(In)visible Hero: Heroism as an Aid in the Extraction of Care Labour During the COVID-19 Pandemic

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Dedication

To my Great Grandma, "Aunt-B." I love and miss you every day.

Abstract

This honours thesis examined the myriad ways in which discourse supported the extraction and overproduction of care labour through the use of heroism labels. Throughout the COVID-19 pandemic, the label of heroism was used to describe the contributions of Healthcare Workers (HCWs) in different settings. Prior to the COVID-19 pandemic, care labour was largely considered an invisible occupation (Hennekam et al., 2020). However, the severe impact of the pandemic on collective health and wellbeing resulted in a drastic shift in the ways that care labour was framed and discussed. I highlight the use of heroism by policy makers, Long Term Care Homes (LTCHs) and mainstream media as a prop to meet the critical needs of heroism through HCW labour.

This sudden shift in care discourse created a potentially harmful arena with limited capacity to support this heroism narrative long after the pandemic has ended. Thus, questioning the motivation, validity and durability of this narrative in a post-pandemic world. One in which care labour will continue to exist and be required in large quantities to sustain the ever-changing LTCH system.

This study utilized critical framing theory (Entman 1993; Fridkin et al, 2017) to further understand how heroism has been positioned and constructed to acquire, maintain, and over-ask of care workers and their labour. Critical narrative inquiries (Austin & Anderson, 2021; Tracy, 2013) were utilized to describe the lived experiences of the heroism narrative amongst HCWs employed in LTCHs during the COVID-19 pandemic. The findings in this research study indicated that HCWs felt as though the use of heroism discourse along with the overproduction of labour disconnected them from rest, respite, and community. Additionally, themes of sacrifice, moral injury and perceived risk in healthcare settings were identified and further

discussed. Future implications including stronger pandemic preparedness policy, and interprofessional collaboration are also considered and discussed.

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Chapter 1: Developing the Pot

As the days went on, cases continued to rise. The atmosphere in the building grew somber and still. We had no idea what to brace for, but all we knew, was that it was here, and it was not done yet. Initially, we were hopeful. Hopeful that after two weeks of strict isolation, we would return back to a sense of normal- togetherness, community and good health. How naïve of us, to underestimate the power and pace of alpha's transmission.

I remember it vividly. It was January 2021, and the LTC facility that I worked at declared a COVID-19 outbreak. We watched as the residents who we considered family, were wheeled out of our home for the last time. They were gone.

The first two weeks came and went; numbers continued to rise, the public health agency was called in to help us and we were utterly speechless. Our frontlines were the two hallways of our LTCH, which housed residents we were employed to care for and protect. One hall had been labeled "COVID Positive" while the other was labelled "Negative and/or pending." Somehow, we the healthcare workers were the heroes in this story. We were heroes for continuing to show up for work despite the circumstances. But truly, if we didn't show up, who would? Helpless heroes, maybe.

In a brief exchange with a PSW colleague in the lunchroom, my entire outlook on the work of caring in this time of COVID-19 shifted. As we rushed food into our bodies to return to the 'frontlines' as quickly as possible, we sat in silence. She stopped eating for a moment, looked up at me, and said "You know Crystal, things are not getting better. They are getting worse. Our residents don't understand, and some are dying. The pressure is just too much and sometimes I question if any of this is even worth it?"

On March 17, 2020, the government of Ontario declared a public state of emergency (Ontario News Room, 2020). This involved the deployment of stringent directives; including forced lockdowns of non-essential retail stores, libraries, and community centres. All LTCHs were prohibited from having outside visitors including family members, friends and primary caregivers. The purpose of such measures was to closely monitor movement in and out of LTCHs to ensure that transmission could be easily monitored (Picard, 2021). As the pandemic crisis continued to unfold in Ontario's LTCHs, it was clear that further actions would be necessary to keep residents safe and alive. This included restricting all HCWs from working at multiple LTCHs (Badone, 2021), and mandatory COVID-19 PCR testing (Ontario, 2021).

As outbreaks continued to ravage LTCHs in Ontario and Canada, the LTCH system pivoted discourse to highlight HCWs who were providing direct care to sick residents. In LTCHs, PSWs, nurses, dietary aides, environmental staff, and recreation staff became the 'heroes' in the fight against the COVID-19 pandemic. On a larger scale, federal supports like support from the Canadian Red Cross were made available upon request of the federal government (Government of Canada, 2021), and the Canadian Armed Forces, were deployed to support the LTCH crisis that was quickly claiming the lives of elders and HCWs (CMFM, 2020). At a time of significant crisis and uncertainty, HCWs felt they had no choice but to ensure the safety and wellbeing of residents; even if this meant placing their own personal needs behind those of their duty to care. The heroism narrative created toxic expectations of selflessness, courage, tenacity, and resilience, which subsequently supported the extraction and overproduction of care labour during the COVID-19 era by all HCWs and individuals in other supportive positions (i.e., cooking, housekeeping).

Traditionally, care labour has largely been provided by female and feminine presenting, immigrant Black, Indigenous people of colour (BIPOC). This is largely embedded in gendered constructs that have positioned women as biologically and socially responsible designates of care work. Thus, extending caregiving provided within the context of family into the workforce (Glenn, 2010; Lopez 2018). Paid and unpaid care work is structured through systems of oppression that evoke the labour of persons affiliated with minoritized groups. And though the provision of care labour is integral to maintaining the health of society, BIPOC women working in unregulated health professions including those working in LTCHs have largely been unacknowledged for their critical position in resident-centred holistic care (Rossiter & Godderis 2021). Distinguishing HCWs employed in LTCHs as heroes is in tension with traditional views

of care work, and the heroism title is dichotomous to the deeply rooted systems of inequity (pay disparities, staffing shortages, paid sick days) (that existed pre-COVID-19), and continue to impact HCWs. Unpacking the doings of the heroism narrative was crucial to understanding how care labour was perceived and how performative allyship helped to develop a storyline that silenced HCWs experiences of care work inequity.

Costumes of Care and Solidarity: A Brief Note on Performative Allyship

> *Our government will spare no expense to protect the health and safety of our frontline healthcare workers... they're always looking out for us, and our government is looking out for them. We'll do everything within our power to ensure our frontlines workers have the necessary resources to take COVID-19 down and keep individuals and families safe. – Premier Doug Ford, March 26, 2020.* (Ontario Newsroom, 2020)

The term performative allyship was utilized heavily amongst anti-Black racism groups a part of the Black Lives Matter justice movement to place a spotlight on the false claims of solidarity that were demonstrated by white politicians, civilians, and the justice system after the killings of George Floyd, Breonna Taylor, Ahmaud Arbery, and Elijah McClain. Performative allyship is guised in support and solidarity. Often it involves claims being made that elude change will come, yet, no formulated plan is created to support these statements. Thus, oppressed groups wait in anticipation of meaningful change to come from statements that were always empty and temporary (Kalina, 2020).

Performative allyship requires a multitude of actions. Acts of performative allyship include those associated with the Blue Ribbon movement (Heslop, 2021): a cause that erupted during the COVID-19 pandemic to show support for HCWs, by tying blue ribbon or plastic bags around trees to reflect HCWs and their contributions. In the case of police brutality and the unlawful killings of Black people, the #BlackOutTuesday movement (Willingham, 2020) required people to post a single black square on their Instagram accounts to show support for

Black Lives was also created. However, as stated earlier, acts of performative allyship can cause more harm than good. Specifically, blue ribbons, hero signs, and public accolades have not addressed the deeply rooted, recurring issues of exploitation and overproduction in the workforce. Instead, it required HCWs to continue engaging in labour production in order to feel valued and worthy of acknowledgement (Glenn, 2010; Lopez, 2018; Rossiter & Godderis, 2021). The black square from #BlackOutTuesday was accompanied by the incorrect use of hashtags which caused posts containing information on how to meaningfully support Black Lives to be flushed out of social media timelines. These examples reflect the inaction arising after a false sense of action; the idea of taking no steps forward. As Kalina (2020) states:

> We cannot post to Instagram to prove that we are not racist, simply because other people are doing so, and then forget about the issue and carry on with business as usual. It does not help the authenticity and progress of a movement if that's all we're contributing, if we're posting just to save face. We shouldn't care because everyone else is. We should care because true injustices exist; ones we really believe in, people we really care about. There's a social cost of not saying anything while everyone around you is speaking up (p.478-479).

Statement of Purpose

HCWs have carried significant pressure on their backs while the COVID-19 pandemic remained persistent in its inequitable impacts on older adults/ individuals living with underlying health conditions. When society required us to stay apart and isolate, HCWs placed themselves amid an infectious disease to protect residents in LTCHs the best they could with what they had. During the first wave of the COVID-19 lockdown, HCWs exposed themselves to severe risk with limited access to personal protective equipment and a limited opportunity to refuse unsafe work due to overstretched duty to care policies (Ruderman et al, 2006).

HCWs shared feelings of isolation, grief, and trauma among other forms of emotional distress (Brophy, et al., 2021). However, among these narratives, unique experiences of HCWs

employed in LTCHs were missing in the literature. This project sought to understand how the heroism narrative was perceived and taken up by HCWs and the influences of the heroism narrative on job roles and HCWs individual sense of worth. This project provided a space for the voices of HCWs in LTCHs to be centred and amplified. This project was supported by critical framing theories (discussed in chapter 2) and narrative inquiry (discussed in chapter 3). The purpose of utilizing narrative inquiry in this study was to develop deeper insights into the unique experiences and understandings of HCWs employed in LTCHs in an era of COVID-19 heroism from a first-person perspective.

The dissonance that we sought to understand was complex and critical: *"Is it worth it?" To be labeled as a hero in the fight against COVID-19, yet feel so empty, and so gutted on the inside?* Has caring become so invisible, so dehumanized, and the future so bleak that we question the worthiness of our labour?

Chapter 2: Literature to Map #HealthcareHero

Throughout the COVID-19 pandemic, Ontario's frontline health care workers have faced challenges unlike anything we have seen before. Across the province, these individuals have demonstrated remarkable bravery and resilience, often putting themselves in harm's way to care for our sick and most vulnerable citizens. We won't ever be able to fully express the depths of our gratitude. - Christine Elliot, June 12, 2021. (Ontario Newsroom, 2021).

*In April of 2020, Arlene Reid was working as a PSW providing community care in Peel Region when she was informed of a patient, she would be caring for was also being treated for COVID-19. When she expressed her concerns about transmitting the virus to a family member who was ill, she was informed that failure to provide care would result in job insubordination. Arlene later contracted the COVID-19 virus from her workplace and died as a result (*Tsekouras, 2020*).*

The purpose of this literature review was to examine the common themes described in literature that attended to performative allyship, heroism, and care labour as it effected care workers employed in Long-Term Care Homes (LTCHs) during the era of COVID-19. This topic was timely as LTC homes in Ontario continued to face the largest public health crises since the SARS epidemic of 2003 (Allin et al, 2021). The stress of the COVID-19 Pandemic on LTCHs across Ontario and Canada rested on the backs of healthcare workers (HCWs) to mitigate as they were frequently asked to submit to precarious care labour in order to do so. In this literature review, I wanted to reflect upon the ways the discourse of toxic resilience in speaking to care worker labour and/ or bodies is utilized to support the system as it mitigated the COVID-19 crisis. The themes below supported my proposed research in impacts and reactions to the discourse of toxicity and thinkings within this topic. I structured this review in a way that situated the following: (1) policy, governance, and ways in which decision makers and key beneficiaries of the system (not residents) used performative language to 'mask' shortfalls in public health policy; (2) first-hand perceptions held by HCWs of heroism and the usefulness of this discourse in a post-COVID era; and (3) intersectionality and systems of oppression that might have supported inequitable extraction of labour from HCWs employed in in LTCHs. I

intended to reflect on these inequities by examining the deep paradox that I feel exists between heroism and invisible identities that are overrepresented in LTCHs (Lopez, 2018).

Performative discourse as a prop to 'mask' shortfalls in public health policy

LTCHs held one of the highest rates of COVID-19 transmission in Ontario and Canada. At the time of writing, the province of Ontario reported 2,095 COVID-19 related outbreaks in LTCHs, and 1,376 COVID-19 related outbreaks in retirement homes. Among these statistics, 23, 153 LTCH residents have tested positive for the COVID-19 virus, and 4,365 have died as a result (Public Health Ontario, 2021). Additionally, 10,007 HCWs have contracted the virus while working in LTCHs across the province and 10 have died (Public Health Ontario, 2021). LTCHs were intended to be spaces of holistic intervention that supported individuals with intensive medical needs. However, the epidemiological data described few protections and unnecessary exposure to risk for both staff and residents.

With regard to pandemic policy, similarities existed between the SARS epidemic of 2003 and the current COVID-19 pandemic. In both outbreak situations, preparedness plans were created, however, the delayed execution of these public health measures was partially to blame for the significant threat that COVID-19 posed to residents and care workers in LTCHs (Allin et al, 2021). Thus, creating an experimental scenario in which "trial and error" was the only viable option (Allin et al, 2021). However, this experimental approach has proven to be unsuccessful in mitigating unnecessary exposure to risk; including high rates of transmission amongst residents and HCWs in LTCHs.

Inequities existing within the LTCH system have been longstanding. Specifically, the provision of fiscal resources from federal and territorial levels of government, wait times for admission into LTCHs, and adequate staffing resources necessary to provide safe and effective care to residents living in LTCHs were highlighted as recurring issues. It is well documented that

the COVID-19 pandemic exacerbated these conditions (Badone, 202; Flanagan et al, 2021). In April of 2020, the Canadian Armed Forces were tasked with supporting various LTC homes experiencing significant COVID-19 outbreaks. During that time, they assisted with various tasks related to care; including feeding, personal hygiene and infection control. At the end of their deployment, a report was created highlighting the far-from-human conditions existing within LTC homes that they supported. The report highlighted inadequate staffing supports and increased rates of transmission due to poorly enforced infection control protocols (CMFM, 2020). It marked the beginning of a deeper inquiry into an eldercare crisis occurring long before the pandemic was declared (Allin et al, 2021). Contributing to this crisis were systems of ableism and ageism that further reinforced harmful narratives on the devaluing of old bodies living in LTCHs (Lopez, 2018). These structures also contributed to further conceptualizations of whom we "save" in times of public health crisis and who are deemed "expendable members of society" (Herron et al, 2021, p. 184).

Though healthcare workers have carried a considerable amount of responsibility to keep residents in LTCHs safe, it has not been entirely by choice. With little support from the LTCH system, provincial government, and privatized organizations, HCWs saw it as a personal obligation to sustain the livelihood of the individuals that they served. Since declaring a public state of emergency on March 17, 2020 (Ontario Newsroom, 2020), healthcare workers in LTCHs experienced a sudden shift in job role responsibilities. Of which, keeping residents alive, COVID-19 free and safety became their top priority. The conditions were grave, and with an extreme shortage of Personal Protective Equipment (PPE) during the first wave, HCWs felt pressure to neglect their own personal concerns for safety and show up to their jobs fearlessly. The term 'Healthcare Hero' was quickly coined by politicians, mainstream media outlets, and the

LTCH system to describe healthcare worker contributions during the pandemic. The 'hero' label implied that the duties HCW's in LTCHs carried out required a distinct level of courage, tenacity and resilience. However, literature suggested that the 'hero' label was a decorated tactic of capitalism that inhibited the extraction and overproduction of labour and pivots the attention away from politics (Cox, 2020).

Heroism centres one person or image as the dominant being in a crisis scenario. Historically, metaphors of (super)heroism have been utilized in times of public health crisis to help regular civilians understand public safety threats; including the HIV/AIDS epidemic of the 1980's, and during the war. These images included visuals of soldiers in battle and more recently, HCWs in superhero costumes (Saji et al, 2021). However, visuals and metaphors in the COVID-19 era demonstrated HCWs standing alone as the sole 'fighter' in the 'war' on COVID-19. In tying together common themes amongst the HIV/AIDS epidemic, SARS epidemic, and the COVID-19 pandemic, it is understood that these crises could not be mitigated and resolved alone; rather, in the presence of collaboration with all levels of government and support from citizens. Rather, 'war' rhetoric evoked the notion that casualties would occur in war and in both declared and biological warfare the assumption of casualties felt like one that was too readily accepted.

Saji and Jaworska (2021, 2020) argued that "using war metaphors can sometimes be constructive in that it can mobilize public health efforts" (p. 145). However, HCWs reported feeling isolated and unsupported in their efforts to mitigate the current COVID-19 crisis (Brophy et al, 2021). There was a lack of interdependence between the provincial government and HCWs in working towards safeguarding the LTCH system. Heightened dependence placed on the heroism narrative, however, served to further the over-production and precarity of care work.

Superhero labels have been tied to notions of care labour at this time due to "... the roles and responsibilities of the superheroes and the virtues characterizing a superhero (i.e. courage, ingenuity, public safety)" (Saji et al, 2021, p. 146). Otherwise suggesting that, by nature of profession, HCWs possessed the resilience and tenacity required to mitigate a crisis of this capacity on their own. A news article written for The Guardian by Charlotte Higgins in April 2020 argued that the heroism narrative was developed out of shame and guilt, and due to a lack of any real support from both society and the government (Higgins, 2020). It was the responsibility of the government to accept accountability for the delayed pandemic response and its harmful consequences on the LTCH system. Yet silence from the government in a time of crisis spoke loudly to the performance of allyship demonstrated by the government elected to protect us.

At this time, HCWs stated wanting more than a heroism label they demanded long-term changes to be implemented to mitigate the challenges that have impacted HCWs employed in LTCHs including increased pay and increased staffing resources (Carter, 2021). Care work is largely governed by a duty to care, which is characterized as a responsibility to uphold the ethic of beneficence and its "... special moral obligation on the part of the [HCWs] to further the welfare of patients and to advance patients' well-being" (Ruderman, 2006, p. 3). However, duty to care doctrines have required HCWs to work despite personal concerns for safety since the SARS epidemic of 2003. The use of distinct labels like 'Healthcare Hero' have not previously existed. Thus, thinking about the mechanisms and the purpose this dominating narrative has is needed to critique the role and motive of politicians and government in their chronic use and widespread sharing of heroism to describe HCWs contributions. How does this narrative withstand the test of time? And in the end, who does it benefit?

The sustainability of the heroism narrative in an era of COVID-19

The portrayal of heroism in movies, literature, and television shows is not synonymous with the way heroism was taken up in the context of the COVID-19 pandemic. Particularly when used to describe the common acknowledgment of HCWs as 'healthcare heroes.' To adequately outline discrepancies between traditional and the present use of heroism in healthcare, a visualization was vital. Imagine a conventional superhero working and living amongst 'regular' civilians. This hero would be aware of their role, who they are, and the contributions that they made to society at large. They were aware that at any moment, the entire fate of humanity could be in their hands. They were made aware of the perceived risk, and yet, made an informed decision to save humanity anyway. Now reflect on how heroism is applied to HCWs; there are some similarities in this use of "hero." HCW's have always been aware of their role, who they are, and the contributions that they have made to society at large. However, the overarching pressure to be resilient and tenacious in the face of a persistent crisis wares on individuals. The gaps in collective responsibility resulted in significant loss, trauma, and uncertainty, painted an entirely different story than the conventional one outlined above. Unlike the superheroes portrayed in movies, comic strips, and televised series, HCW's were not provided the same opportunity to make an informed decision to stay/'save' humanity or leave their jobs. Although HCWs were made aware of the possible health consequences resulting from work with medically complex individuals, the idea of a crisis as grave as the COVID-19 pandemic is less likely to be a constant thought in their minds. In times of health crisis, HCWs are one component of a multi-layered healthcare system. However, discourse utilized throughout the pandemic have framed HCWs to be a modern-day saving grace.

As Cox outlined, heroism could not exist without informed risk and autonomy to make 'heroic' decisions (Cox, 2020). HCWs and residents in LTCHs have lacked autonomy during the COVID-19 pandemic. Residents were forced to isolate away from family, friends, and primary caregivers for extended periods of time in an attempt to slow the spread of COVID-19 (Picard, 2021), HCW's working in LTCHs were required to work at one LTCH for an undetermined period of time (Boden, 2021; Reopening Ontario Act, 2020), and HCWs have had minimal rights to refuse unsafe work (Brophy et al, 2020). In any situation, HCW's have been required to adapt to ever-changing public health measures without being able to express their concerns, frustrations, and fears. The situations above have rendered HCWs powerless in many ways and these conditions are in tension with what heroism has conventionally been portrayed as.

Labour has heavily been tied to personal worth in unregulated professions (i.e., PSW, Dietary support, and Housekeeping) (Lopez, 2018). HCWs in LTCHs provided a significant amount of care to residents while sustaining low wages in spaces that do not empower or encourage advocacy on the part of HCWs. Silence and complacency is often viewed as being selfless; however, their obedience often comes from a place of hesitation to speak up out of fear of potential job loss and ill treatment (Palmer & Evaline, 2012).

The sudden uptake of the #HealthcareHero narrative was accompanied by various public accolades including siren salutes outside of hospitals (Global News, 2021), free hockey tickets (Granger, 2021), and even free coffee and donuts donated to LTCHs by the Tim Horton's restaurant chain (Miller, 2020). These gestures were considered an appropriate way to recognize the sacrifices of healthcare professionals, though there was reason to question the sustainability of this attention long-term or reflect the depth of the sacrifice being made by HCWs. Workers were asked to comply with duty to care policies (with little choice to negotiate capabilities for

the added demand beyond terminating employment), which placed constraints on their ability to honour and acknowledge their personal concerns as humans outside of their occupation, including transmission to family members and considerations of their own health risks and comorbidities (Cox, 2020). Cox further stated that the notion of exposure to risk being part of the duty to care is not new, nor revolutionary. Healthcare workers *have* entered risky situations for the sake of saving their patients' lives yet have not received such distinct levels of gratification. Thus, there was room to question what these framings of heroism (Cox, 2020) continued to provide to the system.

One concept that could potentially answer this question was the notion of social valorization. This term, utilized by Hennekam, et al (2020) in their understandings of hero status was defined as "... a process of mobilizing socially constructed attitudes in the collective elevation of the value and image of certain types of work (and the individuals performing it) that are traditionally devalued" (p. 1089). Pre- COVID-19, HCW's in LTCHs were considered invisible within society (Rossiter and Godderis, 2020). HCWs roles and contributions were commonly dismissed within political, social and organizational structures; even though their work was integral (Godderis and Rossiter 2012; Hennekam at al, 2020; Lopez, 2018). Between the dates of April 24, 2020 to August 13, 2020, all HCWs employed in LTCHs were awarded a Hazard Pay incentive of $4/hour to continue working in LTCH environments (Ontario, n.d.). However, as Cox (2020) implied, HCWs were exposed to imminent risk each day; as this innate risk existed within all public healthcare spaces. However, in previous scenarios, extra fiscal resources have not been provided out of pure effort to keep the system running. Language continued to be utilized as a vessel to glorify care labour in a way that met the needs of the LTCH system and facilitated its survival through its current state of crisis. Perhaps there existed

an assumption that increasing pay would minimize the possibility of HCWs retaliating against unjust working conditions, which could result in HCWs resigning from their jobs in swaths causing further determent to an already overwhelmed LTCH system.

The fictitious superheroes on television and in popular literature do not offer too many parallels with COVID heroism. Yet, this popular imagery was used to draw similarities between the two, imagined and real life, forms of civil service. Saji et al (2021) describes this as *covidity*; this new term conceptualized "philosophical, material, and emotional responses to the COVID-19 pandemic" (p.142). This also suggested that heroism discourse was used by civilians, HCWs, and levels of government to conceptualize their own positioning in the pandemic response and the associated responsibilities they have. Thus, in centering HCWs as the hero in the fight against COVID-19, it minimized the risk and responsibility of all others until the COVID-19 pandemic eventually subsided. Similar to the visuals offered previously, HCWs were expected to "fly in" or "run towards" danger to save humanity. Yet, similar to television and literary depictions of crisis and heroism, once the threat is over, so is the need for saving. Therefore, there is a question of whether or not care labour would still continue to be 'heroic' when the work was no longer deemed critical.

In their research study Hennekam et al (2020) analyzed sudden hero status among non-physician HCWs. They asked their participants how they feel their role had been viewed pre-COVID-19, and how they felt it would be viewed post-COVID-19. They noted a common sense of invisibility felt by most HCWs. In particular, one participant stated:

> people have time to applaud us because they are at home. They think of us because they are at home. The government is thinking of us because it has no choice but to throw flowers at us so that we are ready to go to work without flinching. But in a few months, everything will be forgotten. No applause. No salary increase. No revaluation of professions (Participant 81, social worker) (Hennekam et al, 2020, p.1093).

The foundation of this heroism discourse assumed that if individuals were 'fast-fed' with gratification and made to feel as though their contributions were integral, they would see beyond personal hesitations and contribute to the system as labouring bodies to advance the perceptions and intentions of the system. It is important to note that though the mass spread of COVID-19 in our communities is (projected to be) temporary (as is the recognition that comes with it), COVID is anticipated to remain as will the strain on the LTCH system unless reforms were made. Along with its temporality, the heroism narrative is also conditional. The risk of refusing difficult and risky work has resulted in job loss, harassment, and even death of some healthcare workers (Sperling, 2021). This narrative extended beyond a means of social recognition. It was yet another structure determining worth and value of care labour and those who produced it. It was a matter of life and death.

Paradox between Heroism and (In/Hyper)visible Identities

It was critical to mention that care work is predominately produced by genderacialised bodies (Lopez, 2018). BIPOC Women produced a substantial amount of care labour under precarious, low-paying circumstances within spaces such as LTCHs and other healthcare institutions (Glenn, 1985; Lopez, 2018; Robinson, 2011). Thus, placing HCWs at significantly higher risk due to the intimate nature of care labour within the LTCH context (Godderis & Rossiter, 2013). And although these risks were prevalent to the duties of HCW's like PSWs, the level of perceived risk often went unacknowledged. Rossiter and Godderis (2020) speak on the notion of "absent presence." HCWs presence is acknowledged as crucial to the care they provide, yet absent in acknowledgement to the of level of risk.

Gendered constructs of labour production contributed to the significant caring responsibilities placed on female and feminine presenting bodies. Specifically, care labour

carried out by women in healthcare was often framed as an extension of the care they provided to their own families (Palmer & Eveline, 2012). As a result, low pay was provided to women for giving care that is perceived as 'natural' to their human existence. This disproportionately affected gendered and racialized care workers, not only within the contexts of pay and job security, but also in the way they have been regarded within society. Glenn (2000) states that "when care work is done by people who are accorded little status and respect in the society by reason of race, class, or immigrant status, it further reinforces the view of caring as low- skilled "dirty" work" (Glenn, 2000, p.86).

The ways in which gendered and racialized bodies have been viewed by capitalist structures, frame paid care labour as an employment opportunity that should be appreciated and treated with respect. However, this frame and the lack of regulatory bodies for PSW's placed greater constraints on PSW's abilities to 'push-back' on the system and advocate on behalf of safer and more respectful working conditions. As outlined in a recent report created by the Ontario Centres for Learning, Research & Innovation in Long-Term Care (CLRI), PSW's shared feeling as though systemic issues related to invisibility, stigma, and disrespectful environments further exacerbated feelings of burn-out (Ontario Centers for Learning, Research & Innovation in Long-Term Care, 2021). Present heroism discourse only worked to continue normalizing these conditions, rather than seeking to determine long-term strategies to further support the improvement of care work for the future.

Heroism discourse was utilized as a prop to further advance the needs of the LTCH system during a sensitive time. This discourse underscores the myriad ways in which worth had been directly tied to the value of labour produced by genderacialised identities within capitalist structures (Lopez, 2018). However, invisible identities ached for a sense of worth that supported

the recognition and importance of their work. As stated by Lopez (2018), "worth within the system, especially for racialized women, is an inherent desire due to the structuring of capitalist production, neoliberal nature, and invisibility through marginalisation discussed through the politics of genderacialised care" (p. 274). Racialized women continued to feel replaceable by the system. Thus, further reinforcing systems of individualism that support the extraction of labour by the system yet over-exert the labouring body.

Summary of background literature

The literature presented in this chapter reflected present heroism discourse pertaining to HCWs employed in LTCHs and the myriad ways that care labour continued to be extracted to minimize the pressure placed on the LTCH system. Cox (2020) suggested that present heroism labels provided HCWs with minimal rights to refuse unsafe working conditions due to overarching duty to care policies while also outlining the distinct differences existing between public and governmental responses to previous public health crises in comparison to the COVID-19 response which centred HCWs as 'heroes' in the fight against transmission. However, limited fiscal resources, PPE and staffing shortages created a space for further inquiry into the motives behind the valorization of care workers in the era of COVID-19. Additionally, HCWs employed in LTCHs (i.e., PSWs, dietary aides, maintenance staff, laundry, etc) take on "dirty labour" that was otherwise undesired by organizational leaders and society at large (Palmer & Eveline, 2012) due to ageism and other hierarchical forces. However, the shift from invisible and dirty to integral and vital was paradoxical. By acknowledging that labour production was heavily tied to understandings of worth among genderacialised care workers (Lopez, 2018), it can be further conceptualized that amplifying one's sense of worth could in turn encourage HCWs to continue working in risky environments and provide integral labour to the system. However, as

Hennekam et al (2020) points out in their discussion of social valorization, the sustainability of this heroism status is likely unattainable in healthcare settings and care work post-COVID-19.

This research project took place at a time when disparities and injustices within the LTCH system were grave and detrimental to both elders and workers alike. This conversation was imperative to engaging further discussions on next steps that could potentially mitigate these challenges in the future. It places HCWs in LTCHs at the centre of their own story and empowers them to share their own interpretations of the pandemic experience, which is not only integral to advancing these conversations, but potentially therapeutic for those involved.

Chapter 3: Methods of Knowing: Mapping stories of Heroism as told by HCWs

This chapter highlights in further detail the methods that helped to develop the research component of this honours thesis. The qualitative methods of photo-elicitation, critical narrative inquiry, and framing theory are further discussed in relation to the research questions that were developed to support this project. The purpose of this research study was to understand how heroism has directly impacted the labour of HCWs situated in LTCHs during the COVID-19 pandemic, as well as how they believed the hero label would continue to impact their work in post-pandemic eras. This qualitative study reflected upon the following research questions:

1. How was heroism framed in mainstream media and by the Long-Term Care (LTC) system?
2. How do HCWs employed in LTCHs feel about the heroism narrative at this time, if anything at all?
    a. How did the heroism narrative sit in relation to their unique experiences in care work?
    b. What words/pictures/colours/symbols might be used to describe these experiences?
3. In the area of COVID-19 how did the heroism narrative affect interpersonal relationships? Social reciprocity? Practices of interdependence?

Study Design

When I began imagining and thinking through this project, I imagined creating a space for HCWs employed in LTCHs during the COVID-19 pandemic to reflect on their experiences; how the underpinnings of the heroism narrative have framed their own understandings of the care labour they provide during the pandemic, and imaginings for the future of care labour in LTCHs as told by HCWs. The COVID-19 pandemic highlighted the voices of registered HCWs

(nurses and doctors), their demands for pay increases (Carter, 2021), and vaccination mandates for HCWs in various settings (Jackson, 2021). However, the demands, perspectives and responses of unregulated HCWs including PSWs working in LTCHs was largely minimized in much of the discourse.

Thus, creating a need to center HCWs working in LTCHs in their own story. A story that was utterly critical to one's human experience, but also the imaginings of care work for the futures to come (Tracy, 2013). The goal of this study was to engage in conversation and reflection with HCWs in LTCHs to center their stories, recounts, and experiences of providing care labour to the LTCH system throughout the COVID-19 pandemic; as well as how labels of heroism have further shaped their experiences of providing care. The initial aim of this project was to recruit 5 PSWs working in LTCHs to engage in a 1- hour group discussion on their experiences producing care labour. However, personal constraints shared by HCWs (time, personal hesitations) impacted my ability to recruit 5 participants. Therefore, this study engaged 2 PSW's aged 18 years and older in conversation and also included one self-reflective self-interview outlining my personal experiences as a Recreation Therapy Practitioner working in the LTCH system during the pandemic.

Each participant in this study signed a consent form outlining the measures taken to maintain their anonymity and confidentiality. The consent form outlined the steps taken to maintain confidentiality including personal pseudonyms and a data key that will be stored safely on a separate file on the researchers secured iCloud. As a thank you for their engagement in this process, participants were gifted with a $10 Tim Hortons gift card. It is important to note that recruited participants were previous colleagues. However, the formal invitation letter and

consent form outlined their right to withdraw from the interview at any time without conflict or pressure to remain in the study.

Photo-elicitation, narrative inquiry, and auto-narrative reflection through a semi-structured interview were used to generate data for this research. It was important for me to engage with methodologies that would facilitate thinking *beyond* traditional discourse and *through* imagery and story to further reflect upon their experiences as HCW's in LTC in a time of 'heroism.'

Photo-elicitation is a qualitative research method that uses photographs and art related to a specific topic to evoke deeper reflection and discussion around a specific topic (Harper, 2002). For this project, various images depicting healthcare workers as heroes, signs outside of LTCHs with messages such as "Heroes work here," drawings and illustrations of HCWs donned in superhero attire were utilized. Although healthcare workers are acclimated to these terms and images, discussing them as separate from the self, then returning these meanings back to the self, could provide a nuanced opportunity for further discussion. I also wanted to be mindful of the fact that at the time of writing, the COVID-19 pandemic has taken place for 24 months. These images could be distressing for some. Therefore, I encouraged participants to pause our discussions at any time to recollect themselves and decide if they would like to continue discussing these subjects. As a HCW myself, I have found respite in anonymous crisis lines (i.e. Good2Talk, Canadian Mental Health Association, Monreau Shepell) and I provided participants with a list of these resources upon completion of the interview should they require additional support afterwards. This list of mental resources is included in appendix F. I wanted to create a safe space for HCWs to ebb and flow through their emotions as they reflect upon their unique

experiences of providing care labour at this time (Kantrowitz-Gordon & Vandermause, 2015). However, I respect and acknowledge that this could be a tender process for some.

Although the potential existed for painful memories to resurface through the photo-elicitations, there were also benefits to consider in the use of this method. Kantrowitz-Gordon and Vandermause (2015) acknowledged that photo elicitation could empower the narratives of marginalized identities through its use of storytelling mediums. These narratives could foster a sense of community and comradery among healthcare workers who potentially felt as though their identity was fragmented and exploited. Thus, photo-elicitation held therapeutic value that traditional discourse might not have been able to engage. Harper (2002) states "... photographic studies of identity rely heavily on what is seen, raising the question of what parts of identity are not visible!" (Harper, 2002, p.18). Photo elicitation also took pressure off of the rigid boundaries of traditional discourse-oriented interviews, as it "[mined] deeper shafts into a different part of human consciousness than do words-alone interviews" (Harper, 2002, p.23).

I also utilized narrative inquiry for this project (Tracy, 2013). The qualitative method of narrative inquiry could provide researchers the opportunity to view and understand the stories that shaped one's experiences and perceptions of the world around them; through engagement in "interviews, oral tales, blogs, letters, or autobiographies" (Tracy, 2013, p.29). The unique stories of HCWs in LTCHs reflected their personal accounts of providing care labour during the COVID-19 pandemic. Though each individual story was unique, HCWs stories enacted feelings of solidarity at a time when social isolation and individualism have dominated the current state of care labour provision. Care labour in LTCHs was largely provided by genderacialsed bodies (Lopez, 2018). Thus, narrative inquiry also provided an avenue to further understand HCWs

stories that existed at the intersections of cultural and gendered identities and the unique role that this potentially played in how care is sourced and provided in LTCHs (Tracy, 2013).

Site

Due to the present risk that COVID-19 poses to public health, this study was conducted virtually through the use of the Microsoft Teams platform. Participants were contacted via email to arrange an appropriate time to conduct their interviews. Once a time and date had been agreed upon, I created an interview invitation via Microsoft Teams and sent the corresponding link to the participants via email. I consulted with participants prior to their scheduled interview time to discuss any questions pertaining to accessing the interview link and any questions about the technology to ensure that these are resolved prior to the interview date.

Data collection

This study was completed in one-on-one interviews with the participants though the Microsoft Teams online video platform. The interview guide was separated into four main parts: (1) Demographic information; (2) COVID-19 care provision and reflections of #HealthcareHero; (3) Photo-elicitation; (4) Perceptions of 'heroic' care labour and future imaginings. Research questions included:

1. How long have you worked in your current role?
2. What is your formal job title?
3. How do you self-identify? (Female, Male, non-binary, prefer not to answer)

Additional questions pertaining to personal reflection and photo-elicitation include:

1. After looking through the photos provided, I would like you to select 3 photos that resonate with you. What emotions and memories come to mind? Take note of how you feel emotionally and physically, what can you share about these feelings and experiences?

2. What does heroism mean to you outside of the COVID-19 context? Do you consider your job role to be heroic? Why or why not?
3. How have you been able to prioritize your own self-care and emotional needs during this time? Have current working conditions made it more challenging for you to care for yourself?

The full interview script is included in Appendix D. All participant identities were provided pseudonyms and will also be confidential in the publication or release of the study findings. A formal letter of appreciation was sent to all participants once the research had been analysed and interpreted. Key findings from the study were shared in the acknowledgment letter as well. The data was analysed by braiding together the key ideas that intersect from across the 3 interviews to create a community narrative of performative allyship and heroism during an era of COVID-19.

Analysis

This project utilized critical framing theory (Entman, 1993; Fridkin et al, 2017) to further contextualize the heroism narrative as informed by HCWs in LTCHs. Framing theory examined the various ways that discourse was positioned to benefit a particular group (Fridkin et al, 2017). Frames were heavily utilized within political discourse, but also supported society in developing their own perspectives and positions on a topic (Fridkin et al, 2017). This theory was important to understanding the lived experiences of HCWs who were feeling significant pressure to live up to the heroism narrative that was placed on them by politicians and their fellow civilians.

Framing theory consists of four key factors. According to Entman (1993), frames work to (1) define a specific problem by understanding common themes existing across cultural or societal contexts; (2) diagnose specific issues through analysis of its cause(s); (3) make moral judgments by identifying agents of communication and analyzing their effects; and (4)

suggesting remedies to treat the problem at its source and reflect on potential implications of these remedies (p.52).

Framing theory worked by amplifying certain positions, thus making them more salient and memorable to those who engage with these frames. Therefore, the widespread use of heroism to label and encompass care work at this time was associated with the specific frame that it had been positioned in by politicians, news outlets, and LTCH organizations. Frames also "[determined] whether most people [noticed] and how they [understood] and [remembered] a problem, as well as how they [evaluated] and choose to act upon it" (Entman, 1993, p.54). Additionally, frames could be adapted; taking on many shapes to meet the needs at a specific time and place.

Ultimately, by engaging in framing theory, researchers have been able to reflect upon present frames existing within a specific context and work to determine resolutions and remedies needed to reframe and ensure equity going forward.

Chapter 4: Heroic Reflections: Healthcare Worker Stories

"... I think [this is] a really important conversation that we need to have as healthcare workers working in long term care...our voices need to be heard because it's not an easy job... but we do it because we care. We do it because we value humanity, we value life."
- *CJ, February 2, 2022*

This chapter offers a discussion of the results from research interviews conducted for this project on heroism in healthcare work in an era of COVID-19. A detailed sequence of events prior to the interviews can be found in Appendix A. I connected with past colleagues with whom I worked in a LTCH, provided detailed information outlining what the process would entail, and followed up with an email invitation. After speaking with numerous colleagues[1], Dahlia and Lorna agreed to engage in this process. Initially, I had intended on completing this process with a maximum of five HCWs. However, I understood that at the time of writing, HCWs were feeling the effects of burnout, grief, and fatigue among other things. Therefore, I respected the fact that my advertisement would not garner a larger response. As a result of this, I also engaged in the research process through auto-narrative qualitative methods (Austin & Anderson, 2012).

As stated in the methodology chapter of this thesis, qualitative methodologies including narrative inquiry, auto-narrative inquiry, semi-structured interviews (Tracy, 2013), and photo-elicitation (Kantrowitz-Gordon & Vandermause, 2016) were used for this project. A semi-structured interview guide was created and included a range of interview questions which asked about HCW wellbeing, heroism labels and status, and future imaginings for the LTCH system in Ontario. The full interview guide can be found in Appendix D. These questions garnered various responses further detailed later in this chapter.

[1] To protect the identity of those involved in this research project, a pseudonym has been assigned to each study participant.

Box 1- Personal Reflection

Prior to engaging in this thesis project, I had never conducted research. This thesis opened new doors for me; both personally and academically. It required me to tap into new ways of knowing myself, the spaces that I take up, and the systems I exist and work in at large. Academically, it opened my world to the importance of conducting research, asking hard questions, and challenging traditional ways of thought for the sake of restructuring discourse and bringing to the center new ways of considering, engaging and resisting systems of neoliberalism and capitalism. Thus, setting the foundation for further inquiry in the future.

Throughout this process I had the full support of my thesis supervisor who not only supported me as I learned about various topics related to care, but also as I developed my praxis. Together we challenged my understandings and created new paths for me to gain knowledge, dig deep, and produce a meaningful project. I was nervous that with this topic being so personal to me, I would feel residual emotions from study participants. And though this did happen at times, I also gained so much.

In a world where HCWs are tasked with "putting on a brave face" and moving through the challenges of work and life, the photo-elicitation component provided a space for HCWs interviewed to engage with emotions that do not have words. Bearing witness to that was very impactful for me. Hearing how one image, or comic strip could put entire experiences into perspective for participants made me feel as though this project was truly doing what I had intended for it to do; it was providing a space for HCWs to tend to internalized stories, and express them outwardly.

Initially, I had planned to host a group interview but later decided that 1:1 interview could better accommodate HCWs evolving schedules and create a "safer" space for participants to share their opinions and experiences confidently and without the influence of others potential judgment. Through narrative inquiry, we could engage in conversations about systems of belonging, community, and interdependence (Glover, 2003). As Aurora Levins Morales (2019) states about story sharing and community in her anthology *Medicine Stories: Essays for Radicals*: *"*one after another we said variations of the same things, and slowly comprehension dawned that what we had been experiencing as personal shortcomings were the markers of a shared social oppression. We were just fine. Our situations were not" (p. 42). Narrative inquiry (re)centers areas of tension, injustice and oppression and empowers individuals to come together to imagine new futures.

Additionally, asking participants what they would want to see as the provincial government works to rebuild the LTCH system, provided HCWs who are largely considered invisible a space to share their hopes for the future. Though I do not have the personal power to make these changes, I can make smaller impacts by creating space to speak and feel heard. One participant, Lorna, acknowledged my ability to gather the words that she at times, could not find. This was our brief conversation together:

> Lorna: Exactly... Exactly. My God. You said it perfectly, like why aren't you a writer? [laughs]
> Crystal-Jade: [Laughs]
> Lorna: Oh, my heavens my dear. If I had the eloquent... the eloquence of you, you know of saying these things.... I'm like stammering and stumbling here Crystal.
> Crystal-Jade: But that's my very amazing role in this, I get to put all of the lovely pieces together and bring a really lovely story together. I am so happy.
> Lorna: Good, thanks again.

Through listening to the voices of others, I have found home, comfort, and an eagerness to do more.

Findings from Interviews

Dahlia

I first approached Dahlia about project in early January 2022. Dahlia and I worked together at my previous LTCH and she quickly became a dear friend. I knew that her extensive experience in providing care, nursing, and her experience providing care both in the Philippines and Canada would add a nuanced response to these questions; as culturally, healthcare provision varies from context to context. Dahlia worked in healthcare since 2012 as both a nurse in the Philippines and a Medication Certified Personal Support Worker (Med Cert. PSW) here in Canada. As a BIPOC migrant female, Dahlia exists at the intersection of multiple marginalized identities[2].

The interview began with us discussing the ways that she feels her job has evolved at this time. Dahlia reflects on the fact that working on a memory care floor in a LTCH demonstrated nuanced challenges imposed on resident care during outbreak situations. Specifically, as a Med Cert, she was responsible for overseeing the care of all residents- including hygiene care and providing medication. Constantly having to change PPE and remind residents to stay in their rooms was especially hard for her on the unit that she was assigned to.

> *Well, like, everything changes. Like, how we deal with our residents now in long term [care]. For example, we have to [give] extra care for them as well, because since there's a pandemic we have to be [precautious]. I'm assigned to a Dementia floor, so it is a little bit challenging for us to care for them.*

Memory care floors housing residents living with Dementia and Alzheimer's Disease required an additional level of care and support. Due to the effects of this disease on autonomy, and

[2] Marginalized identities refer to identity groups that are oppressed as a result of social systems, structures, and power relations.

decision making, care was significantly more involved and left minimal room for social distancing and other measures enforced to mitigate risk.

Upon being asked how the heroism label has impacted her work at this time, Dahlia shared that for her, it was a boost of confidence that kept her feeling determined and willing to engage in the work and do it well. She states:

> *... It uplifts. We are more encouraged to work as well, and we feel like we are appreciated. Like when they call us a hero, it helps us more to be determined in working. Because especially with this pandemic, sometimes you have to choose either you have to protect yourself from the residents who have COVID or, you're gonna get sick caring for them.... so, I think it uplifts... our self-esteem and gives us the determination to work harder.*

However, Dahlia shared that she has always felt like a hero in her job, simply because it requires a subset of skills and specialities that other people do not have. Going into work each day and doing her part to keep residents safe reinforced characteristics of heroism for her and this feeling had always empowered her to do her best. Dahlia recounted going from working 35 hours bi-weekly to over 100 hours bi-weekly during outbreak situations and reflects on the impact this had on her ability to engage socially with others and prioritize rest. During times of significant exhaustion, she wished that there were better staffing supports in place to mitigate the over-working of her and her colleagues during outbreaks.

During the photo elicitation aspect of the interview, Dahlia was invited to select three photos that resonated with her in some way. Dahlia chose the following three images.[3]

[3] All images utilized for this research study are located in Appendix G.

We are strong.

This image depicted a HCW standing in the window of a LTCH with the words "We are strong" taped up in large font on the front windows. Dahlia chose this image because she believes that HCWs must be strong in order to do this job, do it well, and overcome this pandemic. Dahlia proceeds to share what strength looks like for her and why it is so important:

> *We have to be strong, physically, emotionally, and psychologically. Especially right now, since the pandemic, a lot of people need our help... So, I think we have to be strong to overcome this thing... If we're not gonna help, if we're not gonna be strong then, we might not overcome, and we might not adjust to this kind of pandemic and we might just be depressed. We're not going to be healthy mentally and physically. I think that's a good portrait to encourage everyone not only health workers, but everyone who experienced this pandemic.*

To her strength was not solely characterized by strength of the physical body, but also strong mental health and determination to work and overcome challenges.

Doctor in full PPE Consoling an Elderly Man.

This image depicted a doctor dressed in full PPE consoling an elderly man by embracing him in a hug. The doctor stares blankly as he hugs the man who is COVID-19 positive. Dahlia shared that this image reminded her of the residents that she had supported throughout the pandemic. She reflected upon the loneliness that they felt and the added responsibility of HCWs to support their emotional wellbeing due to ongoing visitor restrictions and limited access to their larger communities:

> *They're already sad, already lonely even prior to [the] pandemic. And now that the pandemic strikes, the more that the family members can't visit them. You know, everybody is worried [for] themselves... so we are the only people who [are] in there to comfort them... Sometimes I'm not afraid to comfort them physically. Even though in the back of my mind I might get [sick], I think it will help them more. It will uplift them [and] make them feel like someone is there for them.*

Dahlia also reflected on the loneliness that she felt after testing positive for COVID-19 last year, and how her personal experiences of isolation and healing helped to inform her work further:

> *I experience having COVID-19 and it's so hard that you're far away from your loved one even though you're staying inside the one house you still have to isolate in another room. It's really depressing. It's very stressful and everything and so feeling that way, I also put myself in their shoes, you know?*

Healthcare Worker Donned in PPE with Bicep Curled.

Dahlia selected this photo because it reminded her that *"we can do this."* Dahlia firmly believed that with collective action, grit and determination, along with adequate resources and facilities, societies can overcome the COVID-19 pandemic. She also concluded that this collective action will prepare societies to mitigate future pandemic crises as well:

> *We should be one... we can do this all together, you know? The next time we will be stronger... we are stronger, we know better now.*

Dahlia chose multiple symbols of strength; as she believed that strength was the most integral tool to overcoming the challenges being faced by HCWs and the LTCH system at this time. When asked what Dahlia would want to see in the future from the LTCH system, her answer involved stronger staffing supports to prioritize rest and decrease burnout, and simply having the choice to say no when she feels exhaustion:

> *Since we're all giving our best, we might get the disease [ourselves]. So, they must have backup relievers for staff members. So, no retirement home or long-term care home will be vacant. You know what I mean? And there will be no burnout.*

Dahlia's experiences reflected her personal interpretations of heroism discourse used during the COVID-19 pandemic. For her, this label provided her with the strength and determination that she needed to continue supporting her residents. However, this is not without acknowledging the need for greater staffing supports and adequate resources in order to ensure the safety and well-being of herself and her team members.

Crystal-Jade

For this research study I engaged in a self-interview, otherwise known as an auto-narrative interview. In doing so I was able to ask myself the same questions asked to both Dahlia and Lorna. I am grateful that I had the opportunity to engage in this process and found it to be therapeutic in supporting my understanding of how the heroism label has affected my work in position with other HCWs providing care in LTCHs.

I have worked in LTC since 2019 as a Recreation Therapy Assistant (RTA). I identify myself as a marginalized person as a Black woman. I acknowledge that in numerous ways my experience is different because I worked in an entirely different role in relation to the two PSWs that I interviewed. I expressed that the constant change in my job duties during outbreaks made it challenging for me to ensure that the holistic needs of my residents were being met:

> *...we've gone through periods where we provided no programming at all because the main focus was of course keeping residents alive during outbreaks...I think that our field has become incredibly adaptable, but it's also very discouraging to see the many ways that the absence of our work impacts resident care... during a time of heightened social isolation amongst older adults, limited access to family, friends and essential caregivers in the larger community, it is really disheartening to sit back and witness further isolation occur as a result of not being able to engage with people in the ways that I am used to traditionally.*

I acknowledged the adaptability and tenacity of Therapeutic Recreation Practitioners at this time. One evening out of sheer frustration over the lack of regard for the integral role of Therapeutic Recreation in LTCHs, I made this tweet:

> *Check in on your friends working In [LTCHs], some of us are struggling. Also... check in on your friends who are Recreation Therapists working in LTCHs. Our job never seems to make sense to anyone and it's exhausting constantly having to prove your worth.*

It felt like an incredible task trying to justify why my job mattered and why, during a time of increased public health risk to older adults living in LTCH, it mattered even more.

I recounted what it felt like to be labeled as a hero in 2020; for me it felt like an honour to be trusted so heavily with the lives of others. However, as time went on it began to feel as though we were not allowed to voice our concerns, to feel the need to protect ourselves without being punished or intimidated for it. These circumstances made me feel weak and slowly how I came to understand heroism changed. I no longer wanted to be a hero if it meant having to leave my concerns for myself aside. I do not want to be celebrated as a hero. I found the use of heroism in this context to be oversimplified and hurtful. Heroism meant something completely different to me: "*Heroism is a collective effort. It happens when a group of people come [together] from different spaces, acknowledge that there's a crisis and work together in order to mitigate that crisis."* Additionally, to be celebrated as a hero during this pandemic is challenging to accept. If we were not there to do the work, would anyone else?

This pandemic has likely felt like the loneliest period of my life; and like many other HCWs, it was hard to explain what we witnessed with others who did not and could not understand what it felt like to work in these spaces. The lack of understanding that I felt from friends and family drove me further into isolation and made me feel angry that I was experiencing something that they did not have to:

> *People who aren't working in this space don't understand how exhausting it is and how normal [it is] to regularly question [whether] we want to continue working in this space. And I think that we should be free to express those concerns without being reminded of the work that we still have to do... I do decide often not to share anything. I place myself into a space of isolation voluntarily as a means of protecting my mental health.*

Ultimately, when reflecting on moments of heroism in my own life. I acknowledge that working in this LTCH system as it stands right now is a courageous and compassionate act. However, I also *"feel like an imposter to myself, because although I am giving [significant parts] of myself to this system, I am depleting my own wellbeing in order to do so."*

During the photo elicitation component of this interview, I chose and discussed the following three images:

The compassion and care shines through.

I chose this image because the sentiment is true. During my first outbreak experience, I worked on a memory care floor supporting individuals living with various stages of Dementia and Alzheimer's Disease. Our approaches to care relied heavily on the use of tone of voice, body language, and eye contact along with verbal and visual cues. It was incredibly challenging providing care while donned in full PPE. We (HCWs) were unrecognizable. However, we had to

develop and think of new ways of providing compassionate care and in these moments, I realized that compassion is an embodied trait. It must govern my work and influence my practice. It was important for me to demonstrate to residents that we were there to care for them regardless of the barriers imposed on our full ability to provide meaningful care.

> *"...when I lost my ability to smile for residents, I felt like I lost my ability to connect on a deeper level. And so, during those times I had to establish different ways of allowing my compassion, my love and respect to shine through.... no matter how many layers of protection you wear that compassion and care shines through."*

Doctor donned in full PPE consoling an elderly man.

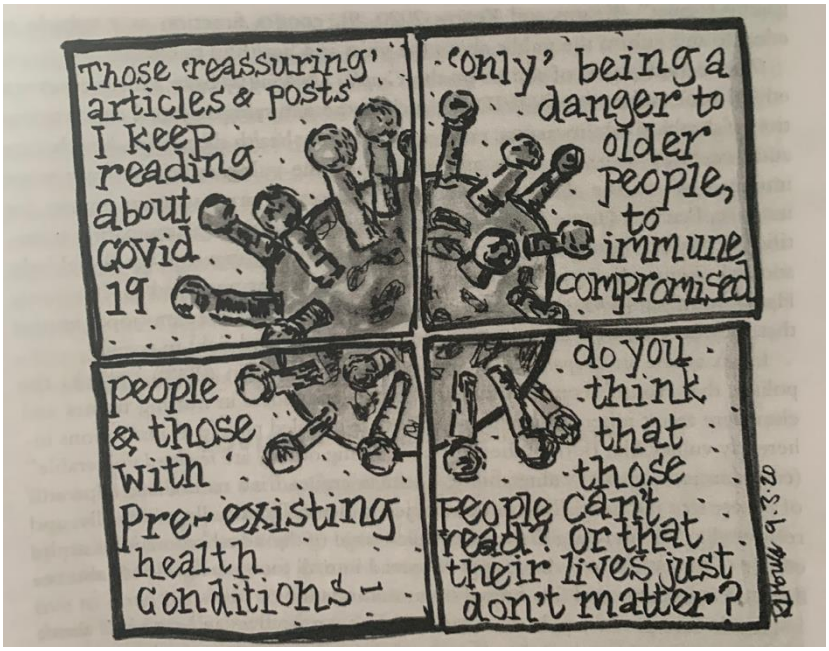
I remembered looking at this image on an Instagram account called Artists4LongTermCare[4] and feeling immediately drawn to the duality of pain and numbness that exists within the doctor's eyes. It felt very familiar. There were times throughout this pandemic that left me speechless. I had no words of encouragement left to share, but I had love and compassion to give in other ways. The

[4] Artists 4 Long-Term Care is an Instagram Account that highlights art and imagery pertaining to LTCHs and those existing within them during the COVID-19 pandemic.

pain came from two years of feeling stuck in a situation that caused fear, pain, death, and separation. The numbness came from not knowing where else to go forward with that pain. As a Recreation Therapy Practitioner working in a LTCH, I have held many hands, consoled many family members over Zoom and FaceTime, but I knew there would come a time when I had no words left to share. Looking at the image of this doctor, I viewed the doctor as a pillar of strength. Someone dedicated to doing the best that they can in every moment. And sometimes that *best* looks like giving someone a hug. No words, just an embrace, an opportunity to let feelings flow:

> *...I think that recreation in Long Term Care, they place a lot of emphasis and a lot of pressure on us to make people feel happy and joyful all the time.... and while I think that is so [important], I think it is so [important] for people to feel joy and happy and [comfortable] where they live, I think it is also very important for us to honour when people feel scared, sad and in distress.*

Comic on COVID-19 being an "old persons" disease.



The last image that I chose for my photo elicitation component was a comic strip with the following phrase:

> "*Those reassuring articles and posts I keep reading about COVID-19 only being a danger to older people, to immune compromised people, and those with pre-existing health conditions. Do you think that those people can't read, or that their lives just don't matter?"*

I resonated with this one the most because of how well it portrays the stigma and perceived worth of older bodies. Especially those living in LTCHs. Overtime, citizens became desensitized to severity of this public health risk. They found comfort in calling this an "old person's disease." However, the "othering" of older adults in this way made it even more challenging to manage the risk of this pandemic on elder lives. To me, it demonstrated a lack of community care that has lingered throughout this pandemic. It also reminded me of how we as a society have always come to understand older lives and caregiving:

> *Disparities [in the LTCH system] and other challenges aren't new things. They didn't suddenly happen as a result of the pandemic. They were always lingering in the background waiting for some sort of stage to bring them to the center and show the truth of what's really been happening within this system for a really long time.... real protection has never been in place for older adults living in long term care.*

My personal reflections added a nuanced voice to this research. I positioned myself in alignment with the HCWs that I interviewed because together, we shared a collective story. This interview brought to the surface experiences, questions and memories that I had otherwise repressed. It reconnected me with my work in a way that felt both humbling and impactful.

Lorna

Lorna and I met while working at my previous LTCH. Lorna is a PSW and has been working in the LTCH system since 2020. Lorna's story is unique, because at a time when many might have resisted the thought of working in a LTCH, she saw it as an opportunity to start fresh and tap into an old passion. That passion being caring for people. When I approached Lorna and asked her to partake in this project, she said yes without hesitation. Upon receiving her verbal consent, I followed up with an email invitation and from there we arranged a time to meet and engage in the interview process.

Lorna did not consider herself to be a hero. Especially during the COVID-19 pandemic. When Lorna thought of heroism and heroes, she thinks about the superhero characters portrayed in movies and television. Instead, she saw the job of caring for others especially her residents as a compassionate act, which requires her to *"put [herself] aside and look on and just barrel through every day."* To her, working in healthcare was just as important to her as anyone's job is to them. And while being called a hero potentially encouraged some to work harder and show their pride, Lorna was more concerned with ensuring that her residents receive the best care possible:

> *These people deserve the best care and the best relationships. The best of everything because they've already put all of their time in this world and they have decided to bring the ending of their life to us. Well, let's give them that ending. But I don't look at it as a heroic act.*

Lorna recounted going from working 30 hours bi-weekly, to working nearly 100 hours in a bi-weekly period during outbreaks. She remembered at the peak of an outbreak at her LTCH feeling as though everyone around her was working in silo's. And at this time, she did the best that she could to keep her community of colleagues together:

> *At times you felt like you were the only one... you see your team members, and everybody looked like they were just kind of on their own at times. And I remember, you know, every chance I could I try and pick somebody up saying either something funny or just being a support because we were all in there drowning together.*

The following portion reflects the images that Lorna chose for the photo-elicitation component of this interview.

The compassion and care shines through.

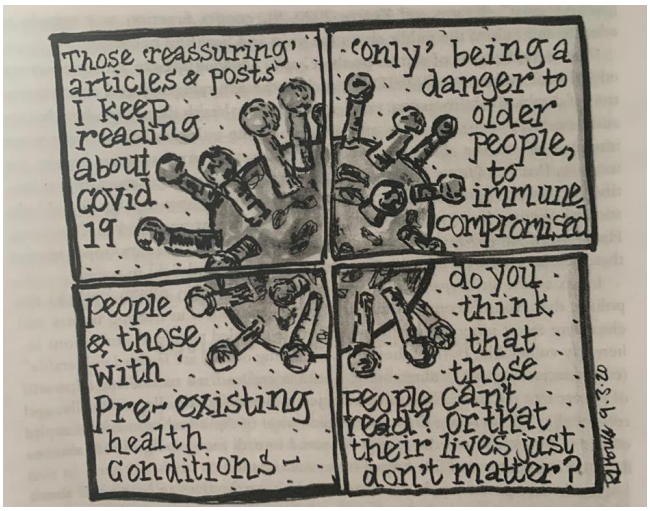
Lorna chose this image because she wishes that she saw more displays of compassion towards residents in LTCH. She felt as though true heroism exists in the compassionate moments that are provided to residents, and that present approaches to resident care within congregate settings lack the compassion needed to truly provide residents with the care that they require. *"That's what a hero is. You know. They sit down with these people and they let them share their lives."*

Don't Forget Us.

Lorna chose this image because throughout the pandemic she felt as though residents knew that they had been forgotten by policy makers and public health officials. She especially felt this in the ways that her and her colleagues were stretched thin by their workload. Lorna recounts feeling concern that her very efforts to keep residents safe, could have single handily placed them at greater risk of contracting the COVID-19 virus:

> *There wasn't enough of us to go [around]. There was to many of them and not enough of us. And we're bouncing around and half of the time we were probably taking the COVID right to them... So that kind of, that hit hard.*

Comic on COVID-19 being an "old persons" disease.



Lorna resonated deeply with this image. When looking at the message attached to the image, she thought about the time she has spent working on a memory care floor. Although her residents did not always fully understand the severity of the isolation measures and COVID-19 at large, she could still sense their fear, anxiety and concern. And for her, as someone who fully understood the intensity of this virus, she could not help but feel as though at times, her and her colleagues partially added to the concern that her residents felt. Additionally, she shared how her resident's inability to fully understand the context of this virus added to their feelings of isolation and invisibility. She stated:

> *...because we're saying no, you gotta get back inside because you know you're gonna get sick and they didn't even understand what we were talking about...like they basically said, well you guys are gonna die and there's nothing we can do about it. Well you know what? We did everything we could to keep them going ... that really just put the health care workers to the ground, didn't it?*

Lorna's sentiment on invisibility made me think critically about the framings of heroism, age, and identity. Especially within the context of caring for older adults living with Dementia and Alzheimer's Disease. This was my brief response to her previous statement:

> *... and so even talking about supporting residents living with Dementia and other forms of brain change. It's like there's also that sense of invisibility. You know to the outside world, and it's like, [older adults] were already forgotten pre-COVID. And now we add this nuance to it, and people feel even more invisible and more forgotten. How do we... how do we support people when we know how society [sees] them? When we know how the healthcare system frames them? It's like [healthcare workers] are the 1%*

Lorna and Dahlia's interviews were impactful and a sheer demonstration of the grit, tenacity and resilience that HCWs have had to display over the last 2 years. It was interesting to notice how little the heroism narrative has impacted their work. It is evident that their concern has largely been centered around resident care, safety and well-being.

The second chapter of this thesis outlined some of the potential avenues that the heroism narrative has taken and how these avenues may continue to pave in post-pandemic worlds. First, the idea that performative discourse was utilized as a prop to 'mask' shortfalls in pandemic policy is identified in the interviews. Dahlia and Lorna recount working over 100 hours during outbreaks and feeling significant exhaustion as a result. It is clear, that even 'heroes' need breaks, respite, and community. Despite the discourse that has enveloped care labour at this time; which encourages HCWs to give as much as they can to sustain the greater good.

Second, thinking through the sustainability of heroism discourse in an era of COVID-19 caring labour. Themes of social valorization and performative allyship have been demonstrated by

politicians, the LTCH system, organizations, and media during this time. The sudden spotlight placed on HCWs enables workers to question the true validity and purpose behind the widespread attention. However, it is evident that Dahlia, Lorna and I do not see much of a difference outside of the label and discourses of heroism. We are still asking for supports that we have asked for long before COVID-19 became a public health crisis. Including, wage increases, paid sick days, stable hours, and greater respect. Participants did not feel as though their position within society will change significantly once the COVID-19 virus is no longer an imminent risk to public health and safety. However, this did not bother them.

Lastly, the paradox that exists between heroism and (In/Hyper)visible identities. Lopez mentions that care labour is largely produced by genderacialised bodies (Lopez, 2018). Furthermore, HCWs are at significantly higher risk of illness on the job as a result of the intimate nature of their jobs. Yet, care work continues to be regarded as invisible, "dirty", and "unskilled" labour. Despite its critical role in collective safety (Godderis & Rossiter, 2013). Socially constructed ideologies of care work, as well as systems of capitalism, neoliberalism, racism, and gender discrimination perpetuate low-pay and dangerous working environments for HCWs. Additionally, care provided by PSWs, recreation staff, dietary staff and housekeeping is unregulated and further confines feelings of unfulfillment to the individual. Knowing this, framing care work as a heroic act appears to be a strategic tactic aimed at uplifting one's personal sense of output for the sake of alleviating pressure on an already crumbling healthcare system. As stated by Gary & Berlinger (2020) "we celebrate COVID-19 carers as "heroes,' but we failed to care for them in advance of the catastrophe through adequate pandemic preparedness and early response" (p.56)

The participants interviewed for this research study shared humble recounts of gratitude and appreciation for the work that they do each day to support residents living in LTCHs. However, it is

important to recognize the ways that heroism supported the over production of labour during the COVID-19 pandemic, ultimately resulting in limited opportunities for rest, healing, and care for the self among HCWs. These findings support further knowledge and understanding of how heroism has been framed as an act of care and ultimately, an act of selflessness. Of which, further perpetuate dangerous working conditions for care workers.

Chapter 5: A Return to the Map: Contextualizing for Further Direction

This chapter marks a return to the literature and theories that have supported this thesis. The content is further categorized into two sections; section one: framing; and section two: contextualizing.

Section One: Framing

Framing theory suggests that messages are positioned in a way that attends to the needs of a particular group (Entman,1993). This thesis used framing theory to further understand how the heroism label has been positioned by the government and LTCH organizations to further extract labour from HCWs in order to mitigate the public health crisis currently present in LTCHs. According to Entman (1993), framing theory occurs within 4 key frames; (1) to define a specific problem by understanding common themes existing across cultural or societal contexts; (2) diagnose specific issues through analysis of its cause(s); (3) make moral judgments by identifying agents of communication and analyzing their effects; and (4) suggesting remedies to treat the problem at its source and reflect on potential implications of these remedies (p.52).

Define the problem

Heroism labels were used broadly to categorize HCWs during the COVID-19 pandemic. The healthcare system faced significant challenges due to the persistent public health crisis which subsequently placed HCWs at the forefront of this crisis situation. This label reinforced the idea that HCWs are solely responsible for the collective wellbeing of their communities. Placing the significant responsibility of maintaining public health on one group of individuals is harmful, exploitive and unrealistic. In tying heroism to the complexities of this scenario, this discourse either works to empower people to continue working or creates feelings of confusion, isolation, and exhaustion. Although certain participants in this research study shared that they either did not feel negatively about the heroism label, or that it provided them with a sense of

encouragement, HCWs are continuing to share their frustration, concern, and resistance on larger social stages including social media platforms and news outlets. HCWs and researchers including Birgit Umaigba (Umaigba, 2021) and Dr. Naheed Dosani (Dosani, 2021) have spoken out publicly on the lack of responsibility on part of the provincial government to care for and protect elder lives during this time of significant crisis, and their lack of respect for care workers. Newspaper articles attending to the repeal of Bill 124, which placed a cap on wages for HCWs across the province demonstrate a deep dissonance between the framings of heroism, its inherent displays of appreciation for HCWs and how HCWs have genuinely perceived the label of heroism during the COVID-19 pandemic.

Diagnose specific issues through analysis of its cause

Generally, many HCWs have resisted the label of Hero during the COVID-19 pandemic. Specifically, participants in this study have felt conflicting emotions and thoughts surrounding the heroism narrative. At this time, it is hard to determine whether or not the use of heroism was for the purpose of appreciating the hard work and dedication of HCWs, or if it was utilized in a way that placed greater responsibility on HCWs to work longer hours with minimal wage increases, little time off, and limited opportunities to care for their bodies. Dahlia and Lorna both express wishing that there was an incentive provided to PSWs working in Retirement Homes as there were for those working in LTCHs since they are doing the same job and tasked with providing all residents with the same level of quality care. The lack of genuine action and support on the part of the provincial government- in the form of fiscal support, greater mental health support, and paid sick days has made many HCWs question the genuine purpose of the #HealthcareHero label.

Make moral judgments

When the pandemic was declared in Ontario on March 17, 2020 (Ontario News Room, 2020), little was known of its severity. As cases continued to present in Ontario, it became clearer that perhaps, the initial two-week state of emergency would not be a strong enough resource to mitigate the impact of COVID-19 on public health. It was also evident that further support (i.e. healthcare, federal funding and militant resources, restrictions for LTCHs) would be required to act against this virus. This is when the province began to see a strict set of guidelines created for the LTCH sector specifically. Some of these guidelines included requiring all HCWs working in more than one LTCH to be strictly placed at one until further direction was given, limited visiting capacity for family members, friends, and private caregivers, and mandatory COVID-19 PCR testing for all team members. At the height of the first wave, with so much uncertainty, HCWs continued to go to work and 'battle' an invisible virus. Additionally, the LTCH system began to see declines in staffing which posed as another risk to the health and safety of residents. One may say that this choice, to continue working in the midst of uncertainty is an act of heroism. In the weeks leading, the label of #HealthcareHero could be seen on lawn signs and heard in the media. And shortly thereafter, the $3/hour hazard pay incentive was created for PSWs, nurses, dietary aides, and environmental staff working in LTCHs[5]. It can be morally and critically considered that initially these actions were demonstrated out of appreciation for HCWs. However, once personal choice became tied to shame, guilt and isolation, the narrative took a different turn.

[5] Initially, the Hazard Pay incentive did not include Therapeutic Recreation Practitioners (TRP) working in LTCHs and Retirement Homes. However, after advocacy and communication between Therapeutic Recreation Ontario and the Provincial government, this was amended to include incentives for TRPs.

Suggesting remedies: Looking forward towards new frames

Throughout the interviews conducted, participants shared many imaginings for the future. (1) greater pandemic preparedness policies for LTCHS aimed at supporting and protecting life. (2) Improved staffing resources to mitigate burnout and exhaustion. (3) Positive regard on the part of the government for residents living in LTCHs so that they too can be decentered from ageism and stigma that has governed the quality of care provisioned throughout the COVID-19 pandemic. Ultimately, greater accountability on the part of the government to ensure resident and HCW safety is imperative to ensuring that the label of heroism steers away from performative allyship and towards a collective understanding of the supports needed and worth of the work.

Section Two: Contextualizing

The main themes of the experiences of HCWs working in LTCHs during the pandemic can be further broken down into three main categories: sacrifice, moral injury, and inherent risk. The section on sacrifice will address what sacrifices have been attributed to the heroism label including the sacrifices of health, self-care, and community. The second section, moral injury, will address the underlying theme of moral injury existing within care work and the amplifications of this through heroism discourse. This section will touch on ideas of interdependence versus capitalism and the overarching burden that it presented to HCWs during this time. The final section will discuss inherent risk and underlying themes of heroism.

Sacrifice

Care labour is driven by duty to care policies (Ruderman, et al, 2006; Godderis & Rossiter, 2012) that require HCWs to attend to their jobs fully even if severe risk to health is present. However, the result of sacrifice during this time is multifaceted and too complex to fully articulate. HCWs have not only sacrificed their own safety, but they have also suffered from isolation, lack of rest, and disconnect from leisure. All of which, are crucial to tending to the

holistic needs of the body, mind and soul. Bayerle et al. (2021) state that HCWs are "shouldering a great burden of duty during the current pandemic" (p. 315) in relation to how much of their personal wellness they have had to neglect in order to care for "...the elderly, the weak, the disabled, and the sick, [and their] entire society" (p.315). It has not been an easy feat and the wellbeing of care workers has become significantly impacted as a result of this.

Although differing positions remain regarding the sacrifice expected of HCWs during times of crisis, HCWs are navigating larger questions surrounding whether or not this level of sacrifice is sustainable in post-pandemic worlds. Specifically, in my auto-narrative interview, I challenge my own understanding and experiences of working in LTCHs at this time and question if the level of stress, pressure and responsibility is one that I can continue to support in the future:

> *... I fell in love with Long-Term Care in 2019 and my time in this space has been very short and there's so much more that I wanted to do. But I think there are so many barriers in place and also personal traumas in place that impact my ability to continue showing up in this space.*

The personal toll that this pandemic has had on HCWs ability to engage in self-care practices was also demonstrated in the literature. Dahlia and Lorna both expressed the fact that their number of hours worked in a bi-weekly period nearly doubled during outbreak scenarios and how this was associated with significant feelings of exhaustion. This was largely due in part to the limited staffing supply and shortages taking place throughout the province. Mills et al (2020) explain that self-care requires "self-awareness, self-compassion, and the implementation of a variety of strategies across physical, social, inner self-care domains" (p. 1138). However, they reflect upon the ways in which personal feelings of shame and guilt for attending to personal needs has impacted HCWs ability to attend to their personal needs and health during this time. They suggest, that rather than making self-care a personal responsibility, it is up to the

organizations HCWs work for to create spaces that are collaborative in nature and foster a sense of support and room for HCWs to tend to their humanity outside of the labour that they provide.

Moral injury

Tying closely to the theme of sacrifice is the theme of moral injury. Moral injury is referred to as decisions that potentially go against a prescribed list of expectations in accordance with a specific job role. Heroism is tied heavily to our collective understanding of moral injury and duty to care policies at this time. HCWs interviewed for this research study spoke heavily of the responsibility that they had to residents in ensuring their safety and wellbeing. This included working nearly double the number of hours that they were used to during situations of heightened stress and outbreaks. It is understood that rest, leisure, and community help to support holistic health; and this is especially true during periods of heightened stress and overwhelm. However, HCWs recount feeling guilt and shame for seeking out these moments to tend to the body. Feelings of guilt and shame might be reinforced by inadequate mental health support and cultures of overproduction that occur within healthcare settings. Hines et al (2021) suggest that in order to demonstrate the harm of prolonged moral injury on HCWs, tying similarities between tending to the physical body when ill or exposed to highly transmittable diseases, and tending to the emotional elements of self when moral injury is present. However, this is not enough to address the hyper-focus placed on HCWs to fix themselves and return back to the workforce. To be successful in any attempt at mitigating the impact of moral injury on occupational health, organizations must understand the critical role they play in either worsening or decreasing experiences of moral injury by supporting HCWs to seek appropriate support-including community, leisure and rest.

Neoliberalism and ‘neoliberal violence’ (Lohmeyer & Taylor, 2021), have exposed some of the existential components to moral injury. Neoliberalism involves requiring citizens to seek

personal success through individualism. Thus, creating competitive work environments that devalue HCWs who seek to resist exhaustion and rest. The COVID-19 pandemic has demonstrated the harm of neoliberalism within the healthcare sector. This is demonstrated through the use and framings of heroism by media and politicians. Neoliberalism has supported the economic needs of the healthcare system at this time by supporting the notion of one hero/ine one for the safety of all. Discourse that acknowledges HCWs for "putting their lives on the line" (Lohmeyer & Taylor, 2021, p. 630) limited opportunities to cultivate co-operative, interdependent systems aimed at collectively mitigating the COVID-19 public health crisis. Furthermore, Lohmeyer and Taylor (2021) state that heroism further enables neoliberal rhetoric that advances economic needs: "...the superhero figure has become a stable mythology that comes to represent fundamental beliefs about neoliberalism, that they are 'removed from discourse of pure nationalism and comes to present a universalized ideal in the context of global capitalism'" (p. 630). Future considerations aimed at mitigating neoliberal violence for the next pandemic included adequate pandemic preparedness policies, proactiveness, acknowledging the severe impact of neoliberalism on collective wellbeing by reflecting on the implications of neoliberal violence of BIPOC women and feminine presenting HCWs who, historically, have been disproportionately affected by public health crises' (Bazzi et al, 2021; Gary & Berlinger, 2020; Hines et al, 2021; Lohmeyer & Taylor, 2021).

Inherent risk and underlying themes of heroism

As stated previously, duty to care policies as well as professional ethics govern healthcare as a field of practice. However, ethical and moral framings of care created areas of blur regarding what is acceptable, and what HCWs can rightfully resist in the workplace. During the research of this thesis, participants continued to discuss that caring for others even in the face of imminent risk is a routine part of the job that must be accepted. Tying this to present heroism rhetoric, it is

determined that the present risk associated with care provision at this time is rooted in obligation and responsibility. However, personal fear for safety is a natural embodied experience, and fight or flight responses during moments of stress have also been part of the human experience since the peak of Darwinism. Yet, HCWs were often required to become desensitized to their own needs in order to prioritize the needs of those they care for. Heroism discourse further extracted care labour by encouraging HCWs to focus on doing what they could for the humanity of others; Even if personal risk is presented to them. Perhaps the question remains then, why do HCWs continue to work in spaces that are increasingly dangerous, knowing the potential outcome that it could have on their health? There is no straightforward answer to this; yet, taking a closer look at some of the larger systems of oppression that influence identity and worth of carers is imperative to understanding the nuanced challenges that HCWs face in resisting dangerous and exploitive working conditions.

Care labour produced both in both institutionalized and domestic settings is largely taken up by BIPOC, migrant women and feminine presenting bodies who are often afforded low pay, limited labour rights, and are without the support of professional regulatory bodies (Lopez, 2018; Bahn et al, 2020). This creates nuanced opportunities for organizations to determine pay, time off, and support precarious work. Additionally, given that care labour is largely considered invisible and dirty work, this position in relation to care workers sense of self further supports the idea that HCWs who are traditionally unseen within society would feel empowered and determined to work harder and support the healthcare system if their ‘heroic’ contributions were acknowledged, centered and celebrated.

Conclusion

This thesis project demonstrated the myriad ways in which heroism discourse influenced and governed care work at this time. In tying human experiences to empirical evidence, it was apparent that the heroism label has impacted the lives of HCWs in ways that would continue to be felt long after the COVID-19 pandemic is over. Although HCWs shared a similar passion for patient care and collective wellbeing, systems of ageism, racism, capitalism and neoliberalism created barriers for HCWs to provide the best care possible while also tending to their own personal needs. Heroism discourse and the use of heroism labels helped to perpetuate false demonstrations of praise and solidarity have only created further feelings of hostility and grief among HCWs from various settings.

When referring back to literature by Cox (2020) on the use of heroism and its harm, there were reasons to believe that heroism discourse had been disingenuous from the start. Perhaps heroism labels were in fact created and utilized to uphold the crucial needs of the healthcare system and not a genuine display of appreciation. In listening to the voices of HCWs at this time, very few were accepting the heroism label as a title of gratitude and appreciation. Instead, they resisted it due to the lack of support and acknowledgement that they have received in the past two years (from the time of writing). When thinking about care work and duty to care policies and tying these understandings back to the SARS epidemic of 2003, there were clear differences between both. During SARS there were no labels of heroism, no pay increases, and no accolades. However, these things have all been present during the COVID-19 pandemic. Thus, forcing researchers and HCWs to question what the significant difference in risk, job duty and healthcare climate is and how these factors have potentially created a much more harmful healthcare system for workers.

What surprised me the most was just how compassionate study participants were about the pandemic. Although they shared feelings of exhaustion and frustration, they also shared still feeling incredibly committed to resident wellbeing and wishes to continue working directly with patients and residents. I was expecting to see and hear a lot more animosity and uncertainty amongst HCWs as it is so routinely demonstrated on social media and larger social stages as well. As humans, we all have a threshold and I expected that three years in, my study participants would have been farther along with feelings of burnout, compassion fatigue and grief. This has led me to question a few things: (1) How have duty to care policies impacted HCWs ability to flow through grief and exhaustion and honour it as a unique and valid experience? (2) How have states of individualism hindered HCWs ability to lean into community for support and respite? And (3) How have HCWs felt as though their feelings of grief have become desensitized due to heroism and duty to care policies?

Future Implications

While journeying through these concepts of performative allyship and heroism, I noticed a gap. Over the course of the pandemic, many HCWs have shared their frustrations about the lack of support received from the provincial government. However, these stories of frustration are dominated by HWCs working in regulated professions (i.e., registered nurses, registered practical nurses, physicians). Thus, little space remained for unregulated HCWs (i.e., PSWs, dietary aides, environmental staff and recreation staff) working in LTCHs to voice their own concerns regarding the treatment they have received at this time. The act of silencing the stories of LTCH workers perpetuates deeper stigma regarding the worth and value of care labour provision in thus space. Thus, reinforcing the idea that LTCHs are invisible spaces where residents go to die; and the work being provided is “undesirable” and “dirty” (Palmer & Eveline,

2012). Therefore, my study aimed to add a new voice to the conversation. This project created a new space for deeper thought and action to occur surrounding current treatment of HCWs in LTCHs, in both pandemic and non-pandemic scenarios. This study created a space for HCWs to reflect on their unique experiences and share their own story. Thus, demonstrating to readers the value and need for respect for care work provided by HCWs in LTCHs.

From a scholarly perspective, this study provided a deeper understanding of the impact of language on care provision at this time. Specifically, how language has been used to 'mask' inaction on the part of the government and the significant pressure placed on HCWs as a result. It also worked to theorize how performative allyship has supported the extraction of labour during the pandemic. In a practical sense, this study sought to provide a sense of community for HCWs working in LTCHs to share their collective perspectives on heroism and care provisioned during the COVID-19 era.

To raise awareness on the harmful experiences faced by HCWs employed in LTCHs during the COVID-19 pandemic, is to acknowledge that inequities existed (at the time of writing) that needed be recognized as we worked towards imagining spaces for HCWs that are just, dignifying, and empowering. More specifically, a space where HCWs are not seen solely as employees, but as humans who produce vital work who also have their own stories, voices, and identities that must be respected. It is a call to action.

This project presented new questions that could influence care labour for pandemics to come. First, have policy makers, public health officials and government officials learned enough from this experience to hold themselves accountable? If so, what changes could support the development of meaningful and effective pandemic preparedness policies in the future? Ones that uphold interprofessional accountability rather than placing significant stress and pressure on

HCWs to carry the stress and burden of keeping citizens alive and well? In raising these questions, it is important to understand that a lack of improvement and failure to learn from this pandemic could result in greater staffing shortages, labour movements, and job abandonment. More than anything, it is imperative that political systems begin to listen to HCWs when they share their experiences, frustrations, and concerns. There are simply not enough HCWs left to pick up the pieces where the last one left off. Without rectification, the crumbling of our current healthcare system is possible. However, with greater awareness and acknowledgement of the current care crisis, future public health risks may be mitigated with accountability, acknowledgment, and support.

References

Allin, S., Fitzpatrick, T., Marchildon, G.P., & Quensel-Vallée. (2021). The federal government and Canada's COVID-19 responses: from 'we're ready, we're prepared' to 'fires are burning.' *Health Economics, Policy and Law,* 1-19. Doi:10.1017/S1744133121000220

Austin, L., & Anderson, M. (2012). Auto-ethnography in leisure studies. *Leisure Studies, 31(2),* 131-146, DOI: 10.1080/02614367.2011.599069

Badone, E. (2021). From Cruddiness to Catastrophe: COVID-19 and Long-term Care in Ontario. *Medical Anthropology,* 40(5), 389-403. https://doi.org/10.1080/01459740.2021.1927023

Bahn, K., & Cohen, J. (2020). A feminist perspective on COVID-19 and the value of care work globally. *Gender, Work and Organization, 27*(5), 695-699. https://doi-org.proxy.lib.uwaterloo.ca/10.1111/gwao.12459

Bazzi, S., Fiszbein, M.m & Gebresilasse, M. (2021). "Rugged individualism" and collective (in)action during the COVID-19 pandemic. *Journal of Public Economics. 195*, 1-20. https://doi.org/10.1016/j.jpubeco.2020.104357

Brophy, J.T., Keith, M.M., Hurley, M., & McArthur, J.E. (2021). Sacrificed: Ontario healthcare workers in time of COVID-19. *New Solutions: A Journal of Environmental and Occupational Health Policy, 30*(4), 267-281. https://doi-org.proxy.lib.uwaterloo.ca/10.1177/1048291120974358

Carter, A. (2021, September 10). Enough with 'hero' talk — pay us fairly, health-care workers say at rally: Bargaining for new provincial contract begins next week. *CBC News* https://www.cbc.ca/news/canada/toronto/health-care-rally-1.6171823

CMFM. (2020). Canadian armed forces long-term care facility report released. *Canadian Military Family Magazine*

Cox, C.L. (2020). 'Healthcare heroes': problems with media focus on heroism from healthcare workers during the COVID-19 Pandemic. *Journal of Medical Ethics, 46*(8), 510-513.

Dosani, N. [@NaheedD]. (2021, September 6). *Reminder: A decent wage is health. Paid sick leave is health. Overtime pay is health. Safe work conditions is health. Non- precarious employment is health. Benefits is health. This Labour Day & every day, let's remember that every worker, everywhere, deserves the right to health.* [Tweet]. https://twitter.com/NaheedD/status/1434872440635658240

Entman, R.M. (1993). Framing: toward clarification of a fractured paradigm. *Journal of Communication, (43)*4, 51-58. https://doi-org.proxy.lib.uwaterloo.ca/10.1111/j.1460-2466.1993.tb01304.x

Fridkin, K., Wintersieck, A., Courey, J., & Thompson, J. (2017). Race and police brutality: the importance of media framing. *International Journal of Communication 11*, 3394-3414.

Flanagan, A., Um, S., Sinha, S., Roche, B., Rosenburg, J., Nicin, M., & McKenzie, K. (2021, July 20). *Leaving no one behind in long-term care: Enhancing socio-demographic data collection in long-term care settings.* National Institute on Ageing, Ryerson University and Wellesley Institute. https://www.wellesleyinstitute.com/wp-content/uploads/2021/07/LeavingNoOneBehind-July-20-2021-FINAL.pdf

Gary, M., & Berlinger, N. (2020). Interdependent citizens: The ethics of care in pandemic recovery. *Hastings Center Report, 50*(3), 56-58. https://doi-org.proxy.lib.uwaterloo.ca/10.1002/hast.1134

Glenn, E. N. (1985). Racial ethnic women's labour: The intersection of race, gender and class oppression. *Review of Radical Political Economics, 17*(3), 86-108.

Glenn, E. N. (2000). Creating a caring society**.** *Utopian Visions: Engaged Sociologies for the 21st Century, Contemporary Sociology*. *29*(1), 84-94.

Glenn, E. N. (2010). Forced to Care: Coercion and Caregiving in America. Cambridge, MA.: Harvard University Press.

Glover, T.D. (2003). Taking the narrative turn: The value of stories in leisure research. *Society and Leisure 26*(1), 145-167. https://doi.org/10.1080/07053436.2003.10707610

Guelph police salute healthcare workers on the front lines of the novel coronavirus pandemic. (2020, April 1). *Global News.* https://globalnews.ca/video/6762387/guelph-police-salute-healthcare-workers-on-the-front-lines-of-the-novel-coronavirus-pandemic/

Godderis, R., & Rossiter, K. (2012) 'If you have a soul, you will volunteer at once': gendered expectations of duty to care during pandemics. *Sociology of Health & Illness, 35*(2), 304-308. https://doi-org.proxy.lib.uwaterloo.ca/10.1111/j.1467-9566.2012.01495.x

Granger, M. (2021, May 31). Ontario to allow 550 health-care workers to attend Toronto Maple Leafs' Game 7. *City News*. https://vancouver.citynews.ca/2021/05/31/ontario-health-care-workers-leafs-game-7/

Harper, D. (2002). Talking about pictures: A case for photo elicitation. *Visual Studies,* 17 (1), 13–26. DOI: 10.1080/14725860220137345

Hennekam, S., Ladge, J., & Shymko, Y. (2020). From zero to hero: an exploratory study examining sudden hero status among physician health care workers during the COVID-19 Pandemic. *Journal of Applied Psychology, 105*(10), 1088-1100. http://dx.doi.org/10.1037/apl0000832

Herron, R., Kelly, C., & Aubrecht, K. (2021). A conversation about ageism: time to deinstitutionalize long-term care? *University of Toronto Quarterly, 90*(2), 183-206

Heslop, B. (2021, January 29). Ontario nurses hosting blue ribbon movement' Monday as frustration grows. *NewsTalk 610 CKTB. https://www.iheartradio.ca/610cktb/news/ontario-nurses-hosting-blue-ribbon-movement-monday-as-frustration-grows-1.14472035*

Higgins, C. (2020, May 27). Why we shouldn't be calling our healthcare workers 'heroes.' *The Guardian.* https://www.theguardian.com/commentisfree/2020/may/27/healthcare-workers-heros-language-heroism

Hines, S.E., Chin, K.H, Glick, D.R., & Wickwire, E.M. (2021). Trends in moral injury, distress, and resilience factors among healthcare workers at the beginning of the COVID-19 pandemic. *International Journal of Environmental Research and Public Health, 18*(2), 488-499. 10.3390/ijerph18020488

Jackson, H. (2021, November 4). Canadian medical association 'disappointed' Quebec, Ontario not mandating COVID-19 vaccines for health workers. *CTV News*. https://www.ctvnews.ca/health/coronavirus/canadian-medical-association-disappointed-quebec-ontario-not-mandating-covid-19-vaccines-for-health-workers-1.5652285

Jaworska, S. (2020, April 13). Is the war rhetoric around COVID-19 an Anglo-American thing? *Viral Discourse. https://viraldiscourse.com/2020/04/13/is-the-war-rhetoric-around-covid-19-an-anglo-american-thing/*

Kalina, P. (2020). Performative Allyship. *Technium Social Sciences Journal, 11, 478-481.*

Kantrowitz-Gordon, I., & Vandermause, R. (2016). Metaphors of distress: photo-elicitation enhances a discourse analysis of parents' accounts. *Qualitative Health Research, 26*(8), 1031-1043. https://doi-org.proxy.lib.uwaterloo.ca/10.1177/1049732315575729

Lohmeyer, B.A., & Taylor, N. (2021). War, heros and sacrifice: Masking neoliberal violence during the COVID-19 pandemic. *Critical Sociology, 47*(4-5), 625-639. https://doi-org.proxy.lib.uwaterloo.ca/10.1177/0896920520975824

Lopez, K. J. (2018). "We are not a machine": Personal support workers' (ante)narratives of labour, leisure, and hope amidst politics of genderacialised care in long-term care homes. *UWSpace.* http://hdl.handle.net/10012/12850

Miller, M. (2020, March 19). Tim Hortons is now giving free coffee to healthcare workers in Canada. *Fresh Daily.* https://www.freshdaily.ca/food/2020/03/tim-hortons-now-giving-free-coffee-healthcare-workers-canada/

Mills, J., Ramachenderan, J., Chapman, M., Greenland, R., & Agar, M. (2020). Prioritising workforce wellbeing and resilience: What COVID-19 is reminding us about self-care and staff support. *Palliative Medicine, 34*(9), 1137-1139. https://doi.org/10.1177/0269216320947966

Morales, A.L. (2019). The power of story. *Medicine stories: Essays for radicals* (pp. 42-46). Duke University Press.

Ontario Centres for Learning, Research and Innovation in Long-Term Care. (2021, January 14). PSW perspectives on the staffing challenge in long-term care: report on challenges, possible solutions, and visions for the future from PSWs across Ontario. *Ontario CLRI at the RIA. https://clri-ltc.ca/files/2021/02/PSW_Perspectives_FinalReport_Feb25_Accessible.pdf*

Ontario Newsroom. (2020, March 17). *Ontario enacts declaration of emergency to protect the public. https://news.ontario.ca/en/release/56356/ontario-enacts-declaration-of-emergency-to-protect-the-public*

Ontario Newsroom. (2020, March 26). *Ontario provides $3.3 billion more to increase health care capacity.* https://news.ontario.ca/en/release/56475/ontario-provides-33-billion-more-to-increase-health-care-capacity

Ontario Newsroom. (202, June 12). *Ontario thanks Canadian health care heroes. https://news.ontario.ca/en/statement/1000328/ontario-thanks-canadian-health-care-heroes*

Ontario. (202, October 15). *Minister's directive: COVID-19- long-term care home surveillance testing and access to homes.* https://www.ontario.ca/page/covid-19-long-term-care-home-surveillance-testing

Ontario. (n.d.). *Archived- COVID-19: Temporary pandemic pay.* https://www.ontario.ca/page/covid-19-temporary-pandemic-pay

Palmer, E., & Eveline, J. (2012). Sustaining low pay in aged work. *Gender, Work & Organization, 19*(3) 254-275. https://doi.org/10.1111/j.1468-0432.2010.00512.x

Picard, A. (2021). *Neglected no more: the urgent need to improve the lives of 67anada's elders in the wake of a pandemic.* Penguin Random House Canada.

Public health Ontario. (2021, November 9). *Daily epidemiological summary: COVID-19 in Ontario: January 15, 2020 to November 9, 20201*. https://files.ontario.ca/moh-covid-19-report-en-2021-11-10.pdf

Public safety Canada. (2021, October 16). *Support for long-term care homes in Ontario extended to manage the COVID-19 outbreaks.* Government of Canada. https://www.canada.ca/en/public-safety-canada/news/2021/10/support-for-long-term-care-homes-in-ontario-extended-to-manage-covid-19-outbreaks.html

Robinson, F. (2011). *The ethics of care: A feminist approach to human security.* Philadelphia, PA: Temple University Press.

Ruderman, C., Shawn Tracy, C., Bensimon, C.M., Bernstein, M., Hawryluck, L., Shaul, R.Z., & Upshur, R.E.G. (2006). On pandemics and the duty to care: whose duty? Who cares? *BMC Medical Ethics, 7*(5) https://doi.org/10.1186/1472-6939-7-5

Rossiter, K., & Godderis, R. (2020) Essentially invisible: risk and personal support workers in the time of COVID-19. *Sociology of Health & Illness, 42*(8), 25-31. https://doi-org.proxy.lib.uwaterloo.ca/10.1111/1467-9566.13203

Saji, S., Venkatesan, S., & Callender, B. (2021). Comics in the time of a pan(dem)ic: COVID-19, graphic medicine, and metaphors. *Perspectives in Biology and Medicine, 64*(1), 136-154. https://doi.org/10.1353/pbm.2021.0010

Sperling, D. (2021). Ethical dilemmas, perceived risk, and motivation among nurses during the COVID-19 pandemic. *Nursing Ethics, 28*(1), 9-22. https://doi-org.proxy.lib.uwaterloo.ca/10.1177/0969733020956376

Tracy, S.J. (2013). Entering the conversation of qualitative research. In Tracy, S.J, *Qualitative Research Methods: collecting evidence, crafting analysis, communicating impact (pp. 20-36).* Wiley-Blackwell

Tsekouras, P. (2020, April 29). Peel PSW who died of COVID-19 remembered as vibrant person with a big heart. *CP24.* https://www.cp24.com/news/peel-psw-who-died-of-covid-19-remembered-as-vibrant-person-with-a-big-heart-1.4917864?cache=yes%3FclipId%3D89750

Umaigba, B. [@birgitomo]. (2021, October 15). *One of the #IENs I taught had over 10yrs of ICU experience, a Master's degree & lots of teaching experience. These are the types of people @fordnation is de-skilling to work as PSWs. Not okay! @canadanurses @RNAO @collegeofnurses* [Tweet]. https://twitter.com/birgitomo/status/1449012009144553472

Willingham, A.J. (2020, June 2). Why posting a black image with the 'Black Lives Matter' hashtag could be doing more harm than good. *CNN. https://www.cnn.com/2020/06/02/us/blackout-tuesday-black-lives-matter-instagram-trnd/index.html*

Appendix A- Timeline of Events Prior to Interviews

- September 25, 2021: TCPS 2 CORE certification competed
- September 23, 2021: Ethics application created
- December 15, 2021: Original Ethics form submitted
- January 17, 2022: First round of revisions submitted to Ethics
- January 24, 2022: Second round of revisions submitted to Ethics
- January 24, 2022: Initial Ethics Application receives Approval

Appendix B- Email Recruitment Script

Dear potential volunteers,

This email is being sent from an upper year Recreation and Leisure Studies student, conducting research with healthcare workers (HCWs) employed in Long-Term Care Homes (LTCHs) during the COVID-19 pandemic.

My name is Crystal-Jade Cargill and I am conducting a research study as part of my undergraduate degree under the supervision of Dr. Kimberly Lopez in the department of Recreation and Leisure at the University of Waterloo. The purpose of my study is to understand the perceptions of heroism and care labour during the COVID-19 pandemic experienced by HCWs working in LTCHs during the pandemic.

This study is guided by the following objectives:

1. Understand HCWs current understandings of care labour provision during the COVID-19 pandemic while reflecting on pre-COVID-19 care work to draw comparison and differences
2. Understand HCWs response and conceptualizations of the heroism narrative as it pertains to the care labour currently being provided to the LTCH system by HCWs.
3. Understand areas of tension/ stress felt by HCWs employed in LTCHs during the COVID-19 pandemic.

Participants should:

- Have worked in a LTCH during the COVID-19 Pandemic providing care to residents
- Adults 18 years of age or older

Participation in this study involves an interview over Zoom where you will be asked questions like:

- How long have you worked in your current role?
- How have you come to understand the label of #HealthcareHero? Has this label influenced the labour that you provide? If so, how?
- Have you been able to prioritize your personal wellness during this time? What limitations have you faced, if any at all?

Participation would take **30 minutes- 1 hour** of time. This meeting will take place via Microsoft Teams, the meeting time will be determined by the participant.

In appreciation of your time, you will receive a **$10 Tim Horton's gift card.**

Please read the attached information letter for information about what participation involves. For more information or to volunteer for this study lease contact me at ccargil@uwaterloo.ca.

This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Board.

Appendix C- Information and Consent Form

University of Waterloo
To Whom It May Concern:

My name is Crystal-Jade Cargill and I am an undergraduate student in the department of Recreation and Leisure Studies at the University of Waterloo. I would like to invite you to participate in a study I am conducting for my REC 471A/B honours thesis project. My supervisor for this thesis project is Dr. Kimberly Lopez. I would like to provide you with more information about this project and what your involvement would entail if you decide to take part.

The purpose of my study is to understand the perceptions of heroism and care labour during the COVID-19 pandemic experienced by HCWs working in LTCHs during the COVID-19 pandemic. This project will support my learnings in the area of research design, collection and analysis of information, and writing an academic research paper. Participation in this research study will not provide any personal benefits to you; however, findings from this study may provide a better understanding of the shared experiences of HCWs working in LTCHs during the COVID-19 pandemic, and support the development of future considerations for social, political and organizational states as it pertains to LTCH care provision post-COVID-19.

This study is guided by the following objectives:

1. Understand HCWs current understandings of care labour provision during the COVID-19 pandemic while reflecting on pre-COVID-19 care work to draw comparison and differences
2. Understand HCWs response and conceptualizations of the heroism narrative as it pertains to the care labour currently being provided to the LTCH system by HCWs.
3. Understand areas of tension/ stress felt by HCWs employed in LTCHs during the COVID-19 pandemic.

Participants should:

- Have worked in a LTCH during the COVID-19 Pandemic providing care to residents
- 18 years of age or older

What does participation involve?

If you agree to participate, you will be asked to take part in an interview that will take approximately 30-60 minutes of your time, depending on how much you would like to share during our conversation. Interview questions will focus on demographic information, personal reflections on providing care during the COVID-19 pandemic as well as your perceptions of the Healthcare Hero narrative, and reflections on the future of care labour in LTCHs. Additionally, you will be asked to review some images provided by the researcher that depict HCWs providing care, illustrations depicting HCWs providing care with phrases that relate to care work, and promotional material from LTCH organizations. You will be asked to choose 3 photos that resonate with you and then you will be asked to share any experiences, thoughts and/or emotions that arise from looking at these images.

With your permission, the interview will be audio and video-recorded to facilitate the collection of information, and later transcribed for analysis. Prior to the start of the recording, you will be provided with the option to turn your camera off. Participation in this study is voluntary and you ,ay decline to answer any of the interview questions if you wish. Additionally, you may end the interview at any time by advising the researcher of this decision.

What you should know about your participation:

- The interview will be conducted over an online platform, Microsoft Teams. Microsoft Teams has implemented technical, administrative, and physical safeguards to protect the information provided via the

Services from loss, misuse, and unauthorized access, disclosure, alteration or destruction. However, no Internet transmission is ever fully secure or error free.

- Your participation will be considered confidential. Neither your name nor the name of your employer will be used in any quotations used from this interview. However, with your permission quotations may be used with a pseudonym in place of your real name. Collected data will be retained for a minimum of one year and will be stored on the student researcher's password-protected iCloud database. You can withdraw your consent to participate and have your data destroyed by contacting us within this time period. Please note that it will not be possible to withdraw your consent once study results have been submitted for publication.
- Even though I may present the study findings to the class, only the course instructor and I will have access to the data.
- Given the topic of the study and its focus on your experiences as it relates to your employment in LTC, some of the interview questions may cause you to feel upset, particularly if you have had difficult experiences related to the care you have provided during the COVID-19 pandemic. Please remember that participation is voluntary, and you do not have to answer any questions that make you feel uncomfortable or emotionally distressed.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB #43784). If you have any questions for the Board, contact the Office of Research Ethics at 1-519-888-4567 ext. 36006 or reb@uwaterloo.ca

To show my appreciation for your participation, a $10 Tim Horton's gift card will be provided. The amount received is taxable. It is your responsibility to report this amount for income tax purposes.

Should you have any further questions pertaining to this study, or you require additional support to assist you in reaching a decision about participation, please contact me at ccargill@uwaterloo.ca. You can also contact my thesis supervisor, Dr. Kimberly Lopez, at 519-888-4567 ext. 32009 or email kjlopez@uwaterloo.ca.

I look forward to speaking with you and would like to thank you in advance for your assistance and support in this research project.

Respectfully,

Crystal-Jade Cargill

Student Investigator

(IN)VISIBLE HERO: HEROISM AS AN AID IN THE EXTRACTION OF CARE LABOUR DURING THE COVID-19 PANDEMIC

CONSENT FORM

By providing your consent, you are not waving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have read the information presented in the information letter about a study being conducted by Crystal-Jade Cargill for a REC 471 A/B thesis project at the University of Waterloo. The thesis supervisor is Dr. Kimberly Lopez. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in any paper or publication that comes from this research, with the understanding that a pseudonym will be used in place of my real name.

I was informed that I may withdraw my consent by advising the researcher of my decision.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB #43784). If you have any questions for the Board, contact the Office of Research Ethics at 1-519-888-4567 ext. 36006 or reb@uwaterloo.ca

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

___YES NO____

I agree to have my video and audio recorded.

____ YES NO___

I agree to the use of quotations in any paper or publication that comes from this research with the understanding that a pseudonym will be used in place of my real name.

___YES NO___

Participant Name: _____ (Please print)

[ ] Verbal consent was obtained.

Participant Signature: _____

Witness Name: _____ (Please print)

Researcher Signature: _____

Date: _____

Appendix D- Interview Guide

Before starting the interview:

I want to go over some key points before we start:

- The purpose of my study is to understand the perceptions of heroism and care labour during the COVID-19 pandemic experienced by HCWs working in LTCHs during the pandemic.
- The interview will take approximately 30 minutes to one hour
- You may decline answering any questions you feel you do not wish to answer
- Your participation is voluntary and you may decline contributing or withdraw from the project without penalty by advising me of this decision during the interview, or at any time after the interview by advising me during the minimum data retention period of 1 year.
- Your participation will be confidential.
- Your name will not be identified in any way.
- The information provided will be used for research and educational purposes only.
- This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB#43784). If you have any questions for the Board, contact the Office of Research Ethics at (519) 888-4567 ext. 36005 or reb@uwaterloo.ca

  Do you have any questions? (**Read consent letter and sign form)**

  Are you ready to proceed with the interview? We will now begin recording. At this time, you are welcome to turn your camera off.

  Proceed with Interview:

Part 1: Demographic Questions (5 minutes)

1. How long have you worked in your current role?
2. Do you consider yourself to be part of a marginalized identity group?

Part 2: Covid-19 Care Provision and Reflections of #HealthcareHero (15 minutes)

1. I would like to invite you to engage in a moment of self-reflection, through your personal COVID-19 related working experience. How have your understandings of your job and yourself changed/evolved at this time, if at all?
2. How have you come to understand the label of #HealthcareHero? Has this label influenced the labour that you provide?
3. What does heroism mean to you?
4. Do you feel supported in your productivity as a healthcare worker at this time?
5. Hs heroism made you feel support or isolation? Please explain
6. Prior to COVID-19, how many hours per week were you working at your current LTCH? How has this changed since the pandemic?

7. Drawing on your understandings surrounding heroism prior to the COVID-19 pandemic, do you feel like a hero in this pandemic? Why or why not?

Part 3: Photo Elicitation (20 minutes)

At this point in our interview, I would like to provide you with a collection of photos. After looking at all of the images and their descriptions, I would like you to select 3 images that resonate with you:

1. Why did you choose these photos?
2. What emotions/ memories come to mind?
3. Do these emotions bring up feelings of tension in your body? If yes, where do you feel these tensions?

Part 4: Embodiments of heroism in care labour and future imaginings (10 minutes)

1. Have you been able to prioritize your personal wellness during this time through acts of self-care?
2. I would like to invite you on another journey of self-reflection. This time on a post-COVID-19 scenario. Imagine a time when COVID-19 no longer poses as an imminent risk to public health safety and we return to some state of normalcy. How do you feel as though your work as a HCW will be seen/ regarded?
3. Do you intent to continue working in LTC? Please explain
4. Reflecting on your working experience, how could you have felt more supported by the government, your organization, and team? What personal message would you share with the MOH-LTC as they work to "rebuild" LTC, if you could?

Final question:

Is there anything that we did not discuss today relating to heroism, care work, and personal wellness that you would like to express?

Upon Completion of Interview

Thank you for your vulnerability and for providing us with valuable feedback on your experiences as a HCW employed in LTC during the COVID-19 pandemic. Your stories will help us to understand how HCWs perceive the hero label and care labour provision at this time.

If you have any questions or comments about your participation, please feel free to contact Crystal-Jade Cargill, student investigator at ccargill@uwaterloo.ca, or Dr. Kimberly Lopez, principal investigator at (519) 888-4567 ext. 32009 or email kjlopez@uwaterloo.ca.

Appendix E- Thank You Letter

Crystal-Jade Cargill BA. (c)
Department of Recreation and Leisure Studies
Faculty of Health
University of Waterloo

University of Waterloo

Dear ***(participant name),***

Thank you for your participation in this study entitled (In)Visible Hero: Exploring the use of heroism as an aid in the extraction of care labour during the COVID-19 Pandemic.

The study was guided by the following objectives:

1. Understand HCWs current understandings of care labour provision during the COVID-19 pandemic while reflecting on pre-COVID-19 care work to draw comparison and differences
2. Understand HCWs response and conceptualizations of the heroism narrative as it pertains to the care labour currently being provided to the LTCH system by HCWs.
3. Understand areas of tension/ stress felt by HCWs employed in LTCHs during the COVID-19 pandemic.

Once all the information is gathered and read, I plan to share this information with the research community through conferences, presentations, and articles.

This project is set to be completed by April 5, 2022. Once this project is completed and updated to the University of Waterloo's Institutional Repository, UW Space, a link will be sent to you via email where you can access the completed project.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB #43784). If you have any questions for the Board, contact the Office of Research Ethics at 1-519-888-4567 ext. 36006 or reb@uwaterloo.ca

Sincerely,

Crystal-Jade Cargill
University of Waterloo
Department of Recreation and Leisure Studies

Faculty of Health

ccargill@uwaterloo.ca

Appendix F- Available Wellness Resources

Virtual Counselling/ Wellness Resources

24/7 Resources

Good 2 Talk 24/7 Crisis Line
Phone: 1-866-925-5454
Text: GOOD2TALKON to 686868

Canadian Mental Health Association 24/7 Crisis Line
24/7 at 1-844-437-3247 (HERE-247)
www.here247.ca

Monreau Shepell 24/7 Crisis Line**
1-800-268-7708

**If you would like to contact the Monreau Shepell non-crisis line, please follow these steps:

Step 1: Call Canada direct at **+1-905-886-3605***. You will be connected to a Morneau Shepell representative.

Step 2: Tell the representative the name of your employer and what country you are calling from and request that we call you back immediately or at a time convenient for you.

Step 3: Provide the representative with telephone number where you can be reached.

Appendix G- Photo-Elicitation Collection

Photo- elicitation Photo Collection

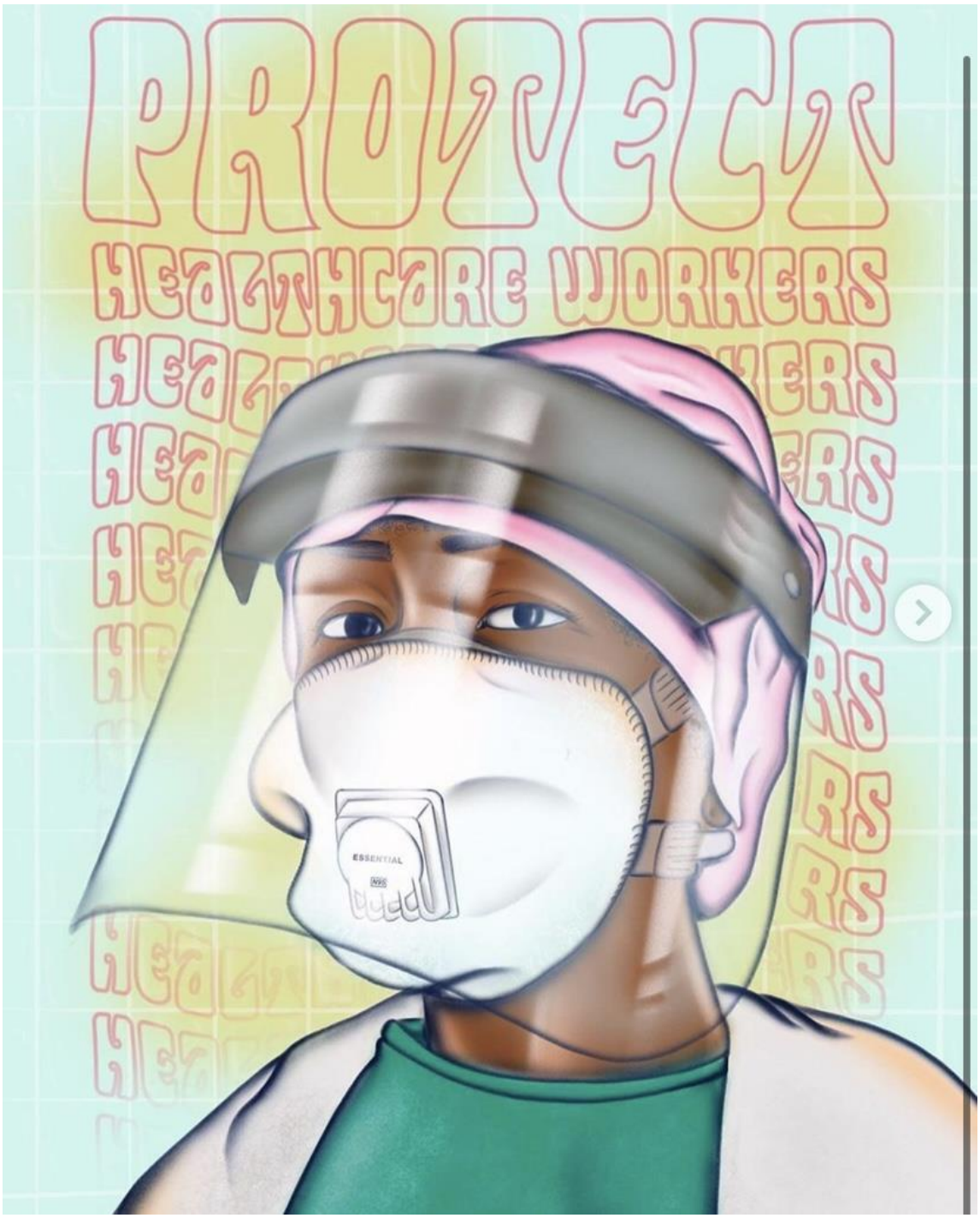
[Photo of HCW donned in PPE supporting a resident. The text reads "No matter how many layers of protection they wear, the compassion and care shines through."] (2020). Retrieved from https://changingaging.org/culture-change/finding-light-in-dark-times-how-one-nursing-home-is-coping-with-the-challenges-of-covid-19/

[Promotional poster for the 500 Days of COVID-19 event taking place at The Village of Riverside Glen] (2021)

[Exterior of photo of The Village at St. Clair, Windsor, ON. With HCW donned in PPE] (2021). Retrieved from **https://windsorstar.com/news/local-news/staff-simply-overwhelmed-as-tragedy-unfolded-in-local-long-term-care-homes**

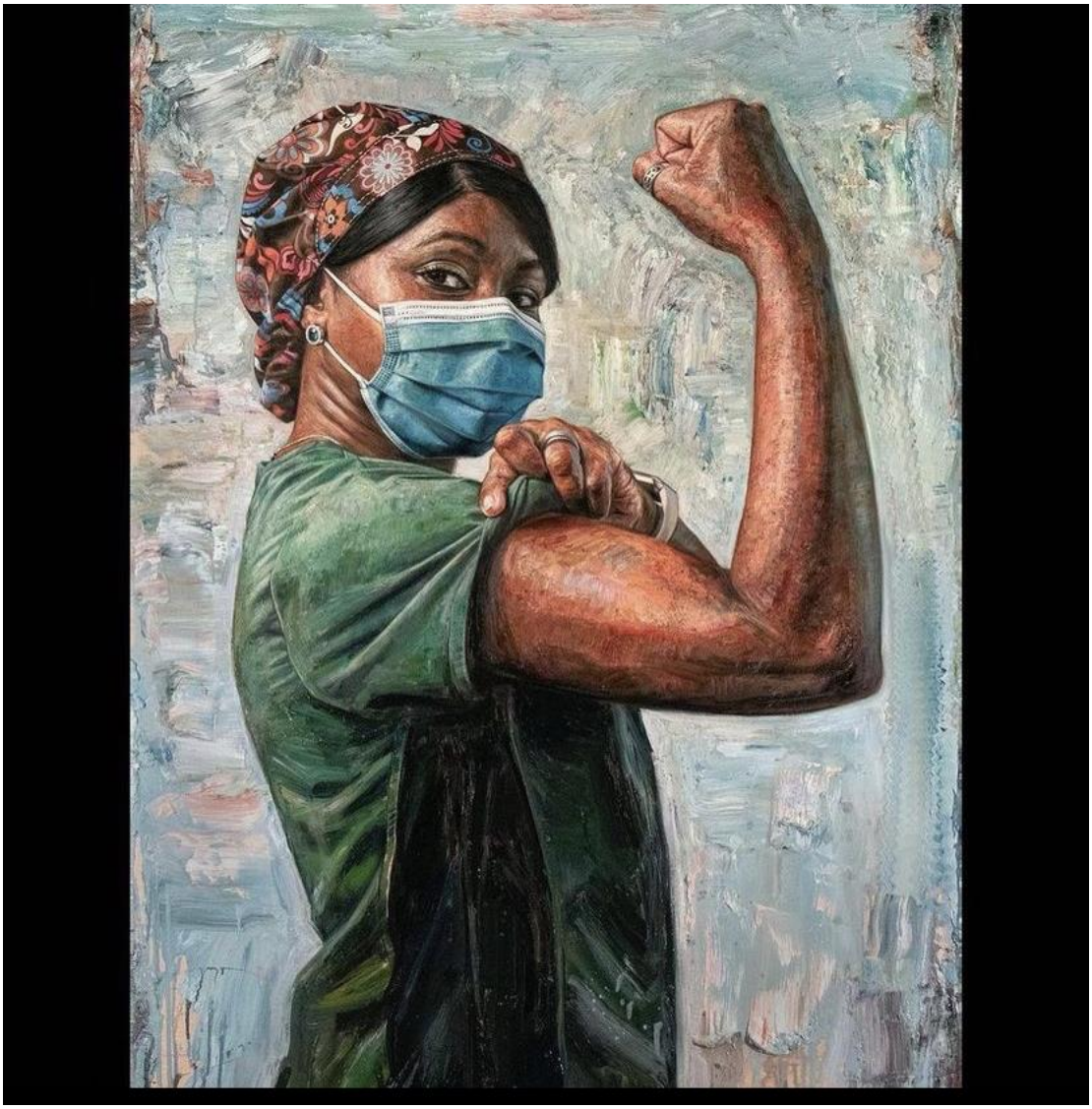
[Promotional material for Caregiver's Week 2021 at Schlegel Villages] (2021) Retreived

from https://www.google.com/search?q=healthcare+hero+schlegel+villages&rlz=1C5CHFA_enCA756CA756&sxsrf=AOaemvIu0Gn9G34Cjn3b5BSF5Nhochu0WA:1635298685652&source=lnms&tbm=isch&sa=X&ved=2ahUKEwjvyYmquunzAhUxkmoFHTBqAgIQ_AUoAnoECAEQBA&biw=1309&bih=665&dpr=2.2#imgrc=G-McvheO1pLHQM



[Illustration of HCW donned in PPE with the phrase “Protect Healthcare Workers” floating in the back.] (2020) Retrieved from https://www.instagram.com/p/CB28q3pAsV3/

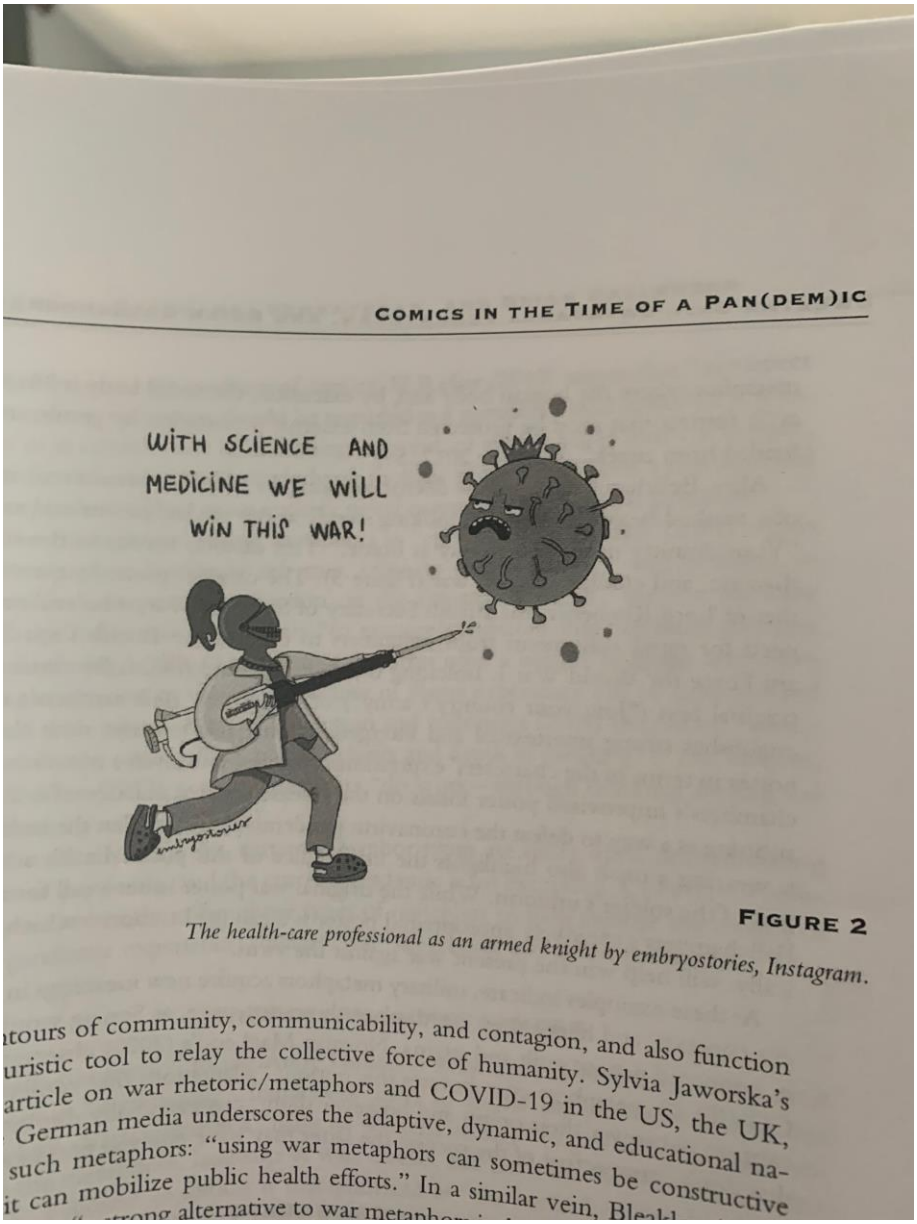
[Illustration of HCW donned in PPE with phrase “Give Long-Term Care PPE” written at the bottom.] (2020). Retrieved from https://www.instagram.com/p/CB_V7YWpp2R/



[Painting of HCW donned in PPE with bicep curled to emulate Rosie the Riveter image] (2021) Retrieved from https://www.instagram.com/p/CN3cSxYAbpE/?utm_medium=copy_link

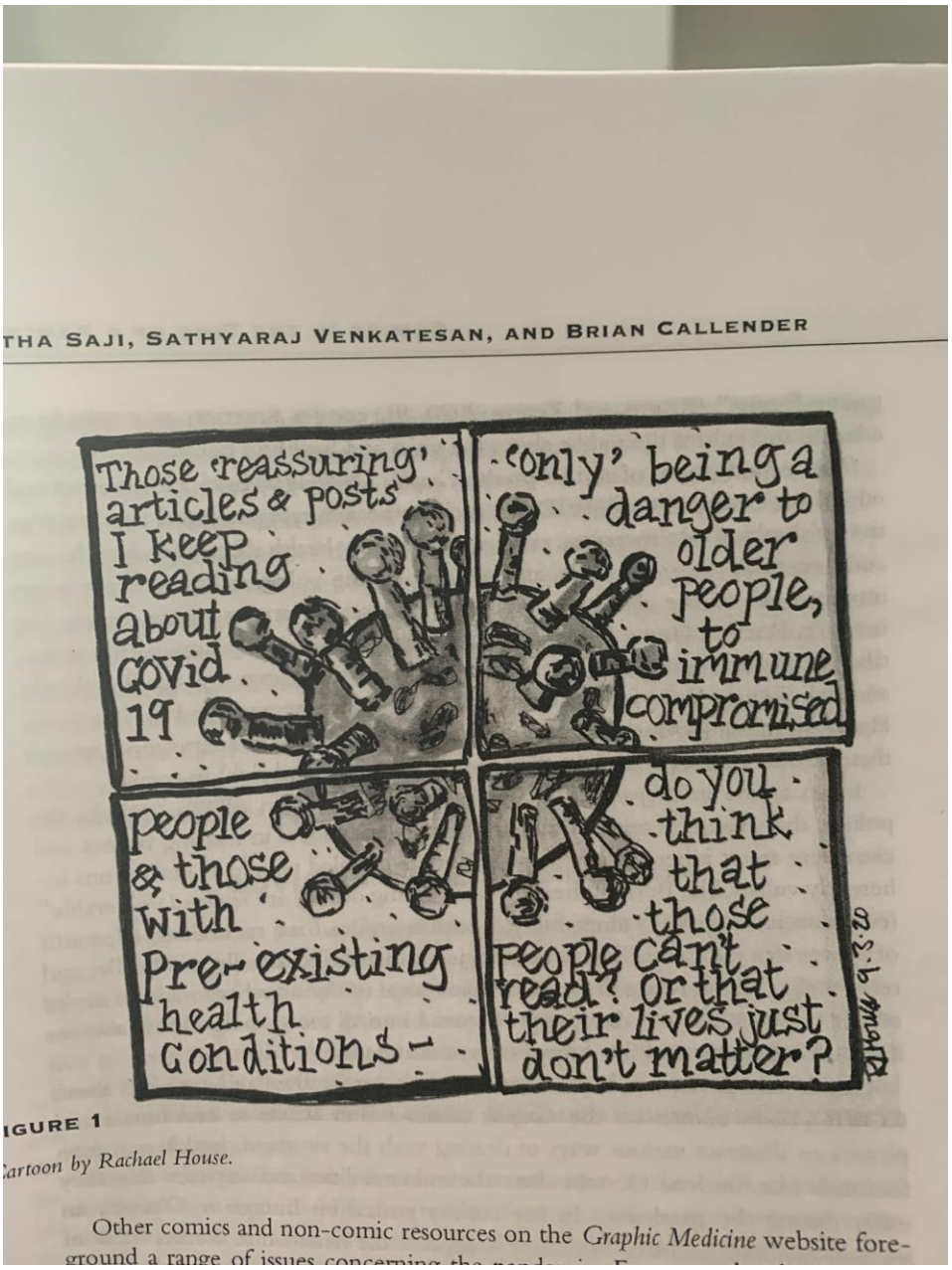
[Illustration of older adult holding a cane with the phrase “please don’t forget us” floating in the background.] (2021). Retrieved from https://www.instagram.com/p/CJwEIjuAZFW/

[Doctor donned in full PPE consoling an elderly man] (2020). Retrieved from https://www.instagram.com/p/CJBI2hmAXh7/



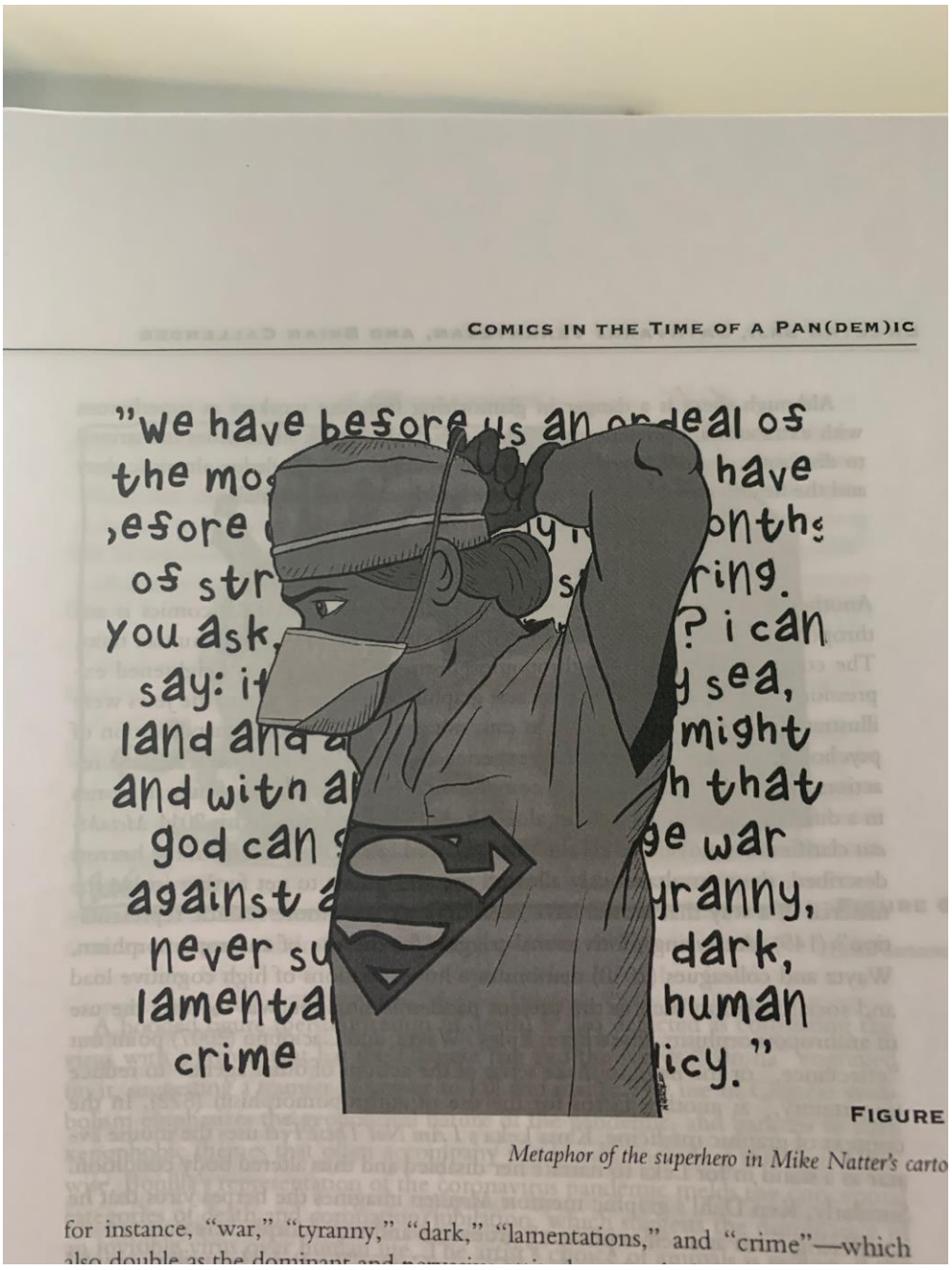
[Comic of HCW donned in scrubs, a white coat, and knightly armour while holding a sword and running toward a COVID-19 spike protein with an irritated face. The phrase "with science and medicine we will win this war!" is floating over the HCW's head.]

Saji, S., Venkatesan, S., & Callender, B. (2021). Comics in the time of a pan(dem)ic: COVID-19, graphic medicine, and metaphors. *Perspectives in Biology and Medicine, 64*(1), 136-154. https://doi.org/10.1353/pbm.2021.0010



[Comic displaying COVID-19 spike protein. The phrase floating behind it states “Those ‘reassuring’ articles & posts I keep reading about COVID-19 ‘only’ being a danger to older people, to immune compromised people & those with pre-existing health conditions- do you think that those people can’t read? Or that their lives just don’t matter?]

Saji, S., Venkatesan, S., & Callender, B. (2021). Comics in the time of a pan(dem)ic: COVID-19, graphic medicine, and metaphors. *Perspectives in Biology and Medicine, 64*(1), 136-154. https://doi.org/10.1353/pbm.2021.0010



FIGURE

Metaphor of the superhero in Mike Natter's carto

for instance, "war," "tyranny," "dark," "lamentations," and "crime"—which also double as the dominant and

[HCW donned in PPE and a scrub top with the 'superhero' logo printed on the front. A message floats in the background relating to the severity of the COVID-19 pandemic.]

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