity is then a discursive construct that can be told by others (Brown 2006). However, according to Brown (2006) many people within the collective identity will have different stories about themselves and the institution they are embodied within.

To understand how nurses' interpreted the meaning of their work through this hero narrative constructed by the media and society, we need to include thoughts of power, ownership, motivations and context (Brown 2006).

1.3 Heroes within healthcare

MacDonald et al. (2018) discuss heroism and nursing in a thematic review of the literature. Even though they encourage the use of heroism within nursing to inspire acting courageously, what constitutes a hero and as heroic is still unclear. Attempts to objectively define heroism remains contested as it is a contextual issue of culture, history and nature of the situation (MacDonald et al. 2018). Heroism is a widely used

concept and range from fictional characters such as superheroes and anti-heroes to factual people from ancient Greek history and up until heroes of today like freedom fighters and in this time, healthcare workers. The contextual circumstances are therefore essential when discussing and defining heroes. Recently, Cox (2020) published a paper discussing the problems following the media focusing on 'healthcare heroes'. Cox defines a heroic act as *"voluntary prosocial actions, associated with an acknowledged degree of personal risk, which transcend the duty of the agent"* (Cox 2020). This definition associate's individual characteristics to the performer of the heroic act. It is a definition based on healthcare workers during the current COVID-pandemic and is contextually comparable to our study.

2. THE STUDY

2.1 Aim

To explore how the media and socially established hero narrative affected the nursing staff who worked in the frontline during the first round of the COVID19-pandemic.

2.2. Design

To understand the hero narrative and the way the nursing staff reacted to this narrative, we must understand the context in which both the nurses and the narrative is embedded, which was possible through hospital ethnography (van der Geest and Finkler 2004). Within hospital ethnography a hospital is not interpreted as an isolated location and physical place but as connected and shaped by life outside the hospital. The hospital is viewed as a window into dominant social and cultural processes affecting and affected by both globalized homogenizing and heterogeneity (van der Geest and Finkler 2004).

Hence, the context is the hospital during the COVID19-pandemic, but context also connect to society, and the stories, debates, and knowledge presented and formed in relation to COVID19 and the hospital staff. Therefore, a hospital ethnographic approach allowed us to understand how the nurses who worked in a COVID19-ward reacted to the hero narrative and connected their experiences to wider social issues of nursing profession, hospital organization and society (van der Geest and Finkler 2004).

2.3 Informants

Nursing staff at the COVID19-ward came from three different located hospitals and ordinarily worked within orthopedics, gynecology, obstetrics, pediatrics and medical departments as well as either in surgery, inpatient and out-patient care. The nursing staff represented a wide range in terms of age, experience, competencies and personal circumstances. The nursing staff's experiences of working in the COVID19-ward varied as some worked either full or part time while others split their workhours equally. Some of the nurses have previously cooperated with the authors but had no direct work relations.

2.4 Data collection

Fieldwork

This part of the empiricism consisted of participant observation and situated conversations (Hammersley, Martyn and Atkinson, Paul 2007). The COVID19-ward is situated in a regular ward. All patients were isolated in their rooms. Due to the need of protective equipment and closed doors regime, nurses had to perform one-on-one care and the opportunity to easily shift between nursing task among patients were not possible. Nursing in this environment is both time and resource consuming. To relief the nursing staff, a runner-position was implemented. This function was handled by other healthcare workers. The runner had to provide service to the nursing staff working in the isolation rooms and to ensure the availability of protective equipment outside each patient room and thereby not fixed to certain patient rooms. Instead, the runner interacted with all nursing staff. This is the position we as researchers had in the COVID19-ward. By positioning ourselves as 'participant-as-observers' our main purpose was to fulfill the task as runners and thereby became integrated into the daily routines with the nursing staff. Furthermore, this also provided access to gain insight into the practice of the nursing staff as they were working in the frontline (Hammersley, Martyn and Atkinson, Paul 2007). This position also made it possible to have informal and situated conversations with the healthcare workers.

Being three nursing researchers, we had a weekly runner shift from beginning of April until the ward closed the 22nd of May 2020. During our shifts we jotted notes and after each shift, we wrote thorough fieldnotes

including experiences, conversations, thoughts and reflections (Emerson, Fretz, and Shaw 2011). We have since gathered the fieldnotes to one chronological document.

Focus groups

As abruptly as the COVID19-ward opened, it also closed again in the end of May, and the nursing staff returned to their original departments. To get insight into how they expressed and perceived their experiences of working at the COVID19-ward and the aftereffects, we conducted five focus groups including 22 nursing staff ensuring all departments and hospitals were represented. Our purpose with focus groups was to get insight into various and complex experiences, views and opinions of the informants (Jayasekara 2012). Some of the focus groups consisted of nursing staff from the same department and others were mixed. Having informants from the same department may lead to more personal stories of effects from working in the COVID19-ward as the space is perceived confidential and safe. To explore the narratives, we encouraged the informants to challenge each other which led to new insights and discussions. The interviews were digitally recorded and transcribed verbatim. Each focus group lasted on average two hours and included three to seven informants.

An advantage of succeeding fieldwork with interviews, is to have a clearer understanding of what is important to inquirer about as well as being able to explore thoughts and findings from the field (Robert M. Emerson et al., 1995). Thus, the interview guide was based on findings from the fieldnotes. First, we asked very openly about experiences. Secondly, we presented 21 keywords that emerged from 'inside' the COVID19-ward e.g. competencies, knowledge, contagion, belongingness, quality and uncertainty. Thirdly, ten keywords representing how the 'outside' world described the nursing staff during the pandemic e.g. sensation, coronavirus, war, battle, frontline and heroes was presented. Words that we also experienced were brought into the ward and reflected in conversations during the fieldwork. We asked them to relate and discuss the keywords, both keywords they perceived relevant and nonrelevant. The hero narrative was discussed extensively among the nursing staff. It was intertwined with other key words and affected how

the nursing staff understood and talked about their work. Therefore, we wanted to explore this relation between hospital work and society and in this paper, we relate our findings to the hero narrative.

2.5 Data analysis

Analytical frame

This study uses abductive analysis (Timmermans and Tavory 2012), which uses empirical material (in our case the field notes and interview transcriptions) that inform the choosing for a theoretical framework. In our study, we experienced a discrepancy between the hero narrative and the nursing staff's experiences by ways of talking about their work, the mirroring of the narrative as well as the collective identity placed on them and we wanted to explore this divergence. Cox' definition contains elements that could help us explore this divergence within this specific socially located context and the nursing staff' positional knowledge (Timmermans and Tavory 2012). This was a strategy to generate new insight by analyzing the empirical voices embodying the identity of heroes. The analysis is therefore structured by the three parts contained in Cox's definition; voluntary prosocial action, personal risk and transcending duty (Cox 2020).

Analysis process

During the fieldwork, we had weekly meetings where we compared and discussed experiences, reflections and possible analytical takes. The fieldnotes consisted of thick descriptions and were eventually gathered to one chronological document containing all three researchers' fieldnotes (Emerson, Fretz, and Shaw 2011). Based on initial readings of the fieldnotes, we recognized a recurring focus on the nursing staff reacting negatively towards a heroic identity. By method triangulation, we succeeded the fieldwork with focus group interviews, where we could nuance and elaborate on found consequences of the hero narrative. This was then also a way to member check whether, or how, the informants recognized these findings.

2.6 Rigour

Trustworthiness was adopted through different strategies (Tan et al., 2003). By researcher triangulation, we were three researchers participating in the hospital ethnography. During initial analytical meetings, discussions were documented in writing and pictures were taken of whiteboard brainstorming. Different triangulation methods and the documentation of methodology conformed to credibility. Analytical documentation of the analysis strategy and data collection conformed to dependability. The inclusion of contextual factors ensured thick descriptions and conformed to transferability. Finally, member checking and describing the authors' positions conformed to confirmability. By following Lincoln and Guba's (1986) criteria of credibility, dependability, transferability and confirmability, we ensured trustworthiness in this ethnographic study (Tan et al., 2003).

2.7 Ethical considerations

The study is approved by the Danish Data Protection Authority and was evaluated by the Regional Committee on Health Research Ethics.

Before our fieldwork, we made a poster containing a short description of the study as well as a picture of us. The poster was placed at each nursing station at the ward. Before every shift, we shortly presented ourselves and introduced the study, our roles, anonymity as well as the poster. During situated conversations, we made sure the nursing staff were aware of our dual position.

Before the focus groups, the informants received a written information including background and purpose of the study as well as a written consent. The consent forms were signed at the beginning of the interviews after repeating ethical guidelines, anonymity and the right to continuous withdrawal etc. All informants received our information in case of withdrawal. Further, the interview setting was presented as enclosed and confidential and following publication, all sensitive information will be deleted.

3. FINDINGS

3.1 Voluntary prosocial action

Most nursing staff in our study recognized their duty as healthcare workers to care for patients with COVID19. However, duty is not equivalent to volunteering. One nurse related this aspect to being a hero: *"I can't take being labelled a hero (...) this is not voluntary"* (Nurse, focus group). This nurse connected being a hero to acting voluntary which she did not. It was their duty as nursing professionals to participate in the care but to be part of the frontline staff was not a voluntary act. A prosocial act leads to an expectation of being invincible and being able to perform the same kind of competent complex patient care to all kind of patients and conditions. Following years of societal and political demands of efficiency, optimizing and specialization within the Danish healthcare system, also the nursing profession has been increasingly specialized. Modern nurses are not a homogenic and generic group with identical competencies. As a result, many of the nurses working in the COVID19-ward had not cared for inpatients or acutely critical ill patients for years but became in responsible for the care of these highly complex patients overnight. The nature of caring for patients in isolation, made the necessary exchange of knowledge and supervision difficult. One nurse explains the feeling of lack of competencies: *"The mental work environment is under pressure. People are upset and frustrated. They feel vulnerable and exhausted. They are nervous they can't perform care in a safe way"* (Nurse, fieldnotes). These feelings were magnified, as proper training or competencies were viewed by nurses as a cornerstone in preventing harm to the patients. The training was described as insufficient: *"We did get to go to a course ... but it was completely useless once you stood with the patients"* (Nurse, focus group). When a 'prosocial action' is 'voluntary', it is not linked to acting according to defined professional standards. However nursing is, and nurses often didn't feel they could meet these professional demands why they experienced a lack of confidence: *"What has been the most difficult for me, is the feeling of inadequacy in my profession as a nurse"* (Nurse, focus group). This feeling of incompetency and insecurity also does not feel very *heroic*.

3.2 Personal risk

Within the nursing profession, a well-known and acknowledged risk exists of e.g. poking on an infected needle or exposure to allergens. However, the risk is minimized through specific procedures, training, presence of relevant equipment and quality measurement as well as organizational guidelines and help in case of any accident. In contrast, the risk the nursing staff experienced during their work at the COVID19-ward diverted significantly from the acknowledged risk: *"From the beginning I was both professionally and personally worried. How do I relate to, and act with, my family? I asked if I had anything to worry about and the answers was 'no, as long as you use the protective equipment correctly'. But then, as time went on, more and more colleagues caught COVID19 and afterwards I've read the nursing staff is a group with many infected. I actually feel they betrayed my trust"* (Nurse, focus group).

The nursing staff questioned whether they as healthcare workers automatically must accept a higher risk as part of their job description. The feeling of not being taken care of properly was a general view and experience among the nursing staff. Therefore, the acknowledged degree of personal risk within nursing can, and should, not be compared to the form of acknowledged degree of personal risk as a hero.

On top of the personal risk extending to the families of the nursing staff, one nurse expressed worry of seeing colleagues falling sick one after one: *"What is happening to my colleagues? You don't know how many of them are sick and I felt quite alone. People just kind of dropped along the way.. it feels a bit like the song 'Ten little soldiers'"* (Nurse, focus group). Of the 22 who participated in focus groups, nine had been sick with COVID19 and they described long-term symptoms: *"I was stricken by Corona four months ago and I still cannot go for a run. How long does this last?"* (Nursing staff, focus group). The nursing staff described a range of symptoms connected to the COVID19 infection from a 'light versions' to more 'server versions' with extended and long-term symptoms. During the fieldwork, many expressed how they wanted to 'get infected and get it over with' as this would ease the uncertainty, reduce the level of worry related to how the infection would affect them personally but also to be relieved from the threat of being an unaware carrier of the virus.

Despite feeling insufficiently protected, the nursing staff continued to take on the responsibly expected by the society and the hospital. One nurse explains this responsibility in regard to other people not taking it as serious: *“For the last three months my life has been solely about Corona. I have not seen my family up until one month ago. And then I get a bit angry by people not following the guidelines. I bike directly to and from work and I don’t see any people in prevention of getting sick and not being able to do my job. And then I live next to this big park and there are big parties happening every night”* (Nurse, focus group). The nursing staff also described how they experienced society took two steps back, if they revealed where they worked. One nursing staff explained how she was expelled from a grocery store after she dropped her work-ID-card and the other customers could see where she worked. Other nurses, who had been sick from COVID19 described how they received suspecting texts from other parents when they sent their kids back to school after the quarantine was done. This points to a stigmatizing affect in society, where healthcare workers are potentially contaminating. A contradiction one nurse explained: *“I absolutely do not feel like a hero, quite the opposite. When I say where I work, people automatically take two steps back”* (Nurse, focus group). The nursing staff paid a personal high price as they had a proportional higher risk of getting COVID19, had to deal with a new and unknown disease, in a work environment that included new colleagues, work schedule and on top of that, being stigmatized for being *potentially contaminating* and thereby a threat to the health of the society. The borders between work and personal life went beyond contagion.

3.3 Transcending duty

Having a job transcending the duty means it is more than a bounded duty. The idea of transcending duties and acknowledged accept of personal risk, leads to thoughts of how nursing used to be described as an altruistic calling. Here, nurses had self-sacrificing personal identities and were always available. One nurse talked about the expectation of sacrificing her safety for the patients: *“Heroes (...) nursing as a calling and willingness to die for our patients. I do not want to do that”* (Nurse, focus group). In modern society nursing is a job like many others, you go to work and when your shift is over, you go home. Nurses strive and feel

obligated to 'do good' for their patients. But within the hero narrative there is also an expectation of nurses justifiably being available beyond their work schedule. The nursing staff experienced an unknown timeframe, their work schedules planned for only one week ahead, days off withdrawn, short work warnings, night- and weekend shifts among nursing staff who normally only worked dayshifts as well as receiving incorrect pay. Some nursing staff also described how they performed self-isolation from family and friends, to prevent infecting others but also to stay healthy themselves so they could continue to provide care to their patients. The nursing staff felt a huge responsibility which further crossed the boundary into their private lives. During the pandemic, boundaries between job and personal life were obliterated. A nurse very illustratively described this idea of a hero as a fulltime identity and how it blurred the line between nurses as employees and as humans: "*We don't just stand in a closet and wait for them to take us out*" (Nurse, fieldnotes). It is important to discuss what can be expected from healthcare workers who also have other obligations and priorities as parents, spouses etc.

4. DISCUSSION

Based on the definition of a heroic act proposed by Cox (2020), we have shown how the hero narrative leads to ideas of being invincible, self-sacrificing, knowingly and willingly working within risk, and embodying a boundless identity. The nursing staff in our study rejected the hero narrative and this might be why. The nursing staff aim to provide the best care for their patients, but many struggled with feelings of insecurities, fear of the virus, feeling insufficiently protected, suboptimal work conditions and other obligations outside their jobs. A hero narrative undermines these valid concerns as they do not seem *heroic*. Feelings of stigmatization outside the hospitals also contradicts heroism. Following, a hero is an individual and independent identity, however nurses do not work independently. They work within a well-defined and defining organization with direct links to society and politics. We will now further discuss these implications on a wider institutional and societal scale.

4.1 Heroic act

The hero narrative is global and has been discussed as problematic internationally (McAllister et al, 2020). Cox (2020) discusses the hero narrative and describe how it might seem fitting on the surface but, when looking at the limitations, question its usefulness. The duty of care becomes unlimited in a hero narrative. Nurses have a duty to use their professional competencies to perform good care but that is not comparable to knowingly risk their own or their families' health and life. The nursing profession is not without risk, as it continues to entail working with contagious and critically ill patients. However, healthcare workers are normally protected by special conditions and rights in their workplace limiting and minimizing the risk. Both nationally and internationally studies, show healthcare workers have a higher prevalence of COVID19 compared to the general public (Iversen et al. 2020; Nguyen et al. 2020). Jeffrey (2020) discuss the professional obligations of duty of care and describe how health care workers are assumed to adopt a view where their duty of care overrides self-preservation. He calls for specific guidance from regulatory bodies on the duty of care and its limits (Jeffrey 2020). Cox (2020) also emphasizes that the duty of care, and the acknowledged risk, are not unlimited for healthcare workers. No one expects a healthcare worker to donate a kidney, but the hero narrative undermines important discussions of boundaries (Cox 2020).

Stokes-Parish et al. (2020) discuss the unintended consequence of the hero narrative, and argue a hero is seen as an individual with divine powers or ancestry. These superhuman attributes takes away from the high level of skills and knowledge demonstrated by the nurses during the COVID19-pandemic. The authors criticize the policymakers' implementation of packages designed to upskill ward nurses with critical care skills in just a short time. The hero narrative underestimates the skills and knowledge necessary for caring for COVID19-patients. The nurses in our study also did not experience the courses provided as sufficient. Stokes-Parish et al. (2020) describe how this leads to a thought of skills and knowledge as assimilated without the need for advanced skill development.

Cox (2020) discuss the norm of acting and being *heroic* in a hero narrative. But not all healthcare workers felt heroic. Downsides like fear, anxiety and stress has shown prevalent and should be addressed, not

inhibited. Greenberg et al. (2020) discuss mental health challenges faced by healthcare workers during the COVID19-pandemic and conclude healthcare workers have an increased risk of mental health problems. We found the hero narrative makes healthcare workers feel ashamed and embarrassed to address very valid aftereffects.

4.2 Reciprocity from society

Cox (2020) discuss how a profession with a known risk, also leads to expectations from society. A social contract based on reciprocity. This contract entails societal support towards the healthcare system and the employees of this system through e.g. working conditions and funding, but it also entails the support of the general population. This contract applies both during a pandemic but also when there is no crisis through e.g. paying taxes and political support. During this pandemic, the social contract includes following guidelines e.g. social distancing. The nursing staff in our study pointed out how they felt the contract was getting broken. This could also be a reason behind the now famous hashtag: *"We came to work for you, please stay home for us"*, which many healthcare workers all over the world have shared. This is a plea based on reciprocity.

4.3 Paying tribute

Healthcare workers have done something extraordinary and, from our experience, they appreciate the recognition and respect gained from this work. However, when nursing staff are applauded for being heroes while at the same time become stigmatized for being the 'impure', and potential contaminators, who should restrain and self-quarantine to protect the society, the praise can appear hollow.

Furthermore, through the medias' focus on the hero narrative, the healthcare workers' possibilities of addressing work conditions and rights are minimized and in worst case ignored, as this is not *heroic-ish*. Additionally, the intense media focus on the hospital staff also resulted in some healthcare workers outside the hospital (e.g. nursing home) were ignored and not view as heroes despite they fulfilled a similar role. In a hero narrative it is up to the hero he- or herself to pull through however, the schism is that healthcare

workers do not work independently. They work in a publicly supported and political organization who define the setting for their jobs. Healthcare workers cannot act on their own.

We are convinced the public and media do not wish to minimize the efforts of the healthcare workers during the COVID19-pandemic, quite the opposite. But we do find the hero narrative should be used with caution, so risk and duties do not become unlimited and the individual healthcare worker do not feel he or she is alone and responsible for challenges they encounter.

4.4 Detachment of political responsibility

This pandemic has left both societies and healthcare systems in a new and unusual position no one expected nor experienced before. Therefore, no one at the time knew the right way to manage it. It is our agenda to show how the hero narrative detaches the connection between the politicians, society and healthcare system despite being a political apparatus. When it is time to reassess contingency plans, we hope knowledge from this study entails political actions.

4.5 Limitations

Limitations of this study include timeframe, inclusion and field. Our first shift took place the 2nd of April, and the ward opened on the 21st of March. This limited the timeframe of the fieldwork as the COVID19-ward closed at the end of May due to a positive decline in admissions of COVID19-patients. We solely included nursing staff in this study which is a limitation as the hero narrative includes all health care workers. Our positioning also acted as a limitation as some days were busy and the tasks as runners were prioritized. Finally, we only included one ward in the study. A defined field of study provides in-depth empirical, however findings relating to e.g. individual characteristics influencing the field should be analyzed with caution. This also effects the ability to generalize findings to a wider population or context.

5. CONCLUSION

The hero narrative strips the responsibility of the politicians and imposes it onto the hospitals and the *individual heroic health care worker*. It should not be the individual hospital and their economy defining what kind of supervision, psychological debriefing or counselling, the frontline healthcare workers should receive. Also, the media ought to alter their approach to a pandemic without having the hero narrative as the reigning filter.

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