

'You just emotionally break': understanding COVID-19 narratives through public health humanities

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ABSTRACT

News reports that feature the experiences of healthcare workers have shaped public conversations about the pandemic from its earliest days. For many, stories of the pandemic have been an introduction to the way public health emergencies intersect with cultural, social, structural, political and spiritual determinants. Such stories often feature clinicians and other providers as characters in pandemic tales of heroism, tragedy and, increasingly, frustration. Examining three common categories of provider-focused news narratives—the clinician as a uniquely vulnerable front-line worker, clinician frustration with vaccine and masking resistance, and the clinician as a hero—the authors argue that the framework of public health humanities offers useful tools to understand and potentially shift public conversation of the pandemic. Close reading of these stories illuminates frames that relate to the role of providers, responsibility for the spread of the virus and how the US health system functions in a global context. Public conversations of the pandemic are shaped by and shape news stories and have important implications for policy. Acknowledging that contemporary health humanities in all its iterations considers how non-clinical factors, such as culture, embodiment and power, impact our understanding of health, illness and healthcare delivery, the authors locate their argument amid critiques that focus on social and structural factors. They argue that it is still possible to shift our understanding of and telling of those stories towards a more population-focused frame.

BACKGROUND

Much of what we know or believe of COVID-19 has come to us through stories. Stories of jobs and lives lost, plans and classes cancelled, symptoms appearing and resolving or, for many, never resolving. Misinformation, too, spreads widely in narrative form. Stories about false cures, the nature of or weaponisation of the virus, and suspicions regarding the motivations behind infection control measures abound on social media, play endlessly on YouTube and spill from the mouths of politicians (Siwakoti *et al.* 2021; Topf and Williams 2021). Stories are consequential. Since the early days of the pandemic, news reports that feature the experiences of healthcare workers have shaped the conversation *about* the pandemic itself. As noted by political scientists Molly Patterson and Kristen Renwick Monroe, '...we create and use narratives to interpret and understand the political realities around us. We do this as individuals and we do it as collective units; as nations or groups' (Patterson and Monroe 1998, 316).

The increasing political polarisation around public health measures in response to COVID-19, as well as the exploitation of such divisions in connection with other public health issues, adds urgency to understanding how narratives are constructed and understood between communities and their impact on structural factors, such as health policy (Boas and Davidovitch 2022). In this article, we argue that applying a framework of public health humanities to three common categories of COVID-19 stories that feature clinicians can illuminate public perceptions of the pandemic that shape and are shaped by media and potentially influence policy. These include the role of providers, responsibility for the spread of the virus and how the US health system functions in a global context. Towards this end, we combine methodologies drawn from literary theory (close reading and textual analysis) and the arts (the framing, constructing and shaping of stories) with public health theory and practice to understand—and potentially shift—important COVID-19 narratives from the early years of the pandemic.

Applying this lens to categories of stories that echo common themes, we hope to demonstrate how we might broaden understanding of pandemic-related risks, behaviour, structural pressures, and population and community-focused policies. These tools are urgent now because COVID-19 is a global public health crisis. The plane on which these stories are unfolding is one that deeply implicates and concerns public health systems. While acknowledging that social, structural and non-medical factors are considerations of contemporary health humanities in all its iterations, we locate our critique amidst approaches that focus explicitly on social and structural forces and hope to push the margin of that discussion towards an even more expansive, public health-informed framing.

In referring to public narratives, we distinguish between stories that appear in the journalism space (eg, newspapers, institutional blogs with a wide public audience) and engage explicitly with the public conversation around behaviour, such as masking or vaccination, and policy issues, such as access to healthcare from reflective writing, literary writing or articles in academic journals. In their research into public health narrative framing, Chris Skurka *et al* note that 'The tension between a tendency to tell stories about individuals and the need for collective solutions matters in the larger policy sphere because news—and news narratives, in particular—are a primary means by which people learn about policies, their importance, and potential consequences if they are (not) enacted' (Broie,



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Hamel, Altman, Blendon, & Benson, 2003 as cited in Skurka, Niederdeppe, and Winett 2020, 4161).

This is not a comprehensive review. We do not suggest that the stories referenced in this article are the only stories that have emerged from the pandemic or even that they constitute a representative sample; rather, we are suggesting that attributes of stories referenced here have appeared often enough in the American popular press (opinion editorials (op-eds), news reports, etc) to contribute to important public narratives about the pandemic. We propose a close reading and analysis of these stories that we hope will illuminate those familiar attributes in useful ways. We focus on stories in the American press that are written by both journalists and non-journalists to underscore how, even in stories that reference social and economic determinants, the frame remains largely focused on individual behaviour and to advocate for a frame that more effectively represents the socioecological model of health.

Finally, though many scholars use the terms *narrative* and *story* interchangeably (Holloway and Freshwater 2007; Hunter and Kathryn 1991; Hurwitz and Victoria 2016), the ubiquity of the word narrative in political discourse hints at a useful distinction. We propose that stories join to form narratives when they echo each other thematically in a manner that strengthens a collective interpretation of representative events. This formulation is similar to what Aleksandra E Olszewski refers to as *stock stories* (Olszewski 2022). In this article, we offer examples of news stories and opinion pieces that contribute to three important narratives or stock stories: the vulnerability of providers as front-line workers, provider frustration with non-vaccinating patients and the healthcare worker as hero.

Health humanities generally involves engagement with history, philosophy, art and literature to facilitate critical thinking about how health-related roles and definitions of illness and disability came to be. Health humanities scholarship explores how personal history, culture and embodied experiences shape perspective, and how those differences have the potential to introduce bias or offer opportunities for empathy and connection (Charon 2001; Crawford et al. 2015; Ousager and Johannessen 2010). Within health humanities, engagement with social influences on health such as racism and economic class exists along a continuum. Medical humanities focuses substantively on how non-medical factors influence the doctor–patient relationship, the culture of medicine, healthcare institutions, and the subjective experiences of patients and clinicians, including questions of bias, burnout and empathy (Macnaughton 2011; Evans 2016). Medical humanities programmes are grounded on the idea that the humanities offer necessary wisdom to medical students, residents and physicians about the context of patients' lives outside the clinic, including the structural and social forces that shape access to resources (Bleakley 2015; Greaves and Evans 2000; Charon 2006). Thus, a medical humanities framework includes consideration of many of the primary concerns of public health, including the social determinants of health (Braveman and Gottlieb 2014). However, it generally remains focused on the way those factors impact the patient's experience of the clinical setting or the clinician's views of the patient (Greaves and Evans 2000). The study of narrative to facilitate self-reflection and empathy is a central component of many medical humanities programmes, including the narrative medicine programme at Columbia University. Its founder, Rita Charon, identifies narrative competence as 'the set of skills required to recognise, absorb, interpret and be moved by the stories one hears or reads' (Charon 2006, 862).

Extending the continuum, *health humanities* (initially proposed by Crawford et al. 2010) references an arguably

broader health system—including non-medical carers—and an increased focus on the world outside the clinic. Current scholarship in health humanities continues to extend the continuum further, largely towards critical and social theory (Atkinson et al. 2015; Crawford, Brown, and Charise 2020). At this end lie approaches which emphasise non-clinical spaces and structural and systemic factors, including social medicine, disability studies and public health humanities (Saffran, in press). Examples of this work include the health humanities portrait approach developed by Sandra Sufian and colleagues (2020) and antiracist pedagogy and structural competency (Wear et al. 2017). As the pandemic further reveals the inequity of social structures, cultural influences on health behaviour, as well as the political dimensions of public health, calls for health humanities training for healthcare workers and researchers that reflect these broader frames have entered the public discussion of the pandemic.

For example, an op-ed in the *New York Times* in April 2021 by historian Molly Worthen noted that 'To make sense of disproportionate Covid death rates in Black and Latino communities or white evangelicals' vaccine resistance, researchers need to consider everything from the history of redlining to theologies of God's judgment' (Worthen 2021, para. 13).

Another editorial, by Wendy Hesford in *University World News*, highlights the value of the humanities not only in understanding the pandemic but also in enduring it. She writes, '...cultural practices and creative expressions are just as important to survive a pandemic as are medical interventions' (Hesford 2021, para. 9).

For many, the pandemic has been an introduction into the way a public health emergency intersects with cultural, social, structural, political and spiritual determinants. These aspects continue to be closely entwined with the narratives it has produced. As Bradley Lewis notes in the *Journal of Medical Humanities*, 'COVID-19 is not simply a biomedical problem, it is very much a narrative problem. What is its past, its present, and its future?' (Lewis 2021, 11). Writing in *Literature and Medicine*, Rebecca Garden highlights how COVID-19 narratives of shared vulnerability and suffering have both a unifying power with regard to community and the potential to obscure how vulnerabilities are unequally tied to economic class, race and disability (Garden 2021).

Stories featuring healthcare providers have been ubiquitous since the beginning of the pandemic. They often feature clinicians and other providers as characters in pandemic tales of heroism, tragedy and, increasingly, frustration. Per our discussion earlier, critical health humanities and intersecting methodologies, such as disability studies and social medicine, contextualise those stories with a rigorous examination of economic, racial and social inequities and a call for the centring of marginalised voices. The argument we make in this article is that it is still possible—and useful—to shift our understanding of and telling of those stories towards a more population-focused frame and that public health humanities provides conceptual tools to assist us in that task.

CLINICIAN AS UNIQUELY VULNERABLE FRONT-LINE WORKER

A public health humanities' reading of stories of clinicians who are overworked and under-resourced offers an opportunity to expand the frame from a common narrative—clinician as uniquely vulnerable front-line worker—to one that reflects public health's broad understanding of the way policy, institutions and community intersect. An analysis that emphasises clinicians as a *community* juxtaposed against other communities

builds on essential health humanities scholarship which highlights the embodied nature of *both* clinicians and patients. It engages the hazards of focusing too intently on the subjective experience of clinicians to the potential exclusion of contextual factors. It emphasises the way that a community's vulnerability or resilience—and clinicians are no different—is compounded by influences within the concentric circles that make up the socioecological model of health—influences that are related to dynamics at the individual, interpersonal, institutional, community and policy levels.

Clinician burnout, grief and stress have long been a focus of health humanities work (Crawford, Brown, and Charise 2020). The creation and study of narratives occupies a central role in understanding the pressures of clinical practice, grief, embodiment, structural racism and the hidden curriculum in medical training. For example, Sayantani DasGupta and Rita Charon have written about how guiding medical students through the creation of a personal illness narrative counteracts a dichotomy in medical training, 'whereby patients are identified by their bodies while physicians' bodies are secondary to physicians' minds. As a result, little opportunity is afforded to physicians to deal with personal illness experiences, be they their own or those of loved ones' (DasGupta and Charon 2004, 351).

Writing about illness (or potential illness) from the perspective of someone who is both a doctor and a patient constitutes core reading for many programmes in medical and health humanities (Van den Berg 2015). Critiques of these texts include the complaint that some exclude broader, contextual factors in their focus on individual, subjective experience (Brown and Garden 2017). As noted by Martha Stoddard Holmes, 'autobiographical writing about illness and disability has generated substantial critical controversy for being narcissistic, sensational, sentimental, or insufficiently political—overall for its management of the difficult balance between individual experiences and larger social issues' (Holmes 2015, 11).

If one of the operating assumptions of health humanities is that engaging with art, literature, history and philosophy offers a way to understand how healthcare providers are more multifaceted than their professional roles, and that their embodied experiences impact them *within* those roles, then the COVID-19 pandemic has made that fact even more concrete. A study from May 2020 found that front-line healthcare workers had a significantly increased risk of COVID-19 infection (Nguyen et al. 2020). The physical vulnerability of healthcare workers to COVID-19, particularly in the absence of adequate personal protective equipment, as well as the accompanying mental stress, was a common theme of COVID-19 stories since the early days of the pandemic. This reality was reflected in stories such as *Doctors Fear Bringing Coronavirus Home: I am Sort of a Pariah in My Family* (Weise 2020), *From Quiet Acceptance to 'Crippling Fear,' Medical Workers Confront Their Own Mortality* (Feldman, Chbria, and Kalamangla 2020) and *U.S. Faces Crisis of Burned-Out Health Care Workers* (Levine 2021), which detailed the fear and exhaustion of healthcare professionals caring for patients and fearing for themselves. A pulmonary critical care physician in California, for example, was quoted in the *Los Angeles Times* article mentioned previously as worrying, 'If I die next week what do I want to teach the kids? What haven't I taught them?' (Feldman, Chbria, and Kalamangla 2020, para. 6).

Adopting a public health humanities framework goes beyond examining social, cultural and political influences on the embodied experience of clinicians or even the way those experiences intersect with how healthcare is provided to others. It involves putting those experiences in a community and

socioecological context. The socioecological model of health, which is a core tenet of public health theory, asks us to consider a variety of influences on health behaviour and outcomes, including cultural, institutional and policy factors. Stories of the vulnerability to illness experienced by doctors and nurses, in an analysis informed by a critical public health humanities' reading, might consider the similarities and differences of them as a community placed alongside other communities with disproportionate—and often intersecting—vulnerability, including people of colour, service workers, teachers and the incarcerated. During the early months of the pandemic when the news was full of stories about doctors, nurses and public health department staff, stories about the close to 7 million essential low-wage workers such as orderlies, housekeepers and personal care aides, who are disproportionately women and people of colour, were rare (Kinder 2020). Shifting the framing thus prompts an examination of the way that both the culture of medicine and the role of clinicians in the broader culture can be simultaneously protective and isolating.

Beyond their fears for their patients and themselves, early COVID-19 stories often highlighted doctors' worries about bringing the virus home. The emergence of new variants and the vulnerability of children too young to be vaccinated underscored the fears healthcare workers had long had of infecting their family members, such as a nurse practitioner from St. Louis who was quoted by the *Washington Post* as saying, 'We can't risk our kids' health for this. It is one thing to say that we took an oath to do this, but our kids didn't take an oath' (Cox, Miller, and Jamison 2020c; Cox, Miller, and Jamison 2020c).

In addition to the threat of infection, healthcare workers also experienced the mental stress of stigmatisation, particularly in the early days of the pandemic. This included exaggerated estimates among community members of how likely healthcare workers in their midst were to spread COVID-19 to others, a fear that often resulted in isolation and shunning of those already exhausted and frightened individuals (Taylor et al. 2020). During a late summer surge in 2021, a Florida doctor was quoted in the *Health Insider* as saying, 'Humanly, you break at some point, ... You just emotionally break' (Reed 2021, para. 16).

A shift in framing towards understanding these experiences in a socioecological context facilitates a deeper investigation of policy, particularly healthcare policy, but also as is increasingly the focus of public health efforts, economic and housing policy, as well as policy related to education, immigration and other factors. It encourages those who craft the narratives (eg, journalists on the health/public health beat, public health storytellers, health humanities scholars, and opinion, culture and policy writers) to look for those contextual factors in stories about clinicians at risk and under stress and to identify the gaps when that context is missing.

Finally, the focus of applied public health work is intervention, impacting the determinants of health in order to improve health outcomes. An analysis which values both the stories and subjective experiences of health workers, while viewing those experiences as belonging to one community among many in a broader political, social and cultural context, offers new opportunities for connection and even solidarity. A discussion of COVID-19 narratives informed by public health humanities is one in which the following quote from a hospital chief executive officer in New Jersey, who anguished over the decision to require staff to return to work, resonates with the experiences of other communities made vulnerable by the pandemic, 'We don't have good choices—or the choices we want' (Levy 2022, para. 3).

Indeed, there are many indications that COVID-19 is fostering those kinds of juxtapositions, with potential political and social impact. Public health humanities can provide a useful framework to support the contributions of individuals such as James Januzzi, Jr, MD, who was featured in Caitlin Cox's TCTMD report on physicians 'finding their voices' through COVID-19. In it he spoke about the growing politicisation of himself and other physicians.

'There's an old saying that has nothing to do with medicine that applies here, which is: you poke the bull, you get the horns', he quipped. 'What has happened in medicine is that there has definitely been an awakening not only with respect to healthcare issues but also social determinants of health, which include violence against minorities' (Cox 2020a, para. 21).

By broadening COVID-19 narratives to focus on systemic factors that make communities vulnerable, the stories of clinician vulnerability and grief offer the possibility of even more than empathy; they offer an avenue for solidarity and the possibility for change.

FRUSTRATION, ANGER, COMPASSION: CLINICIANS CONSIDER EMPATHY AND ATTRIBUTION

A local California news story airing in the winter of 2020 featuring the headline 'California Doctors, Nurses Plead with People to Stay Home on Christmas' (Maher 2020) juxtaposes the concerns of exhausted clinicians with the behaviour of the wider community in the months before vaccines were available. Given the well-documented strains on the healthcare system that the pandemic illuminated, it is notable that the pleading described previously is from one community (clinicians) to another community (the public). It is framed as a direct communication that essentially bypasses the economic, cultural, political and policy environments in which the undesired behaviour might occur.

The story includes two individuals as exemplars of the exhaustion that clinicians are experiencing, including an infectious disease physician from Kaiser Permanente who says:

'We're tired of seeing people coming in sick. We're tired. We're holding hands and comforting when family can't be there. It's a tremendous drain. We have ways to try to go back into that room, go back into the ER, to be there for people when they are sick, but we haven't had a chance to take a break' (Maher 2020, para. 5).

The broader public to whom he is making his appeal is not represented by exemplars in this case. The framing of this story highlights an interesting dilemma when considering narrative in a public health context: stories of individuals inspire greater empathy than those about populations (Bloom 2013; Kogut and Ritov 2005). In this case the population in question is the public, composed of potential future patients as opposed to an actual individual patient in the hospital.

In the midst of the COVID-19 pandemic, it is perhaps useful to think of vaccine refusal/resistance and non-mask wearing as a version of non-compliance. In a clinical context, medical and health humanities programmes seek to inculcate empathy in providers by offering opportunities to consider nuanced and humane approaches to empathising with patient behaviour they find frustrating or do not understand (Graham et al. 2016; Haslam 2007; Schwartz et al. 2020). Shifting to a focus on populations allows us to consider how framing these stories differently might shape public understanding of attribution, with subsequent implications for preventive interventions, including policy. A story that focuses on individuals might inspire understanding,

but it also risks misdirecting our efforts at remediation. Such stories tend to lead public discussion in the direction of interventions focused on changing the knowledge, beliefs and behaviours of individuals. When behaviour does *not* change, frustration on the part of the clinician or public health worker often results.

Writing frequently over the course of the pandemic about the benefits of a risk mitigation approach to COVID-19, Harvard epidemiologist Julia Marcus observed that '...as years of research on HIV prevention have shown, shaming doesn't eliminate risky behavior—it just drives it underground' (Marcus 2020, para. 7).

Communities are comprised of individuals, of course, and effective public health narratives remind us of the uniqueness of each human life and individual human agency through stories of subjective experience. Yet, the degree to which individual behaviour is determined, in large part, by the circumstances in which we live, work, play and learn, including our policies, is a key element of public health theory. The study of narrative in the public health humanities classroom can be effective in shifting perceptions of attribution—blame—for health outcomes from individual to external factors (Niederdeppe, Shapiro, and Porticella 2011; Shaffer et al. 2019). While individually focused narratives that fail to include broader determinants risk prompting readers to assign individual factors as primary causes for behaviour (Iyengar 1994), recent research by Chris Skurka and colleagues indicate that this effect can be mediated when narratives include adequate context, specifically upstream causes and policy solutions (Skurka, Niederdeppe, and Winett 2020).

Accounts that implied attribution (blame) became even more pointed after the introduction of vaccines and the hardening of partisan political responses to public health measures such as vaccination and masking. This was reflected in the stories about clinicians appearing in the press and in op-eds written by them.

For example, a physician and educator writing in the *Los Angeles Times* after vaccines became available opined, 'Last year, a case like this would have flattened me. I would have wrestled with the sadness and how unfair life was. Battled with the angst of how unlucky he was. This year, I struggled to find sympathy. It was August 2021, not 2020. The vaccine had been widely available for months in the U.S., free to anyone who wanted it, even offered in drugstores and supermarkets' (Sircar 2021, para. 6).

Another physician, an obstetrician in New York, expressed in *The Atlantic* her disappointment and sense of betrayal that after months of sacrifice, she was seeing patients who had refused the vaccine: 'But I also kept working because I needed to believe that, if I was ever in danger, other humans would come help me. Our comparative advantage as humans is that we can take care of one another and overcome adversity together. I did my part week after week, month after month... But that's not what happened' (Karkowsky 2021, para. 5).

The presence of a concrete individual, needing care, often expressing regret and accompanied by grieving family members appears as a mediating factor in many of these stories, though frustration and anger may still come through. For example, an article from AL.Com widely shared on social media featured a young physician in Alabama named Brytney Cobia who contrasts hospitalised patients who did not get the vaccine with those she saw prior to when the vaccine was available who 'did all the right things and yet still came in, and were critically ill and died' (Pillion 2021). Dr Cobia's duty to care and compassion activate in the presence of her suffering patients and their grieving families. She says, '...you see them face to face, and it really changes your whole perspective, because they're still just a person that thinks that they made the best decision that they could with the

information that they have, and all the misinformation that's out there' (Pillion 2021, para. 10).

The effort to put health behaviour in a wider context that includes an understanding of social, cultural and economic factors, as well as systemic and structural factors such as racism, is on display in the reflections of health humanist and emergency room physician Jay Baruch. In a piece in STAT News, he calls for empathy with patients who have become ill after refusing to be vaccinated against COVID-19, writing: 'I don't ask "Why?" when a patient with Covid-19 tells me they are unvaccinated for the same reason I don't ask why someone whose alcohol level is four times the legal limit decided to drive, or the badly burned grandmother with emphysema lit a cigarette with oxygen prongs below her nose. Nor do I ask it when I find myself elbow deep in a bag of chips after an overnight shift even though I am fighting high blood pressure' (Baruch 2021, para. 1).

The perspective shared by Dr Baruch is a valuable one when added to the compassion exhibited by Dr Cobia and many others. Indeed, it offers additional insight into the myriad external influences on behaviour, including, as noted by Dr Cobia of her patients, 'They thought it was a hoax. They thought it was political. They thought because they had a certain blood type or a certain skin color they wouldn't get as sick' (Pillion 2021, para. 8).

When Dr Cobia alludes to the way that the presence of these patients 'changes your whole perspective', it points to a potential additional source of value in a public health humanities' framing of these stories. Incorporating an understanding of the ways in which political, cultural and economic influences determine the behaviour of your patients *in the hospital* does not necessarily lead to a nuanced and critical understanding of the way these factors influence the behaviour of communities *outside* the clinical setting, which is largely where public health efforts are focused. A story that frames clinician empathy in terms of patients who have been led astray before arriving for care—and an opportunity to confront their errors—may inadvertently contribute to the polarisation between health and public health authorities and mistrustful communities, a divide that is being exploited for political gain (Recio-Román, Recio-Menéndez, and Román-González 2022). This potentially adversarial framing can be found in stories such as the following, from *Business Insider*, in which a Florida cardiologist reflects on the misinformation around vaccines.

'Ultimately, Floridians themselves will be the arbiters of what happens next', Kessel, the cardiologist, said. He lamented that misinformation about vaccines was partly responsible for upending the state's public health efforts, likening dangerous urban legends to 'superstitions'.

'If we were still believing in superstitions', he said, 'We'd still be using leeches and witch doctors to cure people' (Reed 2021, para. 42).

A narrative that focuses exclusively—even empathetically—on a patient who, in Dr Cobia's phrasing, 'made the best decision that they could with the information that they have' risks some of the problems with empathy raised by critical medical humanities' literature. Writing in *The Lancet*, Macnaughton (2009) argues that it is presumptuous to suggest that medical humanities can help clinicians develop empathy with patients, in the sense of having access to their thoughts, feelings or other subjective experiences. She argues, 'all that is possible psychologically is an awareness of the other as an experiencing being; and, if we are open enough and take time to ask, they can tell us what that experience is like' (Macnaughton 2009, 1941). In a discussion of reflective writing and perspective taking exercises that focus

on actual patients, Rebecca Garden notes that the activity risks becoming an 'exercise in projection' (Garden 2007, 554).

By continually widening the lens on the narrative to include structural and systemic patterns, public health narratives of the pandemic offer an opportunity to both understand that subjectivity and individuality are always at work while nudging the reader to depersonalise attribution. In other words, empathy in this case does not require a clinician or public health practitioner to identify emotionally with the specific details of an individual narrative (eg, someone who says they refuse to get a vaccine because they believe COVID-19 is a hoax). An empathy of this sort does not 'excuse' potentially antisocial behaviour; rather, it reminds us that all human beings are vulnerable to misinformation under the right circumstances. Further, it approaches the issue of antisocial behaviour with the understanding that Marcus advocates in talking about risk in an interview with Boston.com, 'Risk taking often reflects people's unmet needs: for a paycheck, for social connection, for accurate information about risk' (Dwyer 2020, para. 8).

An opportunity to embrace an empathy that, as Mcnaughton advises, recognises others as 'experiencing beings' without projecting our interpretations of their experience onto them does not mean that it necessarily *will* happen. The history of public health is replete with examples of institutional racism, for example (Bowleg 2012; Hardeman et al. 2018). Broadening our sense of empathy thus also prompts an understanding that healthcare providers and public health workers can also be the kind of people who under some circumstances succumb to motivated reasoning, act from implicit bias and misinterpret the behaviour of others.

Throughout the course of COVID-19, we have seen a dramatic politicisation of public health measures, including an erosion of trust in and hardening of attitudes towards the public health system itself (Pollard and Davis 2021). As this trend continues, it will be incumbent on those who operate within the public health system to absorb methodologies of health humanities that promote self-reflection, empathy, humility and the tolerance of ambiguity. Adversarial narratives about *either* the public health system from the community *or* the community from the public health/care system are dehumanising and polarising, with real implications for policy.

HEALTH WORKER AS HERO

Many Americans were introduced to COVID-19 in the *New York Times* on 5 February 2020 with the publication of the article 'Inside the Race to Contain America's First Coronavirus Case' (Harmon 2020). The story featured a county epidemiologist who heroically 'jumped into action' to interview the first known patient with the virus (Harmon 2020, para. 2). In March, Associated Press reporters in Italy published a stirring collection of portraits of Italy's front-line medical workers. 'Their eyes are tired', the introduction read. 'Their cheekbones rubbed raw from protective masks. They don't smile' (Stinellis et al. 2020, para. 1). The *Washington Post* subsequently reported how evening ovations of medical workers had spread among the citizens of locked down cities 'from the Chinese epicenter of Wuhan to the medieval villages of Lombardy, from Milan to Madrid, onto Paris, and now London' (Booth, Adam, and Rolfe 2020, para. 2).

Stories of healthcare workers' physical and emotional vulnerability were, especially in the early days of the pandemic, juxtaposed with stories highlighting their heroism and the recognition they earned. Insofar as hero narratives focus on the challenges faced by an individual who is then transformed by them (Allison

and Goethals 2017), hero narratives serve to deflect attention from health and social systems that rely on these extraordinary individual efforts—systems that are frequently the focus of public health efforts. Writing in the *Journal of Medical Ethics*, Dr Caitríona L Cox notes, ‘A public narrative that concentrates on individual heroism fundamentally fails to acknowledge the importance of reciprocity. Individual heroism does not provide a firm basis on which to build a systematic response to a pandemic: there must be recognition of the responsibilities of healthcare institutions and the general public’ (Cox 2020b, 512).

A public health humanities’ framing of the COVID-19 hero narrative examines how the celebration of extraordinary individual efforts impacts not just individuals but the health system itself. It highlights how these narratives support a system that often results in students and trainees practising beyond their scope of training in under-resourced environments.

In spring 2020, the American news was full of reports of medical schools graduating students early so that students could help hospitals overwhelmed with patients with COVID-19. This followed a wave of similar stories regarding medical students in Europe and the UK (Hu 2020; Kottasova 2020). In May 2020, the *Washington Post* published an article featuring the story of 28-year-old Hailey McInerney, who completed medical school early to work at Stony Brook University Hospital. Her postponed obstetrics and gynaecology residency and the loss of her formal cap and gown ceremony are detailed in an article that, while briefly referencing ‘a pandemic that is straining the American medical system’ (Balingit 2020 para. 5) focuses primarily on McInerney’s willingness to rise to the occasion. The second subheading in the article quotes her directly as saying, ‘This is the job’ (Balingit 2020 para. 5).

The excitement and commitment of the early gradulators is a feature of many articles, including another by Spectrum News 1 in New York, which quotes a student named Olamide Omidede as saying, ‘So I’m overwhelmed with the amount of excitement I have....of course there’s a bit of nervousness’ (Hu 2020, para. 5). While noting that these newly minted doctors would not treat patients with COVID-19 directly, the Spectrum News 1 article also includes the concern, expressed by the union that represents medical interns and residents, that supervision and support may be lacking in an environment that is ‘stretched thin’ (Hu 2020, para. 6).

The enthusiasm of young trainees to help in a crisis and the potential ethical risks to patients if oversight is not sufficient, along with risks to the trainees’ mental health resulting from interactions for which they are not prepared, echo a phenomenon that has been increasingly explored in global health literature that focuses on American students going abroad as part of their training (Doobay-Persaud et al. 2019). Beyond the well-documented ethical and legal questions raised by trainees operating outside their scope of practice (Rowthorn et al. 2019), the pressure to be a hero poses risks to clinicians, as well.

Though laudatory on its face, Urmimala Sarkar and Christine Cassel note in the *Journal of the American Medical Association* that the narrative of the ‘hero doctor’ in fact exacerbates the risk of burnout among clinicians by extolling a stoicism that ‘can lead clinicians to under recognize their physical and emotional needs and to conceal perceived vulnerabilities’ (Sarkar and Cassel 2021, para. 5). While offering examples of extraordinary individuals (eg, Nelson Mandela) who have been called heroes historically, Sarkar and Cassel call attention to the way these narratives map onto hero narratives in art and literature, which often feature superhuman figures. This is an observation that is echoed by Zinaria Williams, who points out in a commentary

in US News that ‘in mythology and folklore, a [hero or saint] is a person of superhuman qualities and often semi-divine origin’ (Williams 2020, para. 1).

The casting of clinicians as heroes thus has the potential to be a form of dehumanisation, a distortion that health humanities training seeks to circumvent with patients and providers alike. Appreciating the lived experience of patients and communities by honouring their stories is an important value in health humanities work. It is central to understanding the complexity of others’ lives and the subjectivity of their experience. The hero narrative, in addition to flattening the experiences of clinicians into an archetype that implies motivation (ie, self-sacrifice), carries consequences for clinicians whose extraordinary performance requires ‘emotional activation [that is] is physically, mentally, and emotionally exhausting’ (Sarkar and Cassel 2021, para. 5).

There are significant differences in the phenomenon of students and trainees performing outside scope of training abroad and the current crisis as it unfolds in the USA, including differences in power and resources, cultural differences in host countries, along with different rates of specialisation abroad versus in the USA (Doobay-Persaud et al. 2019). Yet, broadening the framing in a way that allows domestic stories to be considered in a global health context offers health humanists the opportunity to consider the way that a crisis such as the pandemic exposes weaknesses in a health system sufficient to require these extraordinary measures. Because COVID-19 is in fact a global public health crisis, pandemic narratives offer American storytellers and audiences an opportunity to view our health systems in a global context, which will become increasingly important as we tackle public health challenges on a planetary scale.

CONCLUSION

Stories about clinicians and front-line public health professionals who work at the intersection of life and death capture and hold our attention, never more so than in the midst of a global pandemic. An oft stated goal of health humanities is to humanise both clinicians *and* patients by promoting the awareness that both are embodied, multifaceted and complicated human beings with lives replete with cultural and social influences. It is our view that this objective can be more fully achieved by placing the stories of individuals into a thoughtful, public health-informed context, and by considering how pandemic narratives might be employed to introduce the values and methodologies of health humanities into public and global health. Stories that place American experiences in a global context for American audiences and juxtapose the risks of clinicians and public health workers as communities with the risks experienced by the communities that they interact with have the potential to resonate with a variety of audiences.

In all likelihood, the pandemic will continue to unfold through stories. In spite of the hazards inherent in narrative, it is our view that stories can be powerful tools in shifting public discussion towards equity, empathy and community resilience. Stories that have *both* scientific authority (ie, harness the power of data to help us see patterns and understand context for behaviour and outcomes) and narrative authority (ie, engage us with the specific, concrete and emotional experiences of individual human beings) also have the potential to increase trust in an environment in which trust is rapidly eroding (Hossain 2020; Saffran et al. 2020).

The stories that we hope to see emerge from a public health humanities’ framing of clinician narratives would represent medical care and public health infrastructure as systems that

are porous and intersect with and are influenced by social, economic, cultural and political factors. It is one which, in our view, has real implications for the shaping of those environments through policy.

A public health humanities' framing of resistance to measures to prevent the spread of COVID-19, for example, would thus include individual stories—because they are humanising and compelling—alongside data and analysis to help readers contextualise the behaviour of clinicians, patients and likely future patients (ie, 'non-compliant' community members). It would help readers understand the economic, social and cultural pressures on each of these communities—the way the health system is structured, the expectations of clinicians, systemic racism both within and outside the health system, the political determinants of mistrust in science—in a way that leverages an empathy of connection, not mind-reading or a narrowly focused sympathy for a single suffering individual. Public health theory and practice help illuminate *why* divisions, resistance and puzzling behaviour occur by focusing upstream and allow us to find points of intervention.

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