The hailing heroes myth: raising awareness of stigma experienced by healthcare workers during COVID-19

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Introduction

When the COVID-19 pandemic first began unfolding, an unprecedented outpouring of solidarity, gratitude, and appreciation for healthcare workers (HCWs) was felt around the world. In light of public health restrictions, communities found unique and innovative ways to celebrate HCWs for their efforts in responding to COVID-19. Balconies and streets filled with nightly applause and cheers. Sidewalks were covered with chalk messages thanking them for being heroes. Planes carried out fly-pasts across various cities. Online concerts to honor front-line workers broadcasted widely.

Despite these acts of appreciation, HCWs have faced numerous challenges as the pandemic has progressed. HCWs have become targets of stigma, prejudice, discrimination, and violence. In reality, people participating in such activities of praise are not any less likely to hold harsh and stigmatizing beliefs about the threat HCWs pose.[1] HCWs have also experienced shortages of personal protective equipment (PPE), increased workload, lack of adequate compensation, and difficulty with striking a balance between their professional and personal responsibilities.[2-5] Under the guise of heroism, HCWs have faced violations of their rights: the right to just and favorable working conditions, the right to health, and the right to be free from discrimination and violence. The purpose of this commentary is to raise awareness of the stigma that HCWs have experienced during COVID-19 by providing an overview of the manifestations of stigma, its impacts and drivers, and potential strategies that can be applied to reduce stigma.

Stigma and HCWs

Globally, the stigmatization against HCWs has taken many forms. In this commentary, stigma is defined as the coexistence of "labelling, stereotyping, separating, status loss, and discrimination in a power situation that allows these processes to unfold."[6] HCWs are defined as all nurses, doctors, volunteers, and technicians in healthcare facilities.[7] Given the potential proximity to COVID-19 patients in a hospital setting, HCWs have been perceived by others as "dirty", infected, and contagious by family members, friends, and the general public.[8-10] Family members and friends have reacted negatively after learning that they were working in a hospital at the start of the outbreak.[8] Many avoided interacting with them, joked about them being infected on social media, or perceived them as carriers of contagion.[8-10] For instance, after an outbreak began on a cruise ship in Japan, HCWs who provided care on-site were referred to as "germs".[11] In a recent study in Canada and the United States, 42% of survey respondents indicated that they do not want to be around HCWs who treat COVID-19 patients, while 39% of respondents believed that HCWs who work in hospitals are likely to have COVID-19.[1]

HCWs have faced substantial social ostracism from their communities. In a wide range of countries, HCWs have become victims of acts of verbal and physical violence as illustrated by the following examples. In India, two female doctors were filmed being stoned by a mob after they screened a patient suspected of having COVID-19.[12] Media coverage also revealed incidents of HCWs in India being spat on while carrying out their duties and even receiving threats of sexual violence.[13] In Mexico, the Ministry of Interior recorded at least 47 acts of aggression towards HCWs as of April 28, including chlorine and eggs being thrown at nurses on the street.[14] From March 19 to May 8, the Mexican National Council to Prevent Discrimination received over 250 complaints from HCWs concerning discrimination due to COVID-19.[14] In the Philippines, a nurse was doused in bleach by a group of men who believed he had COVID-19 due to working at the hospital.[13] In Pakistan, doctors were arrested for protesting the lack of PPE required to care for COVID-19 patients.[15] HCWs have also been denied access to various essential services, making an already straining situation more difficult.[13] Across Pakistan, Japan, Mexico, and India, HCWs have reported being evicted from their homes due to fear of them being infected.[13,16,17] Similarly, they have been refused access to public transportation, shops, and grocery stores.[18] In Canada and the United States, 29% of survey respondents felt that HCWs should have restricted freedoms and 28% of respondents felt that HCWs should not go out in public.[1]

It is crucial to recognize that the stigma associated with COVID-19 is not neutral across critical factors such as race and gender. For HCWs of Chinese descent and those perceived as Chinese, the stigma associated with their occupation is compounded with a surge in anti-Chinese stigma. Between March 16-18, 2020, President Donald Trump referred to coronavirus as

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the "Chinese virus" in a series of tweets, which linked race to the virus and insinuated that Chinese communities are responsible for originating and spreading COVID-19.[19] After Donald Trump's tweets, there was nearly a 10-fold increase in the use of phrases such as "Chinese virus" and "China virus" on Twitter across the United States.[20] The World Health Organization (WHO) recommends not naming new human infectious diseases based on geographic locations as it can have negative social and economic impacts as well as foster distrust of public health.[21] Such instances of racism and discrimination are embedded within the historical perceptions of Chinese communities being "perpetual foreigners" who are "sickly" and "disease-ridden".[22,23] HCWs of other Asian ethnicities, including Korean and Filipino, have also experienced racism, including racial slurs (e.g. "go back to China"), physical assault (e.g. being spit on), and patients refusing care from HCWs perceived to be Asian.[24] Ironically, although HCWs have been on the frontlines saving lives, many Asian HCWs continue to be blamed for the onset of the pandemic.[24]

The experiences of stigma are believed to be stronger for HCWs who are more proximal to patients and heavily involved in patient care, such as nurses, who have reported more adverse stigma-related psychological impacts.[8,25] In Canada, women represent over 90% of nurses, which suggests that women may be experiencing stigma at higher rates.[26-28] Women also often carry the burden of caring for their loved ones, have higher participation rates in housework and childcare than men, and are making difficult decisions about childcare in response to school closures.[26] Women are coping with COVID-19 without crucial safety nets, while simultaneously being on the frontlines and putting care at the center of their work.

Impact of Stigma on HCWs

Stigmatization has widespread and profound negative impacts. Physicians and other HCWs experience higher levels of stress than the general population, and during a pandemic, this stress is heightened.[29] HCWs have developed symptoms of PTSD, depression, and substance-use disorders during previous pandemics and outbreaks, such as SARS, MERS, H1N1 influenza, and Ebola.[25,30] Frequently, pandemic-related stress stems from an increased workload and fear of infection.[31] Stigma-based discrimination and prejudice can increase the mental burden on HCWs. In particular, it can increase feelings of social rejection and isolation which can lead to anxiety and depression.[32] For instance, the first COVID-19-related death in Japan was related to mental health, when a government worker who was responsible for returning citizens from Wuhan died by suicide.[11]

In addition to the mental health challenges, HCWs also experience an increase in the prevalence of physical symptoms, such as headaches, sore throat, lethargy, and insomnia.[3,33] When compounded, these physical symptoms can further exacerbate pandemic-related mental health problems and vice versa.[3,33] The stigmatization during COVID-19 is also positively related to burnout and fatigue.[3] Discrimination due to stigma can also lead to poor physical health, greater risk of cardiovascular disease, and hypertension.[34,35]

Impact of Stigma on Healthcare and Communities

The hostility HCWs have experienced is, in many ways, characterized as an attack on healthcare as a system. The World Health Organization defines an attack on healthcare as "any verbal or physical act of violence, obstruction or threat that interferes with the availability, access and delivery of such services."[36] Stigma and discrimination impact HCWs' decision-making, efficiency, and ability to manage the crisis effectively.[16] It can also de-motivate HCWs from their roles and responsibilities and can contribute to staff shortages, as many HCWs may not feel safe coming to work.[17,36] This lack of motivation has direct implications on the quality of care that patients receive and can disrupt the availability and smooth delivery of essential health services in hospitals.[36]

Inconsistent public health messaging combined with the spread of misinformation on social media has led to uncertainty and fear regarding the origins and methods of transmission of COVID-19, as well as respective treatments and preventative measures.[37] The combined effect of misinformation and fear has resulted in a growing mistrust towards HCWs and public health officials. HCWs and their families are being increasingly seen as a risk to communities rather than a solution to this public health emergency.[36] There have been various reports of HCWs' children being bullied, socially excluded, and denied admission to nursery schools because of fear that HCWs will spread COVID-19 to others.[11,31] For example, in Canada, a nurse's daughter was excluded from a neighborhood playdate because many feared that she had COVID-19.[38] This stigma towards HCWs and their families increases public fear and distrust, which can be detrimental to public health efforts, as seen with vaccine hesitancy.

Drivers of Stigma

To understand the increase in stigmatizing beliefs against HCWs, it is important to understand that fear is one of the common drivers of stigma.[39] This relationship is best described by the "COVID stress syndrome" which is characterized by: (a) fear of infection and/or coming into contact with carriers of the virus; (b) worry about personal finances and other socioeconomic costs; (c) xenophobic beliefs that immigrants and other minority groups are carriers of the virus; (d) traumatic stress symptoms associated with direct or indirect exposure to COVID-19 and; (e) compulsive checking and reassurance seeking.[40] A network analysis of these five factors reveals that at the core of this syndrome is fear of infection, thus explaining the increase in stigma and discrimination against HCWs during the pandemic.[40] Furthermore, the analysis reveals an interconnectedness between xenophobia and the fear of infection, which elucidates the layered stigma HCWs of Asian descent have been facing, as previously mentioned.

Strategies to Combat Stigma

Given the scientifically limited and rapidly evolving nature of COVID-19, the spread of misinformation and fear is inevitable. To address this, several guidelines have been released by different entities, including the WHO, Centers for Disease Control and Prevention, UNICEF, and The Centre for Addiction and Mental Health, amongst others.[41-44] These guidelines show similar characteristics in stigma definition, its impact, and how to reduce stigma in healthcare facilities including: learning about the disease of interest and/or

related stigma, encouraging relationship-building with populations that face stigma, and promoting wellness in stigma-afflicted groups.[45] However, to our knowledge, evidence on community uptake of and adherence to such guidelines is limited.

While guidelines provide valuable information, it is necessary to evaluate their efficacy in reducing stigma.[17,45] The heterogeneity of interventions and the lack of standardized measures makes assessing their efficacy in different healthcare settings challenging.[45] In addition, many of the proposed interventions fail to target root drivers of stigma and often take retroactive steps to addressing its impacts.

To address this, we recommend that researchers and decision-making bodies utilize a translational research (TR) framework, which is centered on understanding the uptake of guidelines and interventions that address stigma by community end-users. The TR framework(s), although often adapted, is an iterative process which involves: identifying a problem, contextualizing existing or synthesized knowledge, developing interventions to address the problem, and evaluating the long-term effectiveness of interventions.[46] Within Canada, one of the most widely recognized TR frameworks is the Knowledge-to-Action Cycle.[46] The use of this framework is valuable to HCWs and the general community as it encourages researchers to identify root causes of problems, to tailor interventions to local contexts, and to evaluate their efficacy for sustainable use.

In the context of COVID-19, adopting the TR framework could begin with identifying existing guidelines and interventions designed to reduce stigma towards HWCs published by public health and associated entities. This approach can be followed by community-wide assessments that analyze stigmas, biases, and knowledge that community members hold in relation to HCWs and COVID-19. It could also explore potential barriers and facilitators to the implementation of current guidelines and interventions. In collaboration with community members, the findings could then be utilized to iteratively improve current efforts or to develop new interventions that address the root causes of stigma. In turn, stakeholders can return to the community to assess the intervention's effectiveness in increasing knowledge, reducing fear, and ultimately stigma.

Conclusion

As the COVID-19 pandemic unfolds in real-time, HCWs continue to face substantial stigma, prejudice, discrimination, and violence. Stigma has profound physical and mental health impacts not only on HCWs, but on their families, the patients they serve, and the broader healthcare system. While various guidelines to combat stigma against HCWs currently exist, to our knowledge, evidence on community uptake, adherence, and efficacy is limited. Moving forward, it is suggested that researchers and decision-making bodies utilize a translational research approach to address the stigma HCWs have and continue to face due to COVID-19. While communities are encouraged to continue hailing HCWs as heroes, more needs to be done to ensure that they are structurally protected and cared for during COVID-19 and future pandemics.

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