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From Zero to Hero: An Exploratory Study Examining Sudden Hero Status Among Non-Physician Healthcare Workers During the COVID-19 Pandemic

Abstract

The recent COVID-19 pandemic has raised the visibility of healthcare workers to the level of public heroes. We study this phenomenon by exploring how non-physician healthcare workers who, traditionally believe they are invisible and undervalued, perceive their newfound elevated status during the pandemic. Drawing from a qualitative study of 164 healthcare workers, we found that participants interpreted the sudden heroization of their work as temporary and treated it with skepticism, incredulity, and void of genuinely transformative power. We seek to contribute to the recent call for developing novel approaches to understanding the contours of the paradoxical nature of invisibility in the workplace by offering insights on what makes “invisible” workers accept or reject publicly driven elevation in their sudden social valorization.

Keywords: COVID-19 Pandemic, Hero Status, Invisibility, Healthcare, Temporality

In the healthcare sector, physicians are generally considered to be higher status as compared to non-physicians, making them highly visible and prominent within the healthcare system (Nembhard & Edmondson, 2006). As such, non-physician healthcare workers often regard themselves and their work to be invisible (Allen, 2014) and undervalued (Hewko et al., 2015). Indeed, the literature points at common issues associated with perceived lower status within organizational hierarchy that non-physician healthcare workers face. These issues include economic vulnerability (Hartz & Wright, 2019), workplace bullying (Ariza-Montes et al., 2013), a dearth of promotional prospects (Dill et al., 2014), high workload, stress, difficult working conditions, and a lack of resources (Jones et al., 2015). Although nurses have been studied extensively, research shows that other healthcare workers encounter similar challenges. For example, research has reported on the lack of status of midwives (Day-Stirk & Fauveau, 2012), the need for training for orderlies (Arnon et al., 2018), stress and exhaustion for hospital attendants (Bouillercce & Stoiber, 2018), and the invisibility of janitorial staff (Messing, 1998; Rabelo & Mahalingam, 2019).

Despite documented social marginalization of non-physician healthcare workers inside (Brunetto et al., 2013) and outside their professional environments (Macdonald & Merrill, 2002), COVID-19 has radically changed their condition of invisibility by putting all healthcare employees into the spotlight of public attention and high praise. The outpouring of support for their efforts during the pandemic has recast healthcare staff across all organizational ranks as “essential workers” and elevated them to the position of “heroes” (Booth et al., 2020). This testimony of public recognition has not only come in the form of symbolic gestures of appreciation like rounds of applause (L’express, 2020), mural paintings (McCann, Landau & Mahieus, 2020), and “honk for heroes” parades (Booth et al., 2020); it has also been manifested in material support for workers from non-profit and for-profit

organizations through food donations, airline tickets for future travel, and salary increases from the government as “hazard pay” vouchers (Allen, 2020).

Given the unprecedented nature of such a shift in public perception of the social value of care work, we are interested in studying how non-physician healthcare workers experienced and responded to their newfound and sudden visibility. Specifically, we seek to investigate how they experience the social valorization of their work during the pandemic and their reactions to status elevation. We define social valorization as socially constructed attitudes that collectively elevate the value and image of certain types of work (and individuals performing it) that is traditionally devalued (Wolfensberger & Thomas, 2005). The rest of the paper is organized as follows: first, we present an overview of the current research on occupational invisibility and its social triggers; we then move to a description of our data collection and methodology. Second, we present the analysis of our findings and conclude with a discussion of how our study can enhance theoretical understanding of invisibility at work and its practical implications.

Visibility/Invisibility at Work

“Visibility” refers to “the degree to which an individual is fully regarded and recognized by others” (Settles et al., 2018, p. 2), while “invisibility” designates the experience of marginalized group members who are overlooked or dismissed by the dominant group in terms of professional authority, potential, and recognition (Smith et al., 2019). Sociological accounts of invisibility of work postulate its emergence from several social factors. First, work, and individuals performing that work, may become invisible when linked to occupations that are stigmatized or low in social status (Simpson et al., 2012), such as cleaners (Mahalingam et al., 2019). Certain occupations are, often unconsciously, rendered invisible as a result of sociocultural norms. Secondly, dominant ideologies fail to recognize certain tasks, roles, or occupations as “real” work. For example, several historical studies raised questions about how the social value of work is constructed based on the perception of

skills that it requires (Gaskell, 1987). These studies indicate that the evaluation of skills is shaped by and confounded with a worker's sex (Reskin, 1988). "Care work" has seldom been defined as "skilled" because it has been traditionally performed by female workers and therefore classified as invisible and taken for granted (Acker, 1990). In this context, Vlasses (1997) draws from research on nurses to describe "invisible" work as that which "may or may not be visible but is not recognized ... hidden, unrecognized, unaccounted-for or taken-for-granted" (p. 1). Finally, research on organizational structures indicates that one's position in organizational hierarchies shapes the condition of invisibility through power dynamics that divide organizational members into lower and higher classes (Anderson, 2019). Next, we draw from prior literature that distinguishes between *task-related* ("dirty" work), *skill-related* (social value of work) and *status-related* (position in organizational hierarchy) individual experiences of invisibility.

Task, Skill and Organizational Status-Related Invisibility

Task-related conditions of invisibility often refer to "dirty" work including vocations and job tasks that are widely regarded as "physically, socially or morally beneath the dignity of the profession" (Hughes, 1958, p. 122). Indeed, dirty work often has a stigmatizing effect on workers, particularly for those working in fields involving the handling of trash, bodily fluids, death, and/or dangerous conditions (Ashforth & Kreiner, 1999). There is an inherent paradox in occupations that are considered to be dirty: while they are perceived to be disgusting and undesirable, they are simultaneously viewed as necessary for society to function (Douglas, 1966).

Skill-related conditions of invisibility permeate the experiences of those occupations that fall under the category of "unskilled labor"—work associated with the performance of tasks that presumably do not require formal training, professional credentials, or vocational expertise (Braverman, 1974; O'Shea, 2019). Prior studies have found that that many

individuals prefer to refrain from mentioning work experience at McDonalds, Amazon warehouses, or delivery services, as they are afraid of being perceived as lacking skills for more exigent employment (Shantz & Booth, 2014). The high degree of automation and protocolization of labor in the convenience and service economy further contributes to the denigration of social value of these occupations (Bronson, 2015; Steinberg, 1990).

Finally, despite ongoing efforts to democratize workplaces, most contemporary organizations retain the pyramids of rank and privilege. On the one hand, organizations enable individual fulfilment through the distribution of opportunities for professional development across various layers of activities. On the other hand, the practices of such distribution are carried out in accordance with the hierarchical principles of recognizing merit and assigning worthiness, thus establishing distinct regimes of status-related visibility within organizations (Kreiner et al., 2006). One's position within an organizational hierarchy determines the amount of attention and praise that is attributed to one's work effort, which further defines access to means such as autonomy, flexibility, and income that have a major impact on workers' wellbeing. It also affects how organizational members take into account the reaction and validation of others to determine one's self-esteem and identity in a work context (Ashforth et al., 2007; Dutton et al., 2016; van Vuuren et al., 2012). For low-status healthcare workers, treatment by others, such as co-workers or patients, helps them determine their sense of worth and importance (Dutton et al., 2016; Nembhard & Edmondson, 2006). Indeed, within the healthcare sector, power dynamics impact how different workers are being treated. For example, located at the lower layers of organizational hierarchy, hospital cleaners report being ignored by doctors or disregarded by patients (Messing, 1998).

In sum, invisibility is a predicament that characterizes types of work associated with lower skills—work perceived as undignified and performed by employees positioned at the bottom of organizational hierarchies.

Research Context

This study was conducted in France and focused on non-physician healthcare workers that were deemed “essential” during the COVID-19 pandemic. Non-physician healthcare workers include nurses, hospital attendants, technicians and other staff who maintain the safety, cleanliness, and administrative functions within hospital settings. Although there is a growing demand in the healthcare sector for each of these types of workers (Rapport les métiers en 2022), due to the aging population, institutions that train individuals for these healthcare professions struggle to attract and retain workers. The difficult working conditions, intense workload, potential for harassment, lack of recognition, a dearth of career development opportunities, as well as low salaries, have been put forward as reasons for the lack of appeal of these occupations (OECD, 2020).

Methods

Sample

The sample consisted of 164 individuals working in hospitals in France. Most of them were nurses (52%), hospital attendants (32%) or technicians (6%). The remaining 10% comprised a range of occupations that are outlined in Table 1. Although we did not collect demographic data from our participants, we can estimate from public data that 87% of the nurses, 90% of hospital attendants and 77% of technicians were women with an average age of 40 across all categories (OECD, 2017; INSEE, 2020).

INSERT TABLE 1 HERE

Procedures

Our study was exploratory in nature drawing from qualitative accounts of non-physician healthcare workers who were employed during the COVID-19 pandemic. We were cognizant of our respondents limited availability and consequently, devised a short survey of four open-ended questions to allow individuals to develop their answers on their own

timetable. The survey consisted of the following questions: 1) What is your occupation? 2) How do you think your occupation is perceived by society (before COVID-19)? 3) Do you feel COVID-19 has changed the way people perceive your occupation and if so, in what way? 4) Do you think that COVID-19 will have a long-lasting effect on the way society values your occupation?

The survey was put online using Qualtrics and two hospitals in France (one in Rennes and one in Paris) were contacted to participate. Participants were told that the aim of the study was “to examine whether COVID-19 changes the perception of healthcare professionals that are not physicians.” Paris and Rennes were chosen because Paris has been strongly affected by COVID-19, while Rennes is among the least affected regions in France. Both hospitals were willing to participate and sent out the invitation internally. Two follow-up messages were sent out to encourage participation. Data collection took place between March 26 and April 17. The survey was sent to 333 employees and 180 returned the survey constituting a response rate of 54%. We subsequently eliminated 19 surveys due to incomplete data or because they were completed by physicians who were inadvertently sent the survey. Three in-depth interviews were conducted to complement the 161 surveys.

Data Analysis

Qualitative, inductive techniques were used to analyze the data (Charmaz, 2014; Strauss & Corbin, 1990). First, we read the responses several times to become familiar with the data and developed an initial list of common themes. After several main themes were identified, we coded the data. This was an iterative process involving moving back and forth between the data and extant literature. We used a codebook with the codes and sub-codes as the coding process advanced. Throughout the process new codes were added, some existing codes were split up, and others were merged. We then moved the codes to higher levels of abstractions in which we moved away from the words used by the participants and created

themes that were conceptually meaningful. We subsequently conducted three additional in-depth interviews with individuals representing each of the main non-physician categories from our sample including a nurse, a hospital attendant, and a technician to gain a more complete picture of their unique vantage point, discern differences among each group and determine how well our initial analysis fit their experiences. We provide vignettes of each of these interviews to highlight similarities and differences in experiences across non-physician categories in Appendix A.

Following our primary coding process, we engaged in a secondary coding process to ensure the viability of our final codes and overall fit with the data (Kreiner et al., 2009). We enlisted the help of two research assistants who had previously been trained in qualitative data analysis and NVivo software but were unfamiliar with the study. Each of the coders were given the codebook along with several blocks of text from the transcribed data representing each of the non-physician categories. The coders independently coded the data. Using the coding comparison feature in NVivo, we calculated an average agreement rate of 94% with a weighted Cohen's kappa of .72 (Cohen, 1960). Our data structure, illustrated in Figure 1, shows the relationships among the first order categories, second order themes, and aggregate theoretical dimensions (Gioia et al., 2013).

INSERT FIGURE 1 HERE

Findings

The findings of our study point to three prevailing themes that emerged from the data: the normative experiences of workers' invisibility before COVID-19, their interpretation of the sudden valorization of their activities triggered by the crisis, including the perceived temporal nature of the elevated status of their occupation; and their reactions to their newfound hero status. The participants expressed different types of invisibility that they had grown accustomed to and how they were making sense of their sudden hero status in light of

their normative experiences and in relation to others at work. As such, they deemed their hero status as temporary, and treated it with skepticism, incredulity, and void of genuinely transformative power. We discuss these findings below supported by quotes from the participants. Table 2 provides additional quotes for illustration.

INSERT TABLE 2 HERE

Normative Experiences of Invisibility

It was evident from our analysis that feeling invisible was a common experience of non-physician healthcare workers. The vast majority reported that their jobs were devalued, that they felt marginalized, stigmatized, or non-existent, and mentioned a lack of respect and recognition. Although these sentiments were not surprising given the hierarchical nature of hospital settings and the power distance from physicians, our data revealed some differences in the types of invisibility experienced by participants. While all participants expressed status related invisibility, it appeared to be most salient among nurses and technicians who often compared their status relative to others.

We're seen as failed doctors, because we're not intelligent enough to be doctors, but still come in handy when there's no doctor around (Participant, 84, nurse).

No one knows who we are or what we do. They often see us as nurses (participant 38, technician).

Hospital attendants most often expressed all three types of invisibility but emphasized task- and or skill-related invisibility as most salient.

We are a forgotten profession. Underestimated compared to nurses. Little hands in the shadow (participant 53, hospital attendant).

We're seen as professionals that do work you do not want to do (participant 162, hospital attendant)

Differences in the types of invisibility experienced among the three primary groups of non-physician healthcare workers are outlined in Table 3.

INSERT TABLE 3 HERE

Interpreting Sudden Hero Status

As the media called attention to the “heroism” of healthcare workers who were deemed essential, participants reflected on how the pandemic had changed the way their work had been viewed. They explained that the pandemic changed the way society perceived their occupations and had made them suddenly hyper visible:

The pandemic has made our professions more visible and has highlighted its importance. Healthcare workers are the ramparts against the virus (participant 11, nurse).

Participants were cognizant of the heightened consideration and sometimes even admiration of them. They reported feeling seen, acknowledged, and appreciated by others.

There is respect, admiration and gratitude in the form of applause and food donations (participant 114, hospital attendant).

They interpreted the observed gestures of public support as the recognition of the indispensability of their work for society and its collective well-being.

The media talk a lot about our profession, which is a sign of recognition. It shows also to the public that we are irreplaceable at the hospital and that we are important for the well-being of the patients we look after on a daily basis, with or without COVID (participant 147, hospital attendant).

However, the participants almost unanimously expected their hero status to be temporary. They expressed doubt in their current hero status generating a meaningful and lasting change in the valorization of their work. Their skepticism rested on three sets of projections: the problems of technocratic logic in treating care work, dwindling of media attention, and

persistence of pre-crisis cultural norms. According to some participants, economic efficiency-driven logic of healthcare management would be reinforced after the confinement and impede the development of resource allocation schemes that are more considerate of their occupational needs. Other participants linked an inevitable decay of their status as heroes to a short attention span of the media that will seek to explore and capitalize on new “hot topics” such as economic crisis and financial recovery. Finally, for some participants there were more prosaic reasons to expect the temporality of their status elevation—in a rush to go back to “normal” and leave the anxieties and traumas of the pandemic behind, society will engage in collective forgetting of painful experiences, thus inadvertently restoring the pre-crisis values of individualism. Moreover, they explained that they perceived the appreciation of others to be related to the fact that people were afraid and “needed” them during the pandemic, but once the sense of urgency and vulnerability evaporates, they will be forgotten.

Society is individualistic, once their needs are met, people go back home and we will be forgotten (participant 106, nurse).

It seems to me that it is fear that drives people, for the moment it is still a bit far from us, but implicitly there is the fear of death, his own or that of our loved ones. This spurs the gratitude for all healthcare workers right now (participant 1, nurse supervisor).

In addition, they highlighted that the role of healthcare workers was very salient given the public health crisis, and that people had the time to focus on them. However, they believed that once the pandemic was over, interest in and appreciation for their work would quickly fade away.

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).

In sum, participants believed that their elevated status would be temporary and that their working conditions, social marginalization, and subjugated organizational position would remain immune to meaningful modification.

Once the crisis is over, the image people have of our profession will be again what it was before the COVID: devoted individuals who accept to work under any circumstances “because we love our jobs” (participant 35, nurse).

This brutal recognition is appreciated, but it is simultaneously incomprehensible for most of us whose workload and suffering have been ignored by our hierarchy and the authorities for too long. This valorization of our work right now won't last probably. As soon as society no longer feels in danger, everyone's interests and the economy will once again become the priority (participant 12, nurse).

Reacting to Hero Status

The participants reacted to their hero status in two primary ways. Some embraced it by accentuating its benefits for their social standing. This was largely communicated as a finally found sense of worthiness in the work through its recognition and interest from others.

I feel that my work is important and now it finally gets the recognition it deserves.

People finally realize that our work is very meaningful and useful. So that was positive, it makes you feel valued, so that's great (participant 163, technician).

While some participants welcomed this sudden change and enjoyed the elevation of their status, the vast majority rejected their hero status. It is important to note that many participants reported both a certain level of acceptance as well as rejection. More precisely, while they appreciated the increased recognition, they ultimately rejected it.

I really got a lot of questions, which was a little tiring at some stage. People were curious, they wanted to know what my role was, whether it was hard, whether I worked a lot. So on the one hand it was interesting to share this experience and to tell others what we're doing (participant 162, nurse).

I found that it was good to see and hear, because we indeed put in a lot of effort, so it was good that this was being recognized. But it was a little weird from the side of the media, I felt it was too much in-your-face, too demonstrative (participant 163, technician).

We found that there were three primary responses for ultimately rejecting their sudden hero status. First, they did not see their role as having changed. They critically reflected on the whimsical, exaggerated, and somewhat hypocritical character of these new social reactions, given that the nature and significance of their work activities remained largely unchanged.

[COVID-19] has unfortunately changed the way we are being perceived. We are considered to be heroes because we save lives...but that's what we do all year round (participant 33, nurse).

We're seen as "heroes," while we have hardly changed our working habits (participant 72, hospital attendant).

Apart from highlighting that they were simply doing their job, the second explanation for their rejection of hero status seemed to be related to their resistance to social objectification. They interpreted the sudden social support of their occupation as opportunistic or fake. Some participants seemed to feel used rather than appreciated thus interpreting their hero status as lacking sincerity and an attempt of the public to feel better about themselves rather than expressing a genuine care about healthcare workers.

This whole notion of being a hero, of being oh-so-amazing, is just a manipulation. It is to make us work without complaining. It's a trick and we all got trapped (participant 164, nurse).

A third response consisted of rejecting the hero status as a defense mechanism. They rejected it because they did not see themselves in the way others saw them. One hospital attendant went as far as to explain it as a “form of protection” to not let him/herself get carried away by the praise recognition.

I think that for me, not seeing myself as a hero is probably a form of protection, because I think everyone appreciates to be recognized and respected, everyone. But, if you let yourself get absorbed into being this amazingly valued individual, it probably just hurts too much when at the end you go back to your place. I think it's easier to not really believe and buy into this hero discourse, so that when attention and consideration fades, you don't feel disappointed (participant 162, hospital attendant).

In sum, while some participants embraced their newfound hero status, most rejected it.

Several reasons for the rejection of their elevated status emerged: the perception that they were simply doing their work; feeling objectified, used and manipulated; and as a defense mechanism out of fear of being hurt as they did not perceive their elevated status would last.

Discussion

In this paper, we contribute to the recent call for developing novel approaches to study invisibility to “further our understanding of the contours of invisibility in the workplace” (Mahalingam et al., 2019, p. 236). Feeling invisible or undervalued is important, as the feeling that one's occupation matters has been related to greater self-esteem, lower depression and anxiety, better immune functioning, and more positive affect (Baumeister & Leary, 1995; Rosenberg & McCullough, 1981). While existing research assumes that (in)visibility of work roles is somewhat stable, we find that it can change suddenly during crisis periods but may

not be embraced. Thus, our study calls attention to the “stickiness” of invisible work for individuals in organizational settings due to deeply rooted cultural norms and beliefs about their occupations.

The calls for change through social valorization of invisible work in the healthcare sector have explicitly broken down the established order of occupational worth by stressing the indispensability and significance of work carried out by all individuals employed in the healthcare sector during COVID-19. While prior research indicates that these radical alterations in public discourses and attitudes provoked by catastrophic events move invisible workers to the position of hypervisibility (Mahalingam et al., 2019), we know very little about how workers experience and react to this paradoxical transformation of their social image. Our findings suggest that despite gaining recognition and visibility from being perceived as heroes, our participants do not necessarily relish their newfound elevated status. Interpreting this elevation as temporary seems to be an important factor in how they respond to it leading to its eventual rejection.

Theoretical Contributions

We make several contributions to existing literature on invisibility, social marginalization and dirty work. First, our findings demonstrate that occupational skill, nature of tasks, and position in organizational hierarchy are central to experiencing invisibility. What these three social triggers of invisibility share is not so much a specific property or quality of any particular thing, task, or role, but rather a common set of attributions by others based upon their disrespect for certain kinds of work. Paradoxically, reactions of others that arise from societal shocks such as COVID-19 can catalyze social valorization of typically invisible workers, catapulting them to the rank of heroes and making them highly visible. While prior research has explored the challenges and opportunities presented when workers are navigating

invisible and visible identities (e.g., Deery et al., 2019; Smith et al., 2019), few studies have considered how workers interpret and respond to the sudden rise in visibility.

Thus, we contribute to existing literature on invisible identities at work by drawing attention to the inherent paradox to invisibility that stems from established normative regimes of intersubjectivities that govern the dynamic interplay between work, social interaction, and embodied work identities (Rabelo & Mahalingam, 2019). Our participants may have felt appreciated that their work was being recognized, but they are skeptical it would last. Contrary to research that suggests that feeling valued and appreciated elicits positive emotionality (Simpson et al., 2014; Thiel, 2007), we surmise from our exploratory study that any positive effects that arise from a promotion to a heroic status are provisional and the assumed temporality mitigates any positive effects. Given the exploratory nature of our study, we were unable to quantify the degree to which some workers experienced each type of invisibility. We suggest that a ripe area for future research could address how different forms of invisibility may elicit different types of responses to distinct forms of social valorization.

Furthermore, our findings demonstrate that hero status seemed for many of our participants, regardless of the type of invisibility they experienced in the past, to be too much of a stretch, as many noted they were just doing their job and nothing more. Prior research suggests that workers doing some type of invisible work manage to surmount the everyday disregard of their work by appropriating momentary discursive resources of occupational heroism to continually reframe their work in preferred terms (e.g., firefighters) (Tracy & Scott, 2006). However, this research also points out that workers in other categories (e.g., correctional officers) may struggle or be reluctant to do the same because of unintended or problematic consequences that such attempts of identity enhancement may provoke (Tracy & Scott, 2006).

Our findings offer further insights into this intriguing discovery in revealing several reasons for the rejection of hero status. First, we observe that the rejection of hero status can be driven by workers' resistance to social objectification. Workers may reject valorization of their work because they perceive it as social objectification that disguises the ongoing marginalization of their work. As one worker in an Amazon warehouse pointed out during the pandemic: "*They call us 'essential,' they call us 'heroes,' but I am just going to say it: 'we are expendable.' We did not sign up to be someone's hero*" (Brown & Flowers, 2020). Second, workers may reject hero status because they interpret social valorization of their occupation as opportunistic. Some participants seemed to feel used rather than appreciated thus interpreting their hero status as lacking sincerity and an attempt of the public to feel better about themselves rather than expressing a genuine care about healthcare workers. Finally, some participants rejected hero status because they did not see themselves in the way others see them. Thus, an unintended negative consequence of sudden hero status is potential internal suffering (Higgins, 1989) that forms a mismatch in terms of how they see themselves as opposed to how others view them. The temporality of this situation can make these self-discrepancies less tenable because heralded workers may resist social objectification and believe they are not only being held to unrealistic expectations but that these expectations are also short-lived.

Lastly, we synthesize two distinct streams of literature: dirty work research and social/organizational marginalization literature. Prior research on "dirty work" has focused on identity management strategies, that is, what individuals do to feel better about doing work that others deem "filthy" (physically tainted) or undignified (socially tainted), what normative and discursive resources they have available to do this, and what undermine their efforts to "untaint" themselves (e.g., Ashforth et al., 2007; Ashforth & Kreiner, 1999). Social marginalization literature is less interested in individual responses and more in how

valorization of work is socially constructed and put into practice through attribution of usefulness, merit, and recognition (Ashcraft, 2013; Sennett, 1998). Organizational structures of status incarnate these tendencies and norms by categorizing work and occupations as useful or useless, skillful or unskillful, and accordingly distributing resources of recognition and worth (Sennett, 2006; Anderson, 2019). Thus, social marginalization literature is a useful lens for explaining where invisibility comes from while dirty work literature sheds light on agentic responses to invisibility. Bridging these two literatures, our theorizing suggests that sudden social valorization of certain occupations does not necessarily trigger changes in self-perception, and that workers have a choice as to how to respond to the change in their social image. The response, however, is not as dirty work literature assumes, is driven by purely “strategic” motives, but involves a more critical reflection about occupational dignity, professional integrity and societal hypocrisy.

Practical Implications

The practical implications of our study go beyond the current pandemic. The experience of invisibility has a dual impact on one’s psychological wellbeing as it affects two intricately connected yet distinct aspects of identity – in relation to others and in relation to oneself. Given the importance of feeling recognized and included, chronic invisibility may undermine well-being, especially among marginalized workers in stigmatized occupations (Rabelo & Mahamingam, 2019), and feel like chronic social devaluing (Dutton et al., 2016) leading to apathy and eventually – to distrust towards others and unwillingness to accept potentially positive change. The enduring perception of not being seen and acknowledged by others may ultimately result in social alienation, self-denigration and acute sense of social insignificance (Verhaeghe, 2012).

To avert the negative consequences of chronic invisibility, we recommend that organizations in public care sector (and beyond) engage in the design of what we call

“invisible work dignification policies” that aim at elevating social prestige of low status and socially denigrated occupational categories inside and outside their professional environments. Such measures can pave the way for encouraging a collective occupational identity individuals can take pride in. This would imply creating conditions that can enable invisible workers to step out of organizational obscurity such as granting them bargaining power, actively acknowledging their role in organization, providing living wages and encouraging cross-categorical employee engagement. Put more succinctly, dignification of invisible work is not about its valorization, but about social and organizational willingness to genuinely care about those who take care of us.

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Table 1*Breakdown by Occupation of the Study Sample*

Occupation	Number	Percentage
Nurse	84	52% (51.5%)
Hospital attendant	53	32% (32.2%)
Technician	11	6% (6.2%)
Administrative personnel	3	2% (1.9%)
Nurse supervisor	2	1% (1.2%)
Cleaner	2	1% (1.2%)
Socio-aesthethician	1	1% (0.6%)
Social worker	1	1% (0.6%)
Physical therapist	1	1% (0.6%)
Midwife	1	1% (0.6%)
Occupational therapist	1	1% (0.6%)
Unknown	4	2% (2.4%)

Table 2

Illustrative quotes for aggregate theoretical dimensions

Theoretical dimension	Illustrative quotes
<p>Normative experiences of invisibility</p>	<p><i>[Before the COVID-19, we were] non-existent. No one ever talked about us. Microbes just disappear as by magic as we enter a room. So why are we there? (participant 78, cleaner).</i></p> <p><i>[We are] unknown, forgotten, but an important element in the healthcare system, just like all other professions (participant 70, laboratory technician).</i></p> <p><i>We're an element at the hospital that no one sees. No one understands what functions we have. We're a bit erased (participant 115, hospital attendant).</i></p> <p><i>[My occupation] has a negative reputation. Some people told me: "Ah yes, you clean bottoms" (participant 124, hospital attendant)!</i></p> <p><i>[It's perceived] as a difficult profession, lots of people say they could never do this job. Still, few people are aware of our daily responsibilities, the downsides of the profession, the lack of resources or our remuneration. We are perceived as those little hands that obey to the orders of the doctor (participant 45, nurse).</i></p> <p><i>[We are] ignored, denigrated, undervalued (participant 143, hospital attendant).</i></p>
<p>Interpreting sudden hero status</p>	<p><i>[I get] a lot of recognition from the neighborhood in the form of presents that they leave at my door as they hear me leave every morning at dawn. Families also send me emails thanking me (participant 6, hospital attendant).</i></p> <p><i>Because of the media and the multiple documentaries on our profession since the outbreak of the COVID-19, people have become more aware of the importance of all the medical and paramedical professions and that, without us, the hospital cannot function (participant 68, hospital attendant).</i></p> <p><i>They value us more, like other "essential" professions right now (participant 54, nurse).</i></p> <p><i>Once this pandemic is over, this positiveness and recognition will fade and the profession will fall back in the shadows (participant 153, nurse).</i></p> <p><i>People are going to forget us quickly and the government even faster (participant 164, hospital attendant).</i></p> <p><i>I think that for the moment the profession is in the spotlight but that it will not last... Once the COVID has passed, things will re-establish themselves... it is like a fashion effect, our popularity will be ephemeral (participant 143, nurse).</i></p> <p><i>Unfortunately, I think people have short memories. At the end of the crisis, people will thank us, then a few months later they will forget. Many things in history have shown us that Humanity has a short memory (participant 124, hospital attendant).</i></p>

	<p><i>I don't know...In the beginning [we will be more valued], but this will quickly run out of steam. I'm not sure that at the end of the day we will be valued more, despite all the efforts we're putting right now (participant 102, nurse).</i></p> <p><i>I think we'll quickly be forgotten, like the police with the terrorist attacks. People pay attention to professions that are useful to them at a given moment, so after the crisis, they'll simply forget us as we are no longer needed (participant 130, technician).</i></p> <p><i>The current recognition is a reaction to a temporary phenomenon that appeals to the emotions... a bond of solidarity is tied around this "enemy of the people." We can therefore expect that this recognition will reduce over time. Humans have a tendency to forget (participant 11, nurse).</i></p>
<p>Reacting to hero status</p>	<p><i>Healthcare workers are EVERYDAY confronted with distress, fear, suffering, sadness, illness, poverty and loneliness. Being a healthcare worker is a choice, but it's always difficult, not only during the COVID-19. I think that the majority of people only see those difficulties during this crisis. I don't want to be considered as a hero either, because we're just doing our job, like any other day of the year (participant 71, nurse).</i></p> <p><i>I find it rather funny that we're seen as "heroes" now as our work is the same as usual, under the same conditions, or even worse. We do our job in exactly the same way, we just have a bit more patients in a short period of time, but "heroes" as they call us, that's what we are on a daily basis (participant 35, nurse).</i></p> <p><i>We put our lives at risk, we're perceived as heroes while we just do our work (participant 135, hospital attendant).</i></p> <p><i>They treat us like heroes...while we just continue to do our job (participant 82, nurse)!</i></p> <p><i>Today they call us heroes, because they need us more than ever (participant 80, nurse).</i></p> <p><i>Don't get me wrong, I did appreciate the recognition, of course, we all do, but because it felt insincere and because I've been around for long enough that I did not expect a real change, that you don't really enjoy it, that you're saying to yourself: look how kind they are, just because they need me. It makes you feel even less human (participant 111, hospital attendant).</i></p>

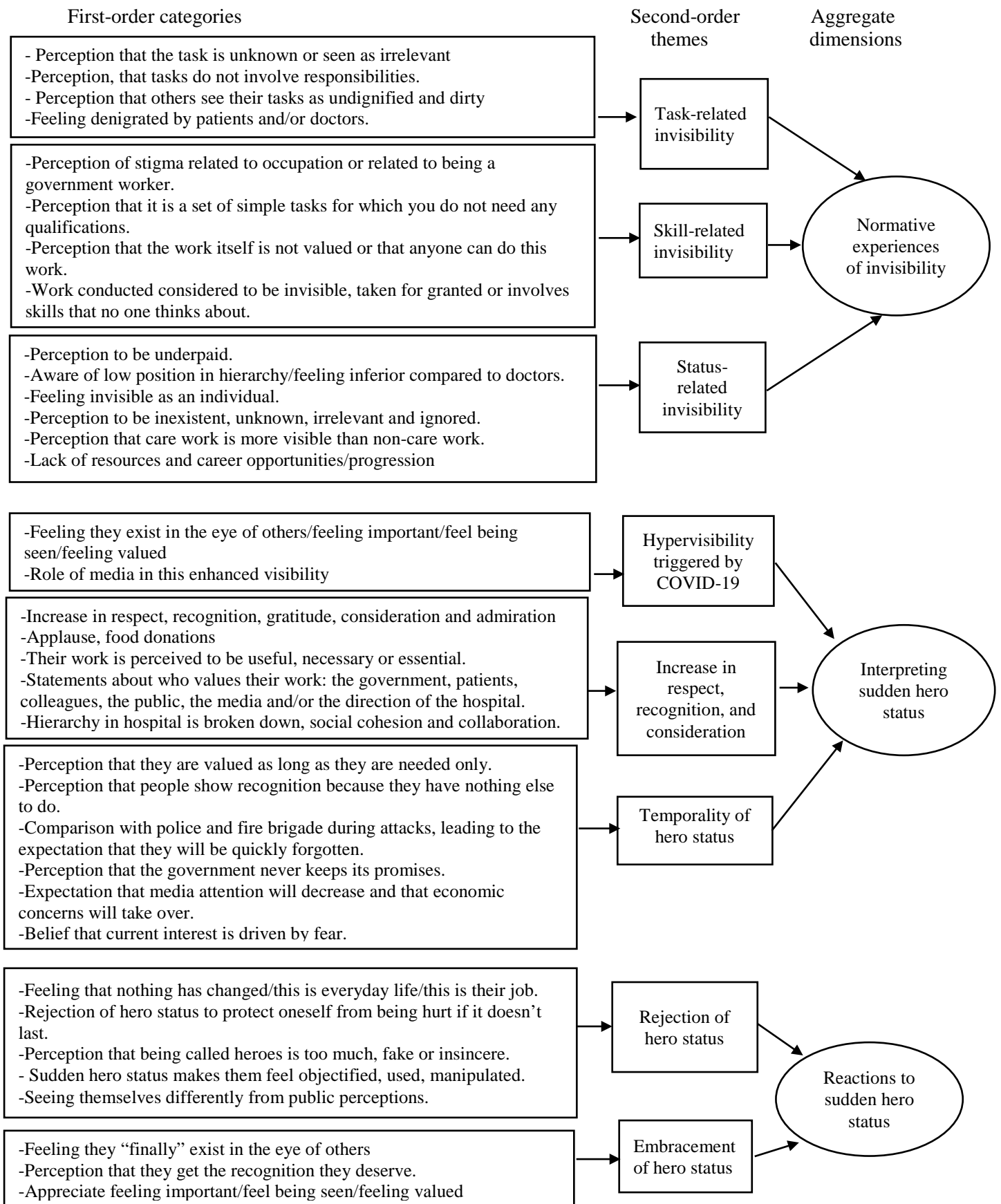
Table 3

Illustrative quotes for second order themes across occupational categories

Occupation	Nurses	Hospital attendants	Technicians
Status-related invisibility	<i>Patients often behave as if they're in a hotel without any form of politeness. We get very little consideration from patients or from some surgeons.</i>	<i>No respect, both physically and verbally towards us. I feel like being a doormat.</i> <i>Doctors devalue us...they look down on you and you really feel that hierarchy, this lower-than feeling hurts me, because I don't think it's justified.</i>	<i>I can feel lots of technicians are frustrated about the invisible nature of their work, they feel overshadowed by doctors, but also feel that others perceive their work to be less important than nurses and hospital attendants.</i>
Task-related invisibility	<i>People know the profession isn't easy, but do not know why exactly (the rhythm, workload, lack of human and material resources).</i> <i>People think being a nurse is easy, while it isn't always easy. You need a lot of practice and I think people also overlook the psychological difficulties.</i>	<i>People think we basically clean poo from old people.</i> <i>We're seen as professionals that do work you do not want to do.</i> <i>The work we do is constantly devalued or taken for granted by patients and doctors alike.</i>	<i>People don't have a clue of what we do. They do not even know we exist. They think that a hospital only consists of individuals who provide direct care for patients.</i> <i>People do not even know our occupation exists. When I say I work at the hospital, they answer: "you're a nurse".</i>
Skill-related invisibility	<i>People believe that nursing is a profession that anyone can do, that you do not need any qualifications for this, while this is obviously not the case.</i> <i>We provide a lot of psychological support to both patients and their families and all that, people never think about it. I think it's actually a big part of the job and you need to be able to handle that, it requires a lot of social skills, but no one seems to notice or realise it. Social skills aren't valued, it's all about your diplomas.</i>	<i>I want my occupation to be recognized in terms of our knowledge and skills.</i> <i>There is this lack of recognition of the fact that many healthcare workers do have some level of qualification and that this is absolutely not seen by society.</i> <i>People see it as simple work that anyone can do and for which you do not need any qualifications.</i>	<i>Most media do not mention us, because the radiologists interpret the x-rays that we make. It's us who are close the patients, who do all the tests.</i>
Increase in visibility	<i>During the pandemic everyone was clapping, we were everywhere, on the radio, on television, on social media, in the newspaper, every single person knew about our extreme efforts.</i> <i>During the COVID the whole world suddenly saw us as heroes, it was a little weird. You go from being no one, to being everything in only a few weeks' time.</i>	<i>I suddenly became very visible, like hyper visible. We were being put in the spotlights all of a sudden. They even talked about us in the media.</i>	<i>Since the COVID, the journals finally talk about us.</i> <i>We were super visible, everyone was constantly asking about how it was to work at the hospital.</i>
Increase in respect, recognition and consideration	<i>During the pandemic, people showed so much recognition, so much consideration.</i>	<i>The government and even patients show a lot more recognition towards the caring personnel and that feels good.</i> <i>People finally realise that our work is very meaningful and useful. So that was positive, it makes you feel valued.</i>	<i>We're getting out of the shadow and that highlights the importance and usefulness of our work.</i> <i>The government has really recognized our huge efforts. They really showed their</i>

			<i>recognition and that feels pretty good.</i>
Temporality of hero status	<i>Our valorisation will last as long as long as the crisis lasts. Afterwards, I don't think there will be any recognition or a revalorisation of our salaries. Promises are never being kept in France.</i>	<i>I do not think that the COVID will have a long-lasting effect on the way society perceives our occupation. Over time, people always forget. Take the example of the heroic acts of the fire brigade and how badly they were treated in certain suburbs several months later.</i> <i>I didn't expect this hero status to last. I clearly expected that over time, people would forget about our extreme efforts and devotion and that nothing would change.</i>	<i>The general public will remember, like usually, the nurses, the hospital attendants and the doctors. The other professions will be quickly forgotten, especially if the public authorities do not valorize the profession.</i> <i>I hope things will change, like everyone else. Often they [the government] say a lot of things, but finally nothing really happens, it's just words.</i>
Rejection of hero status	<i>I personally didn't like it, because we're paid to do this, we've chosen this career path, so we're simply doing our duty.</i> <i>They think that we are "heroes." But actually this is what we do every day, certainly on a smaller scale, but every time we come to work we save lives. This is our daily life... So we are not heroes and this is our job, every day, with or without COVID.</i>	<i>We were heroes because people didn't really have a choice, they wanted us to look after all those patients and one way to incite people to continue going to work, while running the risk to get this virus ourselves, is obviously by overloading us with praise and compliments, so I think it's basically the only thing they could do.</i> <i>I'm just doing my job. I'm asking for more recognition, some more consideration or respect, that's true, but that does not make me a hero. That's simply a step too far.</i>	<i>It's good that our efforts got recognized, but finally we're just doing our work, we're doing this out of vocation, out of passion, and not because we're seen as heroes.</i> <i>They were saying, they are heroes, they are heroes, and that every day. But we're treating people every day, so we could be applauded every day. It was all of a sudden, we were suddenly being put in the spotlights, while we've always done what we were doing. So it was a bit too much.</i>
Embracement of hero status	<i>Feeling suddenly respected and valued is pretty cool and I think that, although most of us thought it was too much, we also appreciated it. Of course it's pleasant that the media talks about your efforts, that people ask how you're doing, that people thank you, that patients show more patience and respect also, all this was definitely cool.</i>	<i>I see why they [called us heroes] and I think that's pretty accurate.</i>	<i>I think this hero status we got was justified somehow. We really did put in a considerable effort, we have never worked so hard before, we never gave so much.</i> <i>We indeed put in a lot of effort, so it was good that this was being recognized.</i>

Figure 1
Data Analysis Structure



APPENDIX A

Vignette 1 Hospital Attendant

A 55-year old hospital attendant in a public hospital reports that she perceived her work was invisible to others in multiple ways. She explains that her work is taken for granted by both doctors and patients, consists of tasks people prefer not to think about and mentions that it is seen as simple work that anyone can do. Also, she highlights that she feels invisible as a person and stresses the hierarchy in her hospital and how she often feels inferior compared to nurses, technicians and doctors. During the pandemic, she suddenly felt very visible and explained she finally got recognized and valued. However, she does not identify as hero, as she felt she was just doing her job. She explained that she expected that this hero status would be only temporary as people had nothing better to do and explained she thought things would go back to how they were before. This expectation of brevity of public appreciation turned out to be accurate in her opinion. She explained that the government never keeps its promises and that the lack of change made her feel that the sudden recognition during the pandemic had been insincere and that she was valued only because people needed her. Furthermore, she highlighted that the sudden hero status and the subsequent lack of interest in real change made her feel worse - used and manipulated. Finally, she acknowledged that the most positive aspect of the pandemic was the cohesion and team spirit at the hospital. However, she reported that once the COVID calmed down, the hierarchy was re-established and that everything had gone back to normal.

Vignette 2 Technician

A 24-year old technician in a private hospital explains that her occupation is not well-known as it does not directly involve care work, making it invisible. However, she mentions that the pandemic has made the public aware that non-care work is also important in providing care for patients. She explains that the sanitary crisis has led to a strong cohesion with others in the same vocation and that she enjoyed being part of something bigger, highlighting her sense of belonging to the profession of biomedical engineer. Moreover, she stressed that the social cohesion at the hospital was also amplified by the pandemic as all healthcare workers had the same goal. This also broke down hierarchies and enhanced collaboration. She explained that although she perceived that some of this cohesion remained after the crisis weakened, the direction of the hospital still did not recognize non-physician healthcare workers. She perceived that the government and the general public showed more consideration and respect during the pandemic. Although she hopes this will lead to structural changes in the way her work and that of her non-physician colleagues are treated, she is sceptical about a possibility of enduring change. In addition, she rejected the imposed hero status as she felt it was too much and too demonstrative. She explained that this made her wonder whether the motives of the public were genuine.

Vignette 3 Nurse

A 44-year old nurse working in a public hospital explains that before the pandemic she did not feel valued and that she was seen as inferior compared to physicians. However, she felt well regarded by patients. The crisis made her visible and appreciated, but she reports that the sudden recognition during the pandemic was surreal and felt fake. She went on to explain that she rejected the sudden hero status, but that she appreciated the fact that her work was acknowledged. At the end of the confinement the perception of being visible vanished and it was a painful experience. This made her think whether the public praise was genuine or whether people valued her because they had nothing else to do and because they needed her during the pandemic. The sudden hero status made her believe that it would trigger a shift in her social status, and when this did not occur, she felt manipulated and abused and engulfed in anger and frustration.