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DIRTY HEROES? HEALTHCARE WORKERS' EXPERIENCE OF MIXED SOCIAL EVALUATIONS DURING THE PANDEMIC

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The sudden onset of the COVID-19 pandemic ushered in an unprecedented era of public admiration for healthcare workers. Indeed, the title "healthcare heroes" became a ubiquitous moniker for healthcare providers of all stripes during the pandemic, a sentiment reflected in countless advertisements and banners. Paradoxically, these same "healthcare heroes" who were being publicly celebrated for their work in the fight *against* a novel coronavirus also faced stigma for their work *amid* the virus and infected patients. Using grounded theory, we document how stigmatized members of an occupation experience and respond to mixed—and even conflicting—social evaluations. We contribute to the literature on stigma and social evaluations more broadly by showing how targets of stigma evaluate their evaluators through nuanced logical and emotional processing and, moreover, that such processing can lead recipients of mixed evaluations toward a number of outcomes not previously theorized. We explore the concept of "dirty heroes," where workers are celebrated and stigmatized along distinct dimensions of work traditionally studied in dirty work (i.e., physical, social, and moral). Our findings further illustrate how high-legitimacy occupations can be subject to "hero-washing," whereby workers are publicly celebrated yet privately neglected.

> I really don't even want the "thank you" for being a hero thing, either. Like, I don't want that as much as I don't want them to be like, "I can't believe you're wearing your scrubs out in public." Like, I just don't want either one 'cause I think both suck. (#86, Nurse)

Social evaluations are ubiquitous in organizational life. As human beings, we assess each other in complicated ways—frequently forming, blending, and holding both positive and negative appraisals. Indeed, mixed evaluations permeate every segment of society—in our homes, in the workplace, and in our increasingly socio-digital, polarizing world. Indeed, as highlighted by the COVID-19 pandemic, the prevalence and vigor of mixed evaluations seem to have risen around political and social issues. One arena in which such mixed social evaluations are particularly compelling and visible is within stigmatized occupations (Goffman, 1963; Helms & Patterson, 2014; Roulet, 2020). Stigmatized workers bring about strong, even visceral, reactions in their stigmatizers as a result of evolutionarily driven nonconscious reactions to avoid disease and infection (Kleck, 1969; Kurzban & Leary, 2001). Paradoxically, there is frequently an implicit, if not wholly explicit, recognition that we need these stigmatized occupations to keep society running—waste needs removal, the sick need treatment, and governments require soldiers. Yet, we often attempt to keep those occupations and the dirty work that they do for us at a comfortable distance (Ashforth & Kreiner, 1999; Ashforth, Kreiner, Clark, & Fugate, 2007), creating an inherently mixed social

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evaluation—positive in one regard and negative in another.

To date, research on social evaluations in occupations has focused predominantly on the experience of one extreme form of social evaluation or another: exceedingly positive (e.g., *moralization*; see [Cameron, Chan, & Anteby, 2022]) or exceedingly negative (e.g., *stigmatization*; see [Phung, Buchanan, Toubiana, Ruebottom, & Turchick-Hakak, 2021]). Binary presentations of social evaluations, however, have ignored the reality that social evaluations are often multiplex in nature. For example, the George Floyd murder set off a duality of social narratives toward police officers—both negative (Black Lives Matter) and positive (Blue Lives Matter). In this regard, the stigma and dirty work literatures have not sufficiently explored how stigma—a negative social evaluation—is experienced alongside a contradictory or competing positive social evaluation, despite the prevalence of both forms. As a result of this theoretically necessary, but exclusive, focus, we lack an appreciation for how mixed social evaluations are experienced and, further, the mechanisms influencing the internalization (or rejection) of such evaluations (George, Dahlander, Graffin, & Sim, 2016). This shortcoming is of heightened importance in an increasingly digital, noisy, fractious, and socially connected world where many occupations (e.g., police officers, teachers, military service members, and mental health professionals) face important and complex problems that need nuanced and thoughtful solutions. Instead, all too often, these professions and those surrounding them are stigmatized or collectively idealized in ways that reduce complex individuals to caricatures and images that represent them as less than their "whole" selves (Goffman, 1963: 3). Furthermore, such broad idealization and stigmatization are often at odds in ways that break the social consensus and increase polarization (Goffman, 1959).

The purpose of this paper is to illuminate how stigmatized occupational members perceive, internalize, and respond to mixed evaluations and, moreover, to elucidate how such mixed evaluations might manifest. We develop the concept of "dirty heroes," whereby occupational members are simultaneously subjected to celebration and stigmatization along three evaluative dimensions of work—physical, social, and moral. We show how positive and negative evaluations may originate from the *same* or *similar* third parties or from *different* parties within a period of time that is then *perceived* as mixed and contradicting by the stigmatized worker. We contribute novel theory to the stigma and social evaluations literatures more broadly by documenting (a) how stigmatized targets (i.e., those being evaluated) respond to mixed evaluations—including contradictory evaluations—with evaluative *criteria for acceptance* and *internalization outcomes*; and (b) how mixed evaluations manifest in actors (i.e., those evaluating) according to the social context and salient evaluative dimension(s) of work. (For example, we illustrate how evaluators engaged in "hero-washing," wherein healthcare workers were publicly lauded yet insufficiently supported.) To do so comprehensively, we begin by showing our readers how social evaluations directed toward a highly legitimate occupation—healthcare workers—diverged dramatically in a parallel yet antagonistic fashion throughout the course of the COVID-19 pandemic. In short, healthcare workers were lauded and idealized as heroes for their service and sacrifice, yet they were often stigmatized for fear of contamination and insufficiently supported by their host organizations. We examine these dynamics by highlighting the surprising finding that, in the main, healthcare workers did *not* positively internalize the hero narrative. Instead, the "healthcare heroes" campaign—ostensibly intended to acknowledge and amplify their work—typically had a null or negative effect on healthcare workers' attitudes, esteem, and morale.

STIGMA, DIRTY WORK, AND MIXED SOCIAL EVALUATIONS

Research on occupational stigma and dirty work has proliferated in recent years (for recent reviews, see Kreiner, Mihelcic, & Mikolon, 2022; Zhang, Wang, Toubiana, & Greenwood, 2021). Stigma is conceptualized as a denigrating social evaluation aroused by a discrediting mark, label, or attribute affixed to an individual or group (Goffman, 1963; Kreiner et al., 2022; Wang, Raynard, & Greenwood, 2021). At its essence, stigma constitutes a discriminant form of social categorization (e.g., stereotyping; see Mikolon, Kreiner, & Wieseke, 2016) whereby an imputation is established between an undesirable attribute and a target's "social identity"—used here in both the literal and theoretical sense (Goffman, 1963; Link & Phelan, 2001; Turner, 1985). In this respect, stigma can represent a very real threat to one's self-concept (Major & O'Brien, 2005; Petriglieri, 2011). More specifically, stigma evokes a discrepancy between the stigmatized individual's internal and external self-presentations (Swann, 1987; Swann & Read, 1981). In other words, stigma creates a condition whereby others "do not see them as they see themselves" (Swann, 1987: 1038). For the victim of stigma, internal–external identity

incongruence has several *personal* consequences, including increased stress, anxiety, emotional labor, and decreased self-esteem (Ragins, 2008). The *social* consequences of a stigmatized identity also include the loss of status and belonging, as well as increased discrimination and harassment (Paetzold, Dipboye, & Elsbach, 2008; Wiesenfeld, Wurthmann, & Hambrick, 2008).

As a social construction, stigma is seldom based upon "true" or "objective" attributions (Crocker, Major, & Steele, 1998; Devers & Mishina, 2019). Regardless of the veracity of its justification, stigmas transform the target "in our minds from a whole and usual person to a tainted, discounted one" (Goffman, 1963: 3). Though much of the extant research on stigma explores the "discrediting attributes" of the stigmatized, recent research has started to explore the relational and contextual determinants of stigma and stigma-related phenomena (Angermeyer, Schulze, & Dietrich, 2003; Shepherd, Maitlis, Parida, Wincent, & Lawrence, 2022). As Goffman (1963: 4) instructed, stigma is a "special kind of relationship between attribute and stereotype." Hence, we may think of stigma more accurately as "relationship- and context-specific … [in that] it does not reside in the person but in a social context" (Major & O'Brien, 2005: 395). The workplace is one such context.

Stigma research within occupations has traditionally been studied as "dirty work"—work that is perceived by society as disgusting, distasteful, or degrading (Ashforth & Kreiner, 1999; Ashforth et al., 2007; Hughes, 1951; Kreiner, Ashforth, & Sluss, 2006). Occupations may be deemed "dirty" according to any one of three evaluative dimensions of work: (a) *physical*—which generally includes jobs involving danger, filth, effluent, bodily discharges, or waste (e.g., nurses or coal miners) (Courpasson & Monties, 2017; Soni-Sinha & Yates, 2013); (b) *social*—which includes subservient roles (e.g., butler or chauffeur) or jobs that involve routine contact with otherwise stigmatized people—an indirect form of stigma that Goffman (1963: 30) referred to as "courtesy stigma" (e.g., correctional officers) (Roca, 2010; Shantz & Booth, 2014); and (c) *moral*—which includes work seen as sinful or of dubious virtue (e.g., abortion providers or casino workers) (Ashforth & Kreiner, 1999; Hughes, 1958) or, alternatively, that which "goes counter to the more heroic of our moral conceptions" (Hughes, 1951: 319). Occupations, organizations, industries, and markets can be tainted along one or multiple dimensions (Ashforth et al., 2007; Clark & Li, 2023; Vergne, 2012). It is worth noting here a common, yet under-scrutinized, observation in the dirty work literature—dirty occupations often evince a paradoxical duality in their evaluators; gratitude by outsiders that the work occurs, yet repulsion at the thought of doing or being near the work (e.g., healthcare workers, police officers, funeral home workers, etc.) (see Ashforth & Kreiner, 1999; Ashforth et al., 2007; Gee & Skovdal, 2018).

Managing Dirty Work and Stigma

Stigma management comprises the efforts made by targets and non-stigmatized individuals to manage the acts of and meaning around stigma (Ashforth et al., 2007; Clair, Beatty, & Maclean, (2005); Kreiner et al., 2022; Lyons, Pek, & Wessel, 2017; Zhang et al., 2021). Ashforth and Kreiner (1999) found that stigmatized workers widely employ two methods of stigma management: *supporting their supporters* (Heinsler, Kleinman, & Stenross, 1990) and *condemning their condemners* (Sykes & Matza, 1957). For example, Helms and Patterson (2014: 1470) found that stigma bearers can proactively take advantage of their stigma to bolster support from their supporters by co-opting the "negative labels used to denigrate them" as a means of garnering support from sympathetic audiences. If there are no outside supporters to amplify, then stigmatizers must seek affirmation primarily from occupational insiders who, consequently, can perpetuate their counter-normative perceptions as insularity increases and exposure to outsiders decreases (Ashforth & Kreiner, 1999). Stigmatized workers may also engage in selective, predominantly downward, social comparisons in response to outsiders who might otherwise threaten their work identity (Crocker & Major, 1989; Wood, 1989). These selective social comparison tactics allow stigmatized workers to dismiss potentially threatening evaluations and celebrate favorable comparisons and evaluations that enhance self-esteem. To date, the dirty work literature has been surprisingly binary in its conceptions of stigma management—in other words, supporters are supported, condemners are condemned, and salient subgroups are disparaged. Moreover, the existing literature has not fully considered how workers might be stigmatized by some and simultaneously celebrated by others.

While some occupations are valorized for their virtues (e.g., firefighters), others are devalued (e.g., sanitation workers) and discredited (e.g., prostitutes). In the latter examples, social evaluations focus on a discrediting mark, label, or attribute indicating

stigmatization (Goffman, 1963). Most stigma research has understandably focused on the negative evaluations of outsiders, but some research has begun to consider positive external evaluations alongside stigma (Dalpiaz & Cavotta, 2019; Kreiner et al., 2021; Ruebottom & Toubiana, 2021). This mixed or "double-edged sword" conception of stigma acknowledges that organizations and occupations may evoke varied reactions from different audiences—supported by some while condemned by others (Helms & Patterson, 2014; Piazza & Augustine, 2022). Herein, we define *mixed evaluations* as a phenomenon where an occupation (e.g., healthcare workers) perceives both positive and negative (i.e., contradictory) evaluations from one or multiple third parties within a relatively short period of time. For example, abortion providers are strongly condemned by pro-life advocates but supported by pro-choice advocates (Piazza & Augustine, 2022). Or, in another example previously referenced, this can be demonstrated by how police officers were evaluated through disparate lenses following the death of George Floyd (i.e., "Black Lives Matter" or "Blue Lives Matter") (Solomon & Martin, 2019). Explorations of mixed evaluations in the literature, though a prevalent experience in organizational life, remain relatively rare, particularly with respect to stigmatized occupations. As a result, we do not have sufficient theory to describe how workers experience mixed or contradictory evaluations and how they may (or may not) internalize such evaluations. Our empirical observations—the striking frequency with which healthcare workers reported conflicting social evaluations coupled with the need to understand the effects of mixed evaluations on workers—brought us to our ultimate research question: How do stigmatized workers experience, evaluate, and respond to mixed social evaluations (e.g., being treated like a "dirty hero")?

METHODS

Research Context: Healthcare Workers during the COVID-19 Pandemic

At the outset of our study, we sought to understand the effects of the "healthcare heroes" campaign and, perhaps naively, expected to find that healthcare workers were experiencing greater professional pride and engagement as a result of the campaign (see Appendix A, questions 2–8). The complexity of their experience and the fallacy of our assumptions, however, quickly became apparent as participant after participant recounted negative evaluations that either loomed larger than or significantly cheapened public displays of admiration. We quickly learned that the COVID-19 pandemic incited widespread stigmatization of healthcare workers (American Psychological Association, 2020; Singh & Subedi, 2020; Villa, Jaramillo, Mangioni, Bandera, Gori, & Raviglione, 2020). The World Health Organization (WHO) warned that "some healthcare workers may, unfortunately, experience avoidance by their family or community owing to stigma or fear" and added that "this can make an already challenging situation far more difficult" (World Health Organization, 2020). In May 2020, members of at least 13 medical and humanitarian organizations condemned over 200 violent attacks on healthcare workers and health facilities (Bagcchi, 2020; WHO, 2020). Similar patterns were reported in countries across the globe (Ramaci, Barattucci, Ledda, & Rapisarda, 2020; Singh & Subedi, 2020; Villa et al., 2020). In a large survey (n = 3,551) of non-healthcare workers conducted during the early days of the pandemic (May 2020), over one-third of respondents reported that they avoided healthcare workers for fear of infection, and over one-quarter of respondents believed that healthcare workers *should* have their freedoms severely restricted and be isolated from their communities and families (Taylor, Landry, Rachor, Paluszek, & Asmundson, 2020). Taylor and colleagues (2020) found participation in "evening clapping" and efforts meant to celebrate healthcare workers were surprisingly unrelated to stigmatizing attitudes.

Although we primarily focus on healthcare workers' experience of stigma, empirical work has confirmed that healthcare workers experienced a multitude of positive and negative outcomes as a result of the COVID-19 pandemic (Giorgi et al., 2020; Kim, Kim, Howell, Doyle, Pettit, & Bizzarro, 2023; Rapp, Hughey, & Kreiner, 2021). In the face of seemingly contradictory findings, we attempt to portray healthcare workers in a manner reflective of our experience with them—as a nuanced and incredibly diverse cohort. Cultural context matters in social evaluations, and we acknowledge that our data cannot speak to all potential cross-country differences. Hence, we present a grounded theory that can account for a heterogenous occupation that experienced countless interactions across many different settings and circumstances over the many months and years of the pandemic (Hughey, Brimhall, Rapp, & Myers, 2023). For this reason, and to ensure we are not generalizing their experience in ways that discount the complexity of their lived realities, we document the full diversity of outcomes we observed, including those outcomes that conflict with or contradict one

another. In this respect, mixed evaluations, with all of their inherent nuance, comprise our primary unit of analysis for this empirical study.

Given healthcare workers' exposure to diverse, even contradictory evaluations en masse and to seldom observed extremes during the course of the COVID-19 pandemic, our research represents a revelatory case elucidating how workers respond to mixed evaluations. The extreme nature of our research context offers an empirically fertile environment for the study of mixed evaluations with implications for a broad range of occupations facing conflicting social evaluations (Eisenhardt, 2021). Over half ($n = 55$) of our participants held supervisory or management duties, and most ($n = 73$) were "frontline" workers who cared for confirmed or suspected COVID-19 patients. (Note that a participant could be both a supervisor and a frontline worker.) Their collective experiences reflect elements of other occupations in which workers transition between roles frequently and face various external evaluations accordingly (Ashforth, Kreiner, & Fugate, 2000). Additionally, as we will discuss, healthcare workers' experience mirrors those of many other professions who may receive public lionizing and idealization while also deeming the compensation and other resources they receive as inadequate.

TABLE 1
Participant Sociodemographics

n	Characteristic
	Role
25	Healthcare administrator
18	Physician or physician assistant
45	Nurse or nurse administrator
10	Other clinician
73	Cared for COVID-19 patients
55	Leadership role
	Setting
68	Hospital and clinics
23	Long-term care
9	Other healthcare setting
	Demographics
92	United States
6	South America
68	Female
30	Male
30	Minority
	Age (years)
35.7	Mean
34.5	Median
22–61	Range
	Healthcare Experience (years)
11.1	Mean
9	Median
0–36	Range

Data Collection and Analysis

Data collection. Much of the data used in this manuscript was collected from interviews that were also used by Rapp et al. (2021). The two projects utilized an interview protocol that was bifurcated early in the process to include specific questions and were tagged and analyzed to be bifurcated with no overlap of data. For this article specifically, we conducted several additional interviews and used a short anonymous survey questionnaire for member checking. Utilizing a grounded theory methodology (Corbin & Strauss, 2008; Glaser & Strauss, 1967), we conducted 98 semi-structured interviews with healthcare workers (see Appendix A for the protocol). These interviews, conducted remotely (primarily via Zoom), generally lasted 60 to 90 minutes. During the interviews, we would ask for clarification or specific examples of general statements. We conducted and analyzed interviews in small waves so that as more abstract themes emerged, we could validate and seek greater depth in later interviews. Our 98 participants (see Table 1 for full participant sociodemographic characteristics) represent a broad and diverse group of workers from the healthcare industry, including nurses and nursing administrators (45), physicians and physician assistants (18), and healthcare administrators (25). The average age and job tenure were 35.7 years and 11.1 years, respectively (the range of experience was six months to 36 years). The majority of participants were female (68), and 30 were ethnic or racial minorities. Some participants were also interviewed for another study which utilized disparate research questions, interview questions, and theoretical codes to prevent data overlap. For the current study, we interviewed additional participants and conducted separate member checking. Although we found no meaningful differences in our codes across specific job roles (e.g., physicians versus nurses), we label each quote in order to allow our readers insight into who is speaking and their role.

Data analysis. At least two authors (always including the author who conducted the interview) independently and jointly coded the vast majority of interviews, utilizing a two-step coding system outlined in Kreiner (2015) and used in multiple management publications (e.g., Kreiner, Hollensbe, & Sheep, 2006; Rapp et al., 2021; Treviño, den Nieuwenboer, Kreiner, & Bishop, 2014). First, two authors read and independently coded the interviews. Next, these two authors met to compare, find agreement, and build off

one another's insights. We placed new codes in a working and evolving dictionary to ensure a common language and meaning. If one author coded an excerpt and the other did not, both authors would reread the passage in question. If the two authors still disagreed, a discussion would take place about context, meaning, and connections to other codes and interviews until they found agreement. These discussions were incredibly generative for theorizing and sensemaking. We also documented our sensemaking and emerging trends in theoretical memos (Charmaz, 2014; Saldaña, 2009) written during coding sessions as well as throughout the research process.

We continually iterated among our coding dictionary, protocol, previously coded interviews, and existing research literature (Charmaz, 2014; Corbin & Strauss, 2008; Strauss & Corbin, 1998). For example, as mentioned, we did not initially consider stigma or any negative evaluations when we began conducting interviews. Initial interviews revealed widespread cases of healthcare workers being stigmatized both at work and away from work for their perceived risk of contagion. Also, they revealed that many workers did not accept being called heroes. We began coding such interactions as *healthcare workers as dirty*; then, by seeing many nuanced examples and reviewing the dirty work and stigma literatures, we added greater complexity to our dictionary with codes such as *physical stigma*, *social stigma*, *duality of treatment*, *inconsistent*, and *reject hero treatment* to reflect the myriad social evaluations that healthcare workers were experiencing and responding to in our interviews. Soon we needed many subcodes ("children" and "grandchildren" codes, per Kreiner, 2015) for *reject hero treatment*, including *reject hero treatment-disingenuous*, *reject hero treatment-uninformed*, and many more, some of which are presented in our findings and tables in italicized fonts (Tables 2–4). We added these changes to the coding dictionary and memos, and we discussed them at length in meetings, whereupon we would alter our protocol to enhance our examination of stigma. We often "re-coded" previous interviews with newly created codes to reflect our continued learning. We found initial evidence for theoretical saturation after coding 58 interviews, after which very few codes were added to our dictionary (Locke, 2001). More importantly, toward theoretical saturation, our coding dictionary and Tables 2–4 reflect the depth and richness of the phenomena studied, and our grounded model conveys the relationships among key concepts (Charmaz, 2014).

The first two authors had previous work experience that afforded prolonged engagement with hospitals and nursing home settings. This knowledge helped us sensitize and provide psychological safety for our participants to disclose nuanced answers (Kreiner & Joshi, 2021; Lincoln & Guba, 1985). Hudson and Okhuysen (2014) identified two reasons why insider status is especially advantageous for studying stigma: (a) stigmatized participants require an increased need for theoretical sensitivity (Link & Phelan, 2001; Strauss & Corbin, 1990); and (b) insider status helps with the ability to procure participants who will provide honest answers (Anteby, 2013). Although our experience did not overlap with the pandemic and, thus, more intense stigma, our sensitivity to nuanced workplace dynamics allowed us to both ask questions and understand answers in advantageous ways that facilitated greater trust and depth. The third author had no prior work experience in healthcare, providing a useful outsider's lens to the interpretive process and giving us a valuable insider–outsider research team, which facilitated conversations that considered and accounted for our various biases and assumptions (Bartunek & Louis, 1996). We also conducted member checking through calls and written communication with 20 respondents in late 2021 and early 2022. None of these member checks revealed objections to the story and lessons we elaborate on in the paper. Indeed, several strongly validated our findings with confirmatory feedback and new examples and thoughts about their experience at different stages over the life of the pandemic.

As it concerns our findings and model (Figure 1), we feel it is important to note that we only interviewed healthcare workers; we did not interview those who evaluated healthcare workers (with the exception of healthcare workers who expressed evaluations of other healthcare workers). In the first third of the model and findings, we utilize healthcare workers' accounts of how others treated them to abductively theorize the role of contextual factors in generating mixed evaluations along three evaluative dimensions of work (see Table 2 for additional empirical evidence). In the second half of our model and findings, we inductively theorize how healthcare workers processed, internalized, and responded to mixed evaluations. In both cases, we rely upon the perceptions and lived experiences of our participants to generate theory. In short summary, the first third of our model utilizes a more *abductive* approach to theorizing, while the latter two-thirds utilize a more traditional, *inductive*, social constructivist approach to theorizing (Denzin & Lincoln, 2000; Sætre & Van de Ven, 2021). In its entirety, the codes and themes presented in our model and findings depict our best

TABLE 2
Supplementary Data: Social Evaluations

Negative Evaluations Based Upon Physical and Social Taint **(Healthcare Workers as "Dirty")**
We had the building divided up into our quarantine unit ... a dirty half of the building and a clean half of the building, for lack of a better term. You didn't see half your coworkers all the time because if you were assigned to that side, you were assigned to that side, literally, quite literally, with red tape painted a line across. We call it the "Mason–Dixon Line." (#9, Nursing Home Administrator)
I would come home sometimes wearing scrubs and be like, oh, how many dirty looks, like not even dirty looks, but people are going to see me and be nervous that I'm spewing COVID germs all over the place. (#23, Physician Assistant)
I've heard some people make comparisons with the AIDS epidemic that, like, when nobody wanted to, or nobody still wants to admit that they have AIDS because there's such a huge stigma around that disease, but this idea that I will get this disease from you just by being near you, which is especially ridiculous with AIDS because the transmission is so different, but it feels like there's a slight parallel with coronavirus, and the idea that you would walk into a store and your scrubs and everybody would look at you like, "Oh my god, you're immediately going to like, if I make eye contact with you, you're going to give me coronavirus" or something, yeah, that's not really how it works and just because I work in a hospital, of course, doesn't mean that I have coronavirus. (#47, Nurse)
I definitely feel like there is a little bit of stigma, but a lot of us, I think, are very strategic and careful of how we do things when we get to work and making sure that even when we get in our car, like take off our shoes and like I don't wear my shoes that I work with in my car and I try to put everything into a bag in the car so that way I'm not possibly taking that home with me or passing it on to somebody else. So I definitely feel there is a stigma, but I feel like a lot of healthcare workers are very, maybe sometimes more careful or like they've probably washed their hands a little bit more than normal, more than the average person. (#76, Nurse)
Positive Evaluations Based Upon Moral Traits **(Healthcare Workers as "Heroes")**
Yeah, I think there's kinda been an outpouring and a lot still on social media to our staff and not so much in person. You know, early on, we had some folks that put some posters and some banners out at the hospital, and that was nice. (#5, Admin)
I think it's definitely nice to be recognized, especially closer to the beginning, lots of companies were doing discounts and perks for healthcare workers. So that recognition was really nice, 'cause they'll often do that for nurses' week. Same thing, just feels, like, special to be recognized. But, yeah, more than just nurses' week was cool. (#14, Nurse)
Like everybody is always like, "Frontline workers, yay, you guys are awesome." And we got a lot of recognition which was great. I don't know. I guess we would have done it anyways, but it was nice to have people kind of rooting for you and supporting you, and there's times when it was just super hard and dark and scary, and so it was nice to have people, sort of, recognize that. It kind of felt like being in the military in a time of war. You felt, like, a sense of pride and glad to be able to help. (#23, Physician Assistant)
I think that people are definitely appreciative of everything that's happening. I feel like I get a lot more comments on, like, "Thank you so much for all you're doing." Like, a lot more patients asking me how I'm doing, like, how I'm holding up, like, "How is everything?" So, I do feel like people do seem a lot more appreciative of everything that's happening. But again, that's just my, like, own personal experience. (#80, Physician Assistant)
Negative Evaluations Based Upon Moral Traits **(Healthcare Workers as "Coconspirators")**
There's no discussing anything because it's like if you are pro-mask, then obviously, you know, you're pro-Democrat, you're pro this left-wing, crazy person or whatever. They've made these like mutually synonymous things that they're like, well, we can't engage in conversation because you don't understand anything. I feel like this pandemic has become just way too politicized. (#26, Doctor)
It's more telling me as if I don't know it, "Well, most people are not that sick." And you're like, "Okay, but there's a lot of people that are that sick." Like, you're not even asking me. You're telling me what my job is like and that you're telling me. The other one that got me was, "Well, you guys are making a ton of money, right, now with COVID?" And it's just hysterical because our hospitals lost 20 million dollars off of COVID alone. We're not raking in money .... They basically told us no bonuses next year, like the hospital's just not making money. They furloughed a lot of our education staff … and the layman person thinks that we're making all this money, and we're really not. (#62, Nurse)
People that are very anti-masks ... I feel like those are the people that are the loudest, and then I do feel like most people are in the middle, but again, they probably don't want to engage because you have somebody that you can't even have a discussion with. So I would say that for the most part, you know, people are in the middle and don't really, you know, they're still supportive of healthcare workers, but I mean, I definitely think that the minorities, not minorities as in a race, but minority, loud, anti-maskers or whatever, are a little bit more vocal, so those are the people that you tend to hear more from. (#65, Physician Assistant)
I know that some people have gotten bashed for expressing their concerns on a healthcare basis. You know, more from the side of people that don't believe it's real. (#76, Nurse)
Experiencing Mixed Evaluations **("You're a Hero, But Don't Get Near Me")**
I think you get like half of people that are like, "Thank you, like you're doing so great." Or they will stop and ask you questions like, "How is it? How's the hospital? Where do you work? Do you see a lot of cases?" And, you know, different things. Or there's people that are kind of afraid and think, "Oh, they've been around it all day" … I think it's just been interesting to see the different reactions of people as far as healthcare workers go, and I've known friends and coworkers that have talked about their different experiences where you know they've been at the store or at the movies or whatever, just after work, they go and, you know, we don't really think anything of it because we know how protected we are but just some people just kind of react a little adversely. But you know, there's a lot of really nice people who, you know, want to talk to us and ask us questions and say nice things. (#13, Nurse)

TABLE 2
(Continued)

Experiencing Mixed Evaluations **("You're a Hero, But Don't Get Near Me")**
But yeah, going out in public, you know, with your badge on in your scrubs on and stuff, people look at you differently, and they, you know, say thank you, or congratulate you, or whatever. There's also like the opposite side of that, where people are like, look at you like you're infected or something. (#14, Nurse)
"Heroes"? They leave the house and go out at 9 p.m. every night and go out and applaud. Then they are sending letters saying they wish [healthcare workers] would go away so they don't get infected. It's not black and white, it's gray. (#17, Admin)
The community is very supportive of the healthcare providers and healthcare workers, which is nice …. Now I have had a couple of people be like, "We don't want you out in town because you're dealing with that stuff. We don't want to be infected." "Sorry you feel that way, but I want to finish getting my gallon of milk and my groceries and go home." (#27, Physician Assistant)
Sometimes I feel happy when I hear the applause, the claps. I don't know. But sometimes we see in social media that other doctors in Chile were attacked or discriminated in their communities because they [treated COVID] patients. It was very strange because some people gave you [strength] to continue fighting and the other part of the community was against the doctors. (#40, Doctor)

efforts at interpreting the subjective experiences of our participants. Accordingly, we attempt to "show" as much data as possible (Golden-Biddle & Locke, 2006) directly from our participants, which we do with direct quotes in the Findings, as well as in Tables 2, 3, and 4.

FINDINGS

Our grounded model (Figure 1) depicts the process of mixed social evaluations and incorporates processual elements from both the evaluator's (actor's) and evaluatee's (worker's) perspectives. As a result, the model consists of three distinct sections: the first depicts evaluation formation and transmission, while the second and third sections depict evaluation perception, consideration, and internalization. We begin with the left-hand side of the model, which reflects how healthcare workers perceived both positive and negative social evaluations in response to what we term a *social evaluation event* (i.e., the COVID-19 pandemic). Social evaluation events disrupt the social working consensus and evoke a reappraisal of extant occupations (Goffman, 1959). In our findings and model, such reappraisals are context-specific—in other words, they are dependent upon which dimensions of work (i.e., physical, social, and moral) were most salient to the evaluator at the moment of interaction. Unlike prior models, our model explicitly permits the formation and transmission of mixed evaluations.

Upon exposure to such evaluations, healthcare workers appraised their validity according to three criteria: the *proximity*, *informedness*, and *authenticity* of the source. Evaluators and evaluations that generally met these criteria led to the acceptance of the evaluation and responses in kind (e.g., supporting supporters or condoning condemners). However, many evaluations did not meet all three criteria. As a result, many participants reported feeling conflicted, ostracized, and generally resistant to the collection of contradictory evaluations they experienced, resulting in discounting their condemners *and* supporters. To capture the nuance of these conflicting experiences, our model accounts for a variety of evaluations, ranging from single, "uni-valenced" evaluations (e.g., "you're a hero") to multiple, "ambi-valenced" evaluations (e.g., "you're a hero, but don't get near me"), and, still further, to an accumulation of mixed evaluations over the course of days, weeks, and years following a social evaluation event.

Social Evaluations Manifested

Social evaluation events. We begin by discussing the pandemic as a social evaluation event, which we define as an event that disrupts the existing social consensus and provokes the widespread reappraisal of existing occupations (Goffman, 1959). An important departure from previous conceptualizations is that, unlike stigma events (Hudson, 2008), moralization events (Cameron et al., 2022), or valorization events (Hennekam, Ladge, & Shymko, 2020), social evaluation events need not produce evaluations of uniform valence (as with the public moralization of gig workers during the pandemic; see Cameron et al., 2022). We noticed the macro-event of the pandemic impacted the micro-interactions of healthcare workers and their evaluators, who evaluated them according to evaluative dimensions of work made salient according to the social context of their interaction. More specifically, we noticed that the formation of mixed evaluations coincided with perceptions of core characteristics of healthcare workers along physical,

social, and moral dimensions of work—dimensions traditionally studied in the context of dirty work (Ashforth & Kreiner, 1999; Hughes, 1951).

Physically, healthcare workers engage with physical elements like bodily fluids and transmissible infections and diseases, which induce taint. The social evaluation event of the pandemic called attention to the high transmissibility of COVID-19 and other viruses, which triggered many outsiders to perceive our participants as tainted. *Socially*, during the pandemic, healthcare workers worked amid COVID-19 patients and consequently received what Goffman (1963: 30) called a "courtesy stigma"—an indirect stigma that affixes to the healthcare worker because of their direct association with physically tainted patients. *Morally*, healthcare workers were largely lionized for engaging in important prosocial work at a significant personal sacrifice. Paradoxically, as the pandemic progressed, healthcare workers increasingly became morally tainted by some as pandemic coconspirators. Some far-right media outlets, for example, accused healthcare workers of exaggeration, concealing evidence, and benefiting financially from the COVID-19 crisis (Jamison, Broniatowski, Dredze, Sangraula, Smith, & Quinn, 2020; Ritter, 2020). Viewed in aggregate, the social evaluation event of the pandemic triggered the formation and transmission of mixed evaluations—targeted at healthcare workers—based on physical, social, and moral aspects of their work. These dimensions then became more or less salient according to the social context within which the actor(s) and healthcare worker(s) interacted, the nuances of which we detail next (see Table 2 for additional quotes).

Negative evaluations based upon physical and social taint. In our research context, the *social stigma* that healthcare workers experienced appeared to be a direct result of the *physical stigma* affixed to potentially treating patients with COVID-19. As a result, it was difficult for us—as well as the healthcare workers—to disentangle which stigma was *direct* (i.e., physical) and which was *indirect* (i.e., social). Accordingly, we chose to combine physical and social stigma together in our analysis because of their close relation and similarly negative taint. The level of taint can vary for an occupation in normal circumstances, but the pandemic intensified the perception of (and attention to) healthcare workers. As local, national, and international news extensively covered the crisis in emergency rooms and intensive care units, our participants began feeling like their previously unremarkable jobs were suddenly inducing a visceral reaction in those around them, particularly those in close physical proximity. And, given the high levels of uncertainty surrounding the virus and its virulence and transmissibility, especially early in the pandemic, as well as constant media coverage concerning the transmissibility and mortality of the virus, outsiders could ostensibly attribute such reactions to science, reason, and exercising caution. Additionally, for a workforce unaccustomed to concealing their occupation outside of work, uniforms, masks, and name tags made healthcare workers easy targets of public criticism and hostility. The owner of a nursing home in Brazil (#28) lamented how the fear and uncertainty early in the pandemic turned violent: "They don't want the people who work in hospitals to be on the bus because they were [near] the virus." This participant also mentioned "10 cases [that] were violent" in her city that led to her employees being afraid of being identified as healthcare workers after people on the bus kicked and assaulted healthcare workers and screamed, "No, you're not coming [on]! You're transporting the virus! You're not going to be here!"

Most participants reported subtler microaggressions, for example, individuals watching them and treating them differently in public. A respiratory therapist (#45) shared, "I've noticed people nervous or seeming uncomfortable. I think they look at me as just somebody who's carrying the disease with them at all times." A home health nurse (#33) described visiting a grocery store this way: "I made the mistake of running into [grocery store] to get my patient something … I walked in, and I've never felt the dagger looks so much, and it's like, 'Wow, they aren't looking at us like heroes anymore.'" Adverse treatment, however, was not limited to strangers. Many of our interviewees noted that they felt stigmatized by neighbors, friends, and family members alike, which seemed to carry a greater impact. A special unit nurse (#6) recalled how she and her children felt stigmatized:

> [Our] neighbors who my kids always play with, who when all of this happened, they were very like, "Don't come near us. Your mom works in a hospital; you could get us sick." And it was very emotionally hard on my children, which was very frustrating to me. Yeah, so that was kind of huge for us.

Several workers complained of having to sit in separate areas at family dinners and field questions; for example, Nurse #74 experienced "constant comments from my family like, 'When was your last exposure to COVID? Can you get tested before [coming to dinner]?'"

Positive evaluations based upon moral traits. *Morally*, the pandemic quickly brought healthcare work to the forefront of public consciousness as signs, commercials, clothing, and high-speed jet flybys praised healthcare workers worldwide (Wang et al., 2021). To show appreciation for the National Health Service, the English Premier League put "Thank You NHS" throughout its stadiums and patches on all their players' jerseys. Attention and praise emanated from disparate sources, including social media, academic journals, local and national governments, and private citizens who would place banners on or near workers' properties to specifically call attention to their local heroes (Bauchner & Easley, 2020; Cox, 2020; Morris, 2020). A housekeeping supervisor (#35, Admin) of a nursing home said proudly, "When the [U.S.] Air Force flew over our building and did the flyover, it gave us a little bit of like, 'Yeah, they're doing this for us because we are the backbone of this pandemic.'" In the United States, Italy, Spain, and Argentina, among many other countries, people routinely went out to their balconies at prescribed times and applauded frontline healthcare workers. *All* of our participants reported being aware of the "healthcare heroes" campaign.

Negative evaluations based upon moral traits. Although healthcare workers enjoyed widespread lionization during the pandemic, we would do our participants a disservice if we did not explain a fascinating evolution in the moral evaluations they received over the course of the COVID-19 pandemic. Moral stigma refers to "blemishes" of character (Goffman, 1963) based on engagement in activities perceived as immoral or sinful (Wang et al., 2021). In our case, we heard a surprising number of accounts of healthcare workers being evaluated conspiratorially as "insiders." Portions of the public accused healthcare workers of lying or exaggerating about the magnitude of the pandemic and the public health initiatives surrounding it. A doctor (#46) reported this coming especially from the political right, stating, "There's a lot of people that watch Fox News down here, and there's a lot of people that still think it's a hoax, that it's not even a real virus. They think it's going to disappear on election day." Physician assistant #65 explained that the "loud anti-maskers or whatever, are a little bit more vocal, so those are the people that you tend to hear more" (full quote in Table 2). A nursing manager (#8) noted,

> I was surprised when someone who I thought was a friend came up to me in the midst of the pandemic height and said, "So, are we just supposed to stay quarantined to protect you guys in the healthcare industry?!"

Healthcare workers being stigmatized as coconspirators provides a unique example of mixed evaluations emerging from the *same* evaluative dimension of work (i.e., moral) given, as previously described, that healthcare workers were also lauded as heroes. Nurse #51 highlighted how the mixed evaluations evolved over a prolonged period of time, with positive hero treatment prevalent particularly early in the pandemic before receding to more negative appraisals:

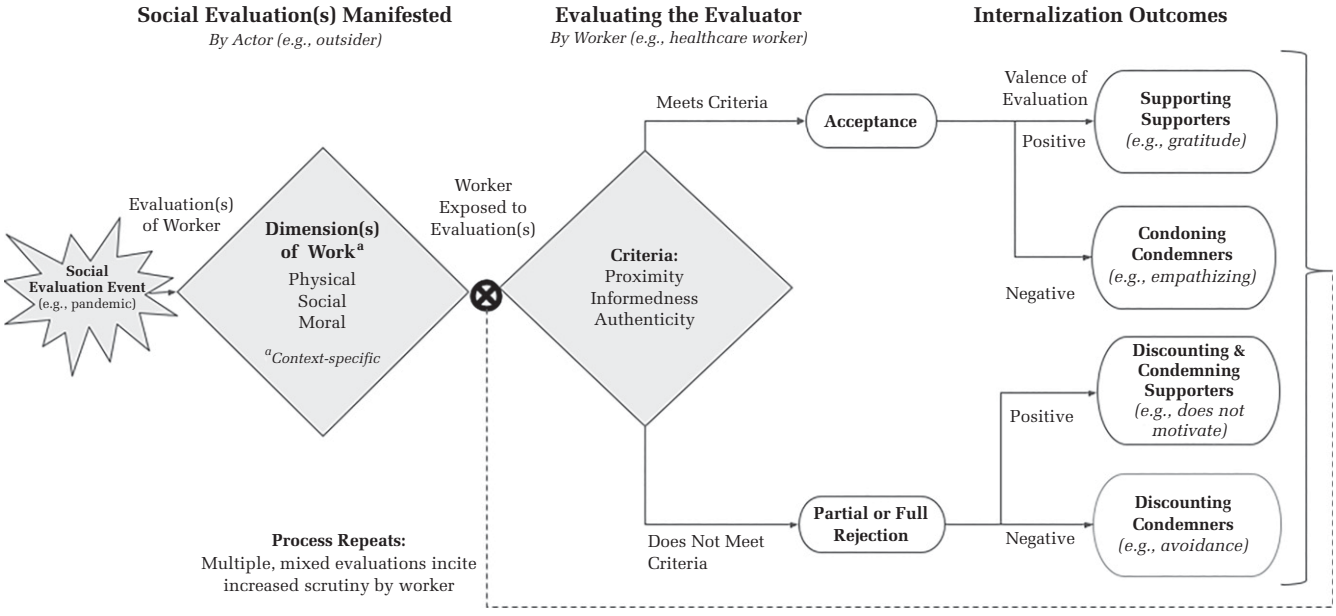
> I think it's funny to look back and see how the community treated healthcare there for a little bit. When all of it was first kind of going around, we had so many *thank yous,* and it was like people all of a sudden realized what we do, but that has faded, and now we're back to, you know, I've been called every name in the book just in the last week, so, I don't think from our perspective, we view our jobs any differently, we show up, we do the same thing, regardless of how we're treated or what's going on in the world, but I think it's interesting to note how community have kind of, they had a massive change in pace there for a little bit, and it was like everyone finally just realized what we do for a living.

Nurse #56 reported his surprise at the reversal of treatment over time, as well:

> Politics plays a huge part in this. It's been, at the beginning of the pandemic, where healthcare workers, doctors, nurses, all the medicals, all the hospital staff, everybody's been revered as these heroes, you know, "essential to the community, where would we be without them?" To almost the reverse now where it seems like medical personnel are playing into these, quote-unquote, "hoaxes of COVID," and so it's been interesting, going from the hospital setting where you see this day-to-day, you're learning about it day-to-day and then going out into the community and just hearing other people and people that know what you do, just be like, "How can you guys say what you're saying about masks, about medications, about treatments, about things like that?" The whole landscape has almost completely shifted in a way where at the beginning, I feel like from a social and economic standpoint, we were being very well supported, to now it's almost basically the opposite, it feels like.

Experiencing mixed evaluations. Healthcare workers reported receiving mixed evaluations from a myriad of sources, including strangers, administrators, friends, and family members. These evaluations varied in their impact on the workers, and we explore those in more depth in the third section of the Findings and in Table 4. Nurse #86 put it this way: "I think that is part of why I really hate the whole hero thing. I didn't like that there was this like, major dichotomy,

FIGURE 1
Mixed Social Evaluations in Stigmatized Occupations



right? It's like, 'Oh, you're a hero, but like, don't get near me.'" On the other hand, some understood the contradiction, like Nurse #76:

> People are showing us a lot of "you're a hero" and a lot of respect, but then obviously, on the other side, they don't want to be near you, which, I get it, I understand. Obviously, you can show your respect from a distance, right? (Full quote in Table 4)

For our purposes, mixed evaluations did not have to be made by the same individual or collective but by any third party who gave both positive and negative evaluations, individually *or* collectively. In fact, besides conspiracy advocates generally being perceived to be from the far-right politically, our participants noted no systematic differences or discrete groups in those doing the stigmatizing. On the contrary, stigmatizers included random people at grocery stores and gas stations, friends, family, and coworkers, which added uncertainty and unpredictability for how they would be perceived and treated. As Nurse #13 sharply articulated:

> I feel like it's easy for people to think they understand things based on what they see on the news and from *far away* because it doesn't affect them *directly*, but as soon as it *could*, they *act and feel differently*. (Italics added for emphasis)

Here, we noticed the character of the evaluation—and the criteria by which healthcare workers were being evaluated—appeared contingent upon the context, specifically the spatial distances at which healthcare workers were being evaluated. For example, we noticed healthcare workers were generally evaluated on the moral dimension (i.e., considered heroes or coconspirators) by people commenting at high distances on social media, printed banners, or private balconies, but were evaluated on physical and social dimensions (i.e., stigmatized) in more intimate settings at low spatial distances that provoked fears of contagion, often with no malicious intent by the evaluator. Nurse #6 told us, "In the beginning, people called us 'healthcare heroes' but also treated us poorly when we were in any public setting." In healthcare workers' retelling of mixed evaluations, the character of the evaluation often, though not always, hinged on spatial distance differences that triggered disparate salient dimensions of their work.

In short, the pandemic served as a social evaluation event upending how healthcare workers were perceived and treated by society. The effects, however, were not homogenous. When greater levels of spatial distances were present, outsiders emphasized the morality of their work, which primarily encompassed notions of sacrifice (e.g., "healthcare heroes") but also

as politically charged coconspirators by some. At close distances, the perceived risk of becoming infected made the physical and social aspects of healthcare work more salient, leading to widespread stigmatization. Given the mixed, conflicting nature of these evaluations, we next address how an occupation internalizes such dichotomous and perplexing appraisals.

Evaluating the Evaluator

When a social evaluation was perceived, healthcare workers subsequently processed the evaluat*ion* and evaluat*or* to determine its validity and, thus, their response. We noticed that even in the case of large banners or slogans about "healthcare heroes" with no obvious source being named, our participants inherently cared about the credibility of the source(s) according to their proximity to the participant, their relative informedness about the nature of the participant's work, and their authenticity in making the evaluation. Therefore, while we label this section and focus on how our participants evaluated their evaluat*ors* (not evaluations), we note that the two are intrinsically connected. In this section, we detail how such social evaluations were received and the criteria that healthcare workers employed to judge each evaluation (see Table 3 for additional quotes on the evaluating the evaluator process).

Proximity. Whether positive or negative, social evaluations were most influential to our participants when the evaluator was *spatially* or *socially* close to the healthcare worker. Although most moral lauding came from distant sources, when healthcare workers were thanked up close and personally, they generally internalized and responded more favorably and reported feeling that the interaction held a greater significance. As a physician assistant (#27) commented, "If I'm going home from work and I'm in my scrubs, and I stop someplace, it's not uncommon to have somebody say, 'Thank you.' It is very appreciated. We do appreciate that." In this vein, we heard a considerable amount of positive regard from participants for the clapping on balconies to recognize healthcare workers for their sacrifices in a way that felt more personal than a tweet or billboard. A New York physician assistant (#65) described the 7 p.m. clap:

> One thing that they did that was actually pretty incredible was the 7 p.m. clap … I think, based on the way New York is set up geographically, *it just felt overall pretty close and tight.* So, I can basically see in the apartment across the street from me. I think it just brought the city together. You know, you stepped outside and heard a lot of cheering and instruments being played, and it just was five minutes out of everyone's day that they stopped, they came together, they thanked people who were in the hospital, and we often would run down, whether we were working or coming on to shift. A lot of people would run outside for that 7 p.m. [clap]. (Italics added for emphasis, Full quote in Table 3)

A physician (#44), also in New York City, expressed general disapproval for "healthcare heroes" but admitted, "All of that cynicism aside, I think it was nice to see at 7 every day, people banging their pots and pans and clapping." Thus, the spatial dynamics of where and how healthcare workers were thanked proved incredibly impactful. Low spatial and social distances helped foster a sense of community in a way that distal sources could not.

On the other hand, negative social evaluations made in close spatial proximity were equally powerful, and as discussed in the previous section, nearly all of the physically and socially stigmatizing evaluations were done at close distances. A physician assistant (#23) in New York City spoke about an elevator interaction with a neighbor and friend:

> I got out of the elevator with my scrubs, and my hospital I.D. and [we] almost physically ran into each other … her eyes rolled back, like, "Oh, my God," … where she was sort of obviously fearful of me but wanted to be also gracious.

This example includes the physical closeness of being in an elevator and the social closeness of a neighbor and friend. As we saw in the previous examples of workers having to eat separately at family dinners, or the nurse (#6) whose children were being ostracized by neighborhood friends, stigma often emanated from people socially close to the healthcare workers, which mattered psychologically. Nurse #2, working in a special pandemic unit, described feeling stigmatized at work by fellow healthcare workers:

> So being on the COVID floor, obviously, we get the COVID patients, and other nurses will call us the "dirty floor." They'll say they don't want to float to us. They'll say that they don't want to be on our floor. I feel like I click on the sixth-floor button in the elevator, and people make comments.

The previous quote from Nurse #2 highlights something complex about this example of stigmatization in that it often felt justified by both the actors and targets. Indeed, stigmatized groups can be actors as well as targets of stigma (Toubiana & Ruebottom, 2022). Amid the scientific uncertainty surrounding the virus and as public health and government leaders called for

TABLE 3
Supplementary Data: Evaluating the Evaluator Criteria

Codes	Proximity
Spatial Distance	So I feel like, to me, [being praised by patients and family] is way more rewarding than hearing from society that they think we're so great. The profession is so profoundly large .... And so, I don't really like being socialized into this big applause. I want to feel that individual pride, and I just really think that that's something that nurses should be looking for at the bedside, not from the population. If you want to be a good nurse, your focus should be there. (#4, Nurse)
	I was at Chipotle the other day picking up dinner for my husband, and I was in my scrubs, and the person in line in front of me saw me come in, and they moved up a little bit in line, and I was like, "I'm not infected." We still have to stand six feet apart like you're not going to catch anything from me, if I even did take care of somebody that you know had coronavirus, like I wear so much protection that there's no way that it could even affect you standing six feet away from me in line, but they totally moved up a little bit, and I was like, "Okay, like I get it, you think I have coronavirus, it's fine." It's just different experiences like that where you know people will kind of move aside from you in the store. I've seen it happen at Walmart. People will come in in their scrubs or whatever after work, and people in Walmart will kind of just scoot a little more to the side than they probably would for another person. And something that I've noticed as a healthcare worker [is] how other people treat us in public when we're out wearing our work clothes …. They're like, "Oh my gosh, this is something to be really, really afraid of right? And we should be afraid of the people working with it because they have it on them. They are carrying it in their hair. They're carrying it on their clothes." (#13, Nurse)
	I went and got the husband, and I brought him back to the room so they could be together in that horrible time. Anyways, later on, he acknowledged how grateful he was that I was able to bring him back and how grateful he was to nurses and doctors who were taking care of his wife. I think there's a sense of pride in advocating for your patients and doing the right thing in a difficult time, and I think there's just a lot of pride in just like helping others. (#48, Nurse)
	I think the one thing that they did that was actually pretty incredible was the 7 p.m. clap ... I think based on the way New York is set up geographically, it just felt overall pretty close and tight. So, I can basically see in the apartment across the street from me. I think it just brought the city together. You know, you stepped outside and heard a lot of cheering and instruments being played, and it just was five minutes out of everyone's day that they stopped, they came together, they thanked people who were in the hospital, and we often would run down, whether we were working or coming on to shift. A lot of people would run outside for that 7 p.m., and just kind of got this little uplifting feeling ... I think that was a big thing, at least for me, and I think for a lot of my friends in healthcare. (#65, Physician Assistant)
Social Distance	And I think it's a neat thing, honestly, a lot of it, but like, I got COVID from a resident. I felt so bad because I passed it to so many people. My family were all very supportive. Like, "(Participant), that's the best way to get COVID because you were sacrificing to help this person who was having a diabetic coma, making sure they can breathe." And so that's been really great and helpful to me, to see people saying, "Wait a second, what you're doing is good." (#29, Admin)
	This just kind of feels like getting a little bit more praise than I should for doing a job that I signed up to do, and as time has gone on, I feel like it has just turned into a marketing thing. From an internal perspective. Where they put out, you know, companies will put out how much they value their employees and how much our service means to them and the community and everything like that, but it almost feels like they're doing it just to maintain a pristine PR image. Right now, if anybody on the executive level were to say, "You guys are healthcare heroes," I mean, I'd probably say nine out of ten people would probably roll their eyes at it, knowing that they are just doing it for marketing, just to try to facilitate some feeling of loyalty in their employees. You know, it kind of loses its meaning, kind of loses its luster, and you just get really sick of hearing it, to be honest. (#56, Nurse)
	I think it's mostly just like, put a good face on the organization, or people want to show that they're supporting us but it's kind of like a lot of things with social media, everybody posts things, but that's about the extent of it is they post a message, it doesn't seem like it ever bleeds into real life. (#77, Physician)
	I feel the most pride not from management or the higher-ups but when my patients recognize our hard work and diligence. (#91, Nurse)
Codes	**Informedness**
Uninformed	Yeah, I mean, it's hard. I work with people who maybe stopped at the grocery store or the gas station on their way to work and were like verbally attacked for being in scrubs. Like people are mad that we're gonna infect them because they work in a hospital, and it's very unnecessary. I mean, we're doing everything we can to keep ourselves safe. Like obviously, none of us are being reckless cause we don't wanna get sick; we don't want to get our family sick. So to just assume that we're automatically contagious or a hazard is hurtful. My sister just had a baby, and she also works in healthcare. She's a pharmacist. And one of her in-laws had made

TABLE 3
(Continued)

Codes	Informedness
	a comment about how they couldn't, they wouldn't come see the baby because the baby might give them COVID because of my sister. Like, no, it's a newborn, but it's just kind of hurtful things like that. Like we're not, we don't carry the plague. (#6, Nurse)
	I miss those days that we were able to interact just normal, even trying to talk to my donors about we're running a little bit late, and they, just, if I'm close within two feet, it's like an offense to the older donors. "Oh my goodness, I'm wearing a mask, I'm taking my precautions," but you really see that some people are really scared. (#11 Certified Nursing Assistant, CNA)
	You just got that feeling, kind of like the double-take of, like, "She didn't just come in here in scrubs." I mean, I get the fear, but I think people are living off of so much fear rather than thinking about reality and being rational because I'm probably a lot cleaner in my scrubs, even if I'd been to multiple visits versus those folks who were going to grocery stores and Home Depot and daycare. (#33, Nurse)
	Not so much with my mother-in-law, but with my sister, I had a long phone conversation with her about it. I'm happy to wear a mask or do whatever to make people feel comfortable, but in reality, like I mentioned to you, I actually feel like I'm less exposed than most people because of the testing that's going on and, she, for example, is a receptionist at a dentist office who are seeing patients all day, every day and right now, they're super busy, so I don't feel more exposed than she is, for example, or my other sister, who's a schoolteacher, who's currently teaching large classes. I don't know why this stigma, just the idea that I'm in the hospital, means that I'm more exposed. (#45, Respiratory Therapist)
Same Job as Always, Signed Up for This	All the cartoons and the drawings of nurses with their face masks on, and they're crying tears, and they're just so upset. It just seems really stupid because it's a profession they chose. We know what we're getting into. You go to school and you hear about all the diseases that you're capable of coming in contact with, and you go to work and know exactly what disease the patient has been tested or not tested for and whether or not they have it if their tests have come back. So you know what you're up against. You know that it's going to be a risk and a chance, and so I feel like, with the whole COVID thing, it shouldn't be any different just because it's a different disease. (#4, Nurse)
	I don't like it. I mean, I was trained to do what I do. I'm getting paid for doing what I do. There are a lot of everyday heroes, too, that are doing their best to keep the country going. They are not getting applause. I don't know. We are getting paid for this, so it's part of what I decided as a career. Actually, it's funny to me because I think that it is one of the best times to be alive as a doctor because it's something that probably we're not going to live in our lifetime again. So, it's kind of a mixed feeling that you have with the situation. (#43, Doctor)
	I don't know. At the end of the day. You're just doing your job. You didn't cure the thing. You come up with a cure, you can call yourself a hero. Until then, just do your job ... I would never call myself a hero. I don't identify with that at all. I don't think I've done anything beyond my job ... I think healthcare providers calling themselves heroes is obscene. To me, it's just my job. I think it's important that people [understand that] just because there's a pandemic doesn't mean we do a better job. We're not gonna do a worse job tomorrow. It was a job before a pandemic; it's been the same job. We bring the same value systems with us to work every day since even before. (#48, Nurse)
I'm Not the Hero	I haven't really promoted it a lot because part of me is just not, I don't really consider us the heroes, and that probably sounds just like a humble thing to say, but I really feel like the real heroes are the ones in the hospital and are really dealing, and really at risk and a lot of our staffers, they're just doing what they normally do. (#1, Admin)
	And I don't treat COVID patients, you know, I treat arthritis, or, you know, sports injuries, and we had, like, barely any COVID patients admitted on our floor, but people's, like, perception of healthcare workers is like, different. And they're like, "Oh, you work in healthcare, you're a hero." And it's like, "No, just a normal job." I don't know. Maybe that's an unpopular [opinion], but I, like, hated seeing all those signs everywhere. Because it's just like, you know, the rest of us still have to, like, show up and work even though we're not on the front lines of COVID. (#81, Physician Assistant)
	I think that's another component of the appreciation thing. It feels a little bit embarrassing to get so much credit heaped upon us when we're just doing our job and doing what we're doing. And the COVID situation here has just not been as bad, and so here it just feels like other than wearing the PPE and having to be a lot more careful, it just feels like we're doing our job and doing what we've always done just more carefully. It's not like in New York. We weren't watching patients die alone, and we weren't watching, you know, it just wasn't anything to the same degree. (#83, Doctor)
Excluded	There are just so many different things you can do with nursing; you don't even have to touch patients, you can work in insurance, so I think that there is a lot of bias there and then the one like, you know, "You weren't a healthcare hero unless you were working on the front line of COVID." It is kind of the feeling I got from a lot

TABLE 3
(Continued)

Codes	Informedness
	of people. You know, they were like, "Well, why is it affecting you?" And it's like, "Well, because the government seized my PPE!" (#33, Nurse)
	I feel the professions that aren't, that don't have an MD or a DO behind their name quote-unquote "get lost in translation" when it comes to all this. I mean, doctors, as fantastic as they are and as great as they are, they are just a very small piece in the clockwork and the clock that is healthcare, and I have seen respiratory therapists. I have seen my own nursing assistants. I have seen phlebotomists. I have seen even housekeepers, you know, people that clean rooms. I've seen them do some amazing things during this pandemic, and their professions are not the ones that are being televised. Their professions are not the ones that are being glorified and revered and all that stuff. (#56, Nurse)
	Some of the employees felt left out. You know, like just for instance, like housekeeping, they are there every day, they're cleaning all the stuff that is soiled and from that unit and, you know, they weren't, there was all those like when you talk about the healthcare heroes and the public. You know, there's lots of things being discounted or given away or whatnot. Like they weren't able to take part in any of that because they didn't have the title of a nurse or nurse aide or whatever. So I do know some people felt left out. (#71, Admin)
Codes	**Authenticity**
Disingenuous	I think sometimes people just say it just because that's the cool thing you're supposed to say to all that. (#9, Admin)
	When this first started, we had a lot of people that would donate food to the hospitals, that would donate masks, but I think that a lot of that was because everybody else was doing it. I mean, it was, of course, a nice gesture, but a lot of people, I feel, jumped on the bandwagon, did it to promote their business, and then as soon as other things started to break out in the news, that died down immediately. It just stopped abruptly. (#20, Admin)
	I find it a little bit disingenuous to congratulate everybody because I don't think everybody was doing the right thing, or that everybody had the right intentions, or was even meaningfully contributing. (#44, Doctor)
	I think it's mostly in the media to, like, put a good face on the organization, or people want to show that they're supporting us. But it's kind of like a lot of things with social media, like, you know, everybody posts things, but that's about the extent of it is they post a message it's not, it doesn't seem like it ever gets, bleeds into real life, you know what I mean? At least, that's more about my interpretation. Yeah, it just feels more like signaling to me, and people do it with all sorts of like political, social movements, you know, with social media posts, you know, something that they believe, but I don't feel like the thoughts necessarily represent actions. People don't really change their actions, even though they'll say they think a certain way, and that's why, even though I've seen those advertisements about the healthcare hero as a thing, I don't think patients have necessarily changed their view on us. I don't get a whole lot of like, "You're a hero" or anything like that when I walked in the room ... I think sometimes people just do it to, for whatever reason, if it, you know, bumps the amount of likes that they get on social media or gives them attention. I think it is more of, like, a self-driven thing ... because I don't see, like, follow through with a lot of those thoughts. (#77, Doctor)
	I feel like it's more just for the publicity of, like, saying that you're supporting healthcare workers, you know, whether a business is saying it or whether it be more visually, I don't think it's something that people are going out of their way to really go and like support a healthcare worker ... I signed up to be a healthcare worker. I signed up to go to med school. I signed up to be around sick people, and so, you know, it is partially something that I chose to do in my life. So I can't be too offended if I feel like people aren't supporting me. I'm glad that they put out positive messages. I think it's better, at least, acknowledging what people in healthcare are doing ... maybe the public display isn't that genuine, but you feel like the more private displays are sort of more representative of how people are feeling ... It makes more sense the way people actually behave when you're around them versus what they're saying. (#77, Doctor)
Hero-Washing	I think people need to know that. It's not just, "Oh, hey, cool. I'm gonna go buy this healthcare worker Starbucks, and everything's gonna be fine." That's a great gesture. That's nice, and it's appreciated. But I imagine, certainly not to the degree of like veterans, when people say, "Thank you for your service." I think sometimes people just say it just because I think that's the cool thing you're supposed to say to all that, but I know that there are a lot of veterans they've been through hell, and yeah, they get a thank you, and it's like, "Okay," but there's still that weight there; still, that burden that they carry and I think a lot of our healthcare personnel carry that. (#9, Admin)
	It's like anything that gets attention for a little while. I think that there is, to a degree, a higher, there's just more awareness I guess that like, "Oh, there are healthcare workers that do these jobs that suck a lot of times." And so there's a level of respect but I think once the hype is over, give it a little while and it'll go away again. It's just like anything. That if there was a big fire or something like that and a building burned down and some

TABLE 3
(Continued)

Codes	Authenticity
	firefighter died or something like that, there would be a big thing about it for a year or something and there'd be all these donations and all this stuff going to firefighters and then it would die off and it would go away. I think it's just the same as anything. (#16, Nurse)
	I don't know, the word "heroes," I think you say doctors are heroes ... like that gives you reason for not paying well and the bad hours and all the sacrifice, all because they're heroes. Maybe we could have better conditions and just not the heroes and do our job, you know? If they cared about you, they would give you better conditions. (#36, Doctor)
	I really was bothered by the whole language of heroism around health care during the pandemic because it felt to me like, in some ways, if you call someone a hero, then all of a sudden, it's okay to mistreat them or expect them to make major sacrifices. As long as you call healthcare workers heroes, that it's okay that they get coronavirus and die. You know, I really would prefer if we just treated healthcare workers as professionals and provided them with tools to do their job safely and took out the language of heroism. I don't feel like serves a big purpose in health care. (#47, Nurse)
	I'd say a lot of that has come from the administration side of things. I feel like my value as a healthcare worker, generally speaking, I feel like I'm valued in the public perception as a healthcare worker. Like, "Oh yeah, you're a nurse. Nurses are great." You know, my colleagues, your doctors are fantastic, generally speaking, I feel like that's the public. However, when you get internally, I feel like there is more of a business being at play and that I am just a piece in that business and that my position isn't as revered or isn't viewed as, quote-unquote, "essential," as maybe they make it sound to be. You know, we've been asked to do a lot with very little over the last several months, and it has really become a very stressful environment to work for everybody and I feel like a lot of it has to do with just the feeling of being expendable. Expendable to a budget based on what the accountants pump out in their spreadsheets. So that level of uncertainty is kind of added to that stress and added to the feeling of a little bit of devaluation. (#56, Nurse)
Did Not Sign Up for This	I feel that the constant short-staffing caused all of us to feel like we had to work extra to help out our coworkers and that our mental health wasn't as important as meeting the needs of the community. Using the title of hero invoked this sense of selflessness that none of us asked for. Like, if we were these community heroes, we were willing to sacrifice our own needs and obligations to ourselves and our families to help others. (#62, Nurse)
	There's just something about exposing myself to something that I feel like I don't have a choice in. It kind of feels like we're being drafted as nurses into this, and we don't have a say, and that, that's frustrating to me to feel like I don't have a choice any more of like, "Do I want to take care of these patients or do I not?" Yeah, or just that and just kind of being thrown haphazardly into this, at least in the beginning. That's what it felt like where it was like this, "No one really knows what's happening. No one really knows what this virus could do. No one really knows if the PPE we have is going to work," and it's like, "Well, you don't have a choice so this is your job." Like this isn't the job I signed up for him. This isn't what I wanted. (#84, Nurse)
	When they were talking about the lack of PPE and PPE shortage or whatever, and nurses were going on strike saying, like, "We need our PPE," and people would be like be against the nurses and be like, "Well, that's selfish that you're not in there taking care of the patients" and we're weak. We are doing a job, first of all, and second of all, we didn't come in here to, like, sacrifice ourselves to, like, for the greater good, you know? We're not like soldiers in a battle. We're, like, paid professionals, which, I think, may be in the hero talk. People could say a lot of these, you know, soldiers, people who have been to war, people have done good to, like, protect their cohorts, and in war, those people get called heroes, and I'm not one of those people. That's not me. Don't do that. (#86, Nurse)
Poorly Treated	I always thought that people had respect for people working in healthcare, and I also felt like most healthcare workers were paid on the low scale. They're worth more, like CNAs and housekeepers and people like that who do the work every day, I feel like they're underpaid for what they do, especially right now, because all the direct care staff are right in the middle of it. (#35, Housekeeping Supervisor)
	I think when the pandemic hit was that I'm so grateful. I get to contribute to the solution. I get to be a part of helping. That's why I became a nurse. I love that. There's this one side of me that loved that I had the skills to take care of these patients. Then the other side of me feels very underappreciated and undervalued as a nurse, particularly. I think, several examples, one being compensation. When I was hearing of people on unemployment that were getting paid more than me, and I was on the front lines, risking, in essence, my life. (#74, Nurse)
	No one in the nursing community enjoys being called "heroes" because we are not treated that way. We were seen as heroes and quickly disregarded by everyone and abused by patients as well administrators in hospitals who want to work us to death. (#94, Nurse Practitioner)

TABLE 4
Supplementary Data: Internalization Outcomes

Codes	Supporting Supporters
Pride	Yeah, I mean, I feel a little more heroic, I guess, and it's nice that people are actually listening to my opinions and my education. I have had a lot of people coming like, "Oh, you're a nurse; what do you think?" There's like a respect level there now. Instead of, "Oh, you just wipe butts all day." (#4, Nurse)
	It wasn't necessarily something that I really thought a lot about until the pandemic hit, and all of a sudden, people were like, "Oh my gosh, like nurses and doctors and you know CNAs and respiratory therapists and everybody like, you guys are so awesome"... I just was hit differently by that because I was like, "Oh, this actually, this is a big deal to people," and I didn't realize that, and it's definitely changed the way that I've felt about [being a nurse]. (#13, Nurse)
	I feel like there wasn't a lot of recognition until people were like, "Oh, shit, this is big. We need nurses. We need doctors. We need equipment. We need people to take care of people who know what they're doing, and it was awesome." You know, in the beginning of COVID, especially, there are people like dropping off food to us, and there were signs everywhere saying "Thank you for healthcare workers" and for those that are on the front lines, and I think there's something to be proud about. You're putting yourself out there. You're putting yourself at risk. (#48, Nurse)
Gratitude	I mean, it kind of makes me sad that it took a global pandemic for people to appreciate healthcare workers. I think that's really unfortunate and because we've always been there, and not a lot has changed, even though the world has, and I mean, but I have to say when all the meals were coming in, and all these, like, really random, but nice acts of kindness were happening. I definitely appreciate it. I was very grateful. (#51, Nurse)
	I mean, the hospital, you know, they've gone out of their way, you know, to do what they can for night shift workers; they do free food. Like, we never have to pay because a lot of the day shift got free meals out in public, and I would say that, you know, for the most part, that response has been really nice. (#62, Nurse)
	I appreciate it. I think it's pretty cool. I don't think we go into medicine for recognition. But I think everyone appreciates being recognized and appreciated for what you do when you sacrifice a lot of your personal time and your family time and things for your job. I think it's just it is really nice to feel appreciated. That's kind of the best thing about it, yeah, it's just that it's been nice. I mean, again, sometimes almost to the point of being a little bit embarrassing. But I get it. Yeah, all the cities where people are banging on pots and pans every night. I mean, that was just so cool. (#83, Doctor)
Codes	**Condoning Condemners**
Empathizing with Stigmatizers	There's a degree of truth around, at least for me, when I was working, my partner was not working. He was just staying at home and leaving the house to walk the dog. So he had like zero chance of getting coronavirus, and his cousin was working from home, so the two of them had just no possible way to get coronavirus, and I was the one that was going to work and not just going to work but like going to work in a place where I knew people had coronavirus so if anybody was going to get sick, it was going to be me and I was going to be the one that was going to bring it home to them. So there is like there is a tiny degree of reality to the fact that, like, most healthcare workers don't have coronavirus and are not going to get coronavirus but especially at the beginning when the PPE thing was all messed up, it was like we are the ones that would get sick of anybody. (#47, Nurse)
	I like very openly labeled, like, with friends and family, and, you know, even people you barely come in contact with. I've been very open with the fact that I deal I work with COVID patients come over to my house at your own risk, and if you elect not to hang out with me, that's fine. Our friendship will live through this, I promise. I think a lot of it is because I'm a healthcare worker, and I've had a lot of people ask me before, like, we'll make plans to go eat out or whatever and one of the first things they ask is, well, have you come in contact with any COVID patients? I think they're just curious to see how bad it really is in our region, not because they're scared to hang out with me, but they think I might have some inside scoop about something but yeah, there's definitely been a few people who, like, have canceled plans or don't come over or whatever, just because we work in health care. I'm not offended. (#51, Nurse)
	People are showing us a lot of "you're a hero" and a lot of respect, but then obviously, on the other side, they don't want to be near you, which, I get it, I understand. Obviously, you can show your respect from a distance, right? But also, like, I don't want people to fear that I am running around with the virus and getting other people sick, and healthcare workers would never, obviously, do it purposely, so we also have to like go on living our lives and take care of our family and have a life outside of the hospital, you know? I definitely feel like there is two sides to it, and there's people on both sides that are going to either love you or hate you, so all you can really do is just, you know, do your best to not only protect yourself but protect other people, you know, the best way that you can without feeling like you're being put down or looked down upon, I guess. (#76, Nurse)

TABLE 4
(Continued)

Codes	Condoning Condemners
Blaming Other Factors	It's a really hard time to come into nursing. You're dealing with a lot of ... different things that you're having to navigate and learn about and stuff, but I'm proud of it. And I feel like other people may not see that or feel that way, which is totally fine. I can understand both sides. I really can. It is a scary thing, I think, to people, and they feel like there's something out there that they can't see or feel or control, but I feel like I just try to remind myself whether or not people feel adversely toward you because you're a healthcare worker, you're still going every day and doing what you need to be doing and taking care of people, and that's something to be proud of. (#13, Nurse)
	I don't let it affect me, to be honest. I understand there's a lot of misinformation out there. There's a lot of fear and the media is partly to blame for that. The media's just really polar. (#46, Physician)
	I doubt that that logical progression was happening in their heads ... I don't think the people that are going to look at healthcare providers in that way [that] nothing has changed for them. They don't understand how N95 masks work and, like, that's just an irrational fear to have. I guess my point was there was some rationality to that fear at the beginning when we didn't know what was going on. (#47, Nurse)
	It depends on who it is because my grandparents [are at greater risk], totally understand, right? My sister? I mean, like I said before, I think it's a lack of knowledge and the unknown. I don't take it personally. (#48, Nurse)
	And then, you know, other ones of my friends haven't been around, and they're upset because they're like, well, why do you hang around your friends from work, but you won't come to dinner with us? And I'm like, well, I'm around these people and around COVID like, that's a certain amount of risk that I'm okay to take. I don't feel comfortable being around you because you're not around that same risk. And I would not want to give you something. (#62, Nurse)

Codes	Discounting and Condemning Supporters
Insufficient	But I think it was nice that the community and everybody reached out to do that, but, to be very honest, the people that were in it and in the heat of it—it didn't mean a whole lot. They would have much rather preferred a body versus a sign if that makes sense. Yeah, it was nice. It was that appreciative. I'm not trying to downplay that, but I think they put their efforts in the wrong direction. (#57, Nursing Home Administrator)
	If [heroes talk] came from the public, [it was] fine. I think we'd get the encouragement from within the hospital. I don't want to say hypocritical. That's a very strong word. I'll have to say, I will give my hospital a ton of credit. We did not furlough people. We were able to maintain our staffing. Hypocritical is the only word coming to mind. It's just a little too strong, because I don't think of it totally that way, but just felt a little empty. (#74, Nurse)
	The healthcare system, for nurses, in particular, and I can't speak for anybody else because I've been there, but shortages are evidence of that. Or compensation, you could throw that in there, but the general feeling that nurses are like, where everything gets put on us to implement, that weight and pressure. (#85, Nurse)
Did Not Motivate	There were some things that like the universities, I'm sure you've seen them put up like "heroes work here" signs, which was like nice to be acknowledged, but we dealt with diseases and illnesses comparable to COVID before this and weren't recognized. So it's kind of, I don't know, interesting that it, they just choose now to recognize it and then they do like the fate of the fly over, which I thought was kind of ridiculous because of how much money it costs to do that. They could put that money back into the healthcare system instead of flying jets over the hospital. (#6, Nurse)
	I don't generally like identifying with what I feel is sometimes chest-beating, ego-boosting, "I'm a hero in a pandemic." That kind of language doesn't always sit well with me. I don't think there's any greater pride in going to work in the middle of a pandemic versus going to work every other day because, before the pandemic, I saw plenty of terrible, sad things and helped plenty of what I did at work was the same before the pandemic and after the pandemic. (#47, Nurse)
	For example, my hospital put out an ad in [local news channel]. You know, like a thank you video ad. That's great and all, but I would rather [receive support] than putting on a public display of, "Oh, you guys are so great." (#66, Nurse)
	Some people call me a hero or something, but what I want from the community is for them to just be working together for what's for the best for everyone. Don't be stubborn; wear a mask. I think what I do, I should be doing for God's work … not to be called a hero." It's good, it's fine. It's just a responsibility when people need your help. (#87, Nurse)
Annoyance and Anger	It kind of gets under my skin when I go anywhere and most of my family will be like, "You're a hero, thank you for everything you do." And like it's just my job, I'm not doing any more than I have been doing for five years but I'm just like, "Just do your part and help out." (#6, Nurse)

TABLE 4
(Continued)

Codes	Discounting and Condemning Supporters
	In my head, I usually call a lot of people morons. You can hear (my wife) laughing in the background. Everybody has their own opinion, and they're not going to make me react to them. I'm respectful to them and say, "Okay, thank you for your concerns. I appreciate it. I make sure I take the measures to ensure that you are safe as well as myself and my family are safe, and so I'm gonna finish my shopping. Then I'll be out of the store." (#27, Physician Assistant)
	Well, I actually kind of get mad with that because, at 9:00, people would always like clap in their houses, and at the beginning, everyone was staying home and everything but then people were going out and being irresponsible, and then at nine at night they would clap, and if you did everything right, you wouldn't have to clap for anyone. (#36, Doctor)
	Not well, I get angry and, on many occasions, have told someone off in public. (#37, Nurse Manager)
	I got really sick of the hero—oh, my God—the hero thing was making me insane. Like, even my dad was like, "Oh, you're my hero." And I was like, "No, no, everyone else needs to go be everyone else's hero. Like you got to stay home and wash your hands and wear your mask." (#86, Nurse)

Codes	Discounting Condemners
Feeling Ostracized by Friends/ Family	I feel like people are afraid to be around me because I've been exposed. I have a friend who wouldn't walk with me because I potentially could have it because I've been around it all. Yeah, so, more isolation. Yeah, you can tell people are uncomfortable. They don't exactly always say anything, but like I wouldn't get invited to go on mom walks anymore, and you can just tell they … they look uncomfortable when I'm too close to them, and then all the time, I get asked, "Have you taken care of somebody yet? Have you taken care of somebody that's been positive?" And if … I were to take care of a positive, my mother-in-law said we couldn't come to dinner. Yeah, I mean, I feel like it's a little excessive to not invite me to things just because I am out there 'cause I'm more protected than anybody else because we have all of the extra stuff, like the masks and the goggles and the face shields and the gowns. Always I'm like, "You're way more likely to get it from somebody at the grocery store." Yeah, well, my mother-in-law, she just is terrified about it … She refused to babysit my child for like three weeks, which was really hard 'cause I need babysitting, and then she just distanced herself from us, but it didn't hurt my feelings that much 'cause she's my mother-in-law. (#3, Nurse)
	I do have a couple of kids that my daughter hangs out with in the neighborhood, and I noticed they don't really, like, come to the door and knock on the door anymore. Even now that people are getting out more, I have noticed that. And I've never heard them say anything specific, but I do kind of think in the back of my mind, are they concerned, since I do work in the hospital, that they obviously don't want their kids playing with my kid or things like that. (#76, Nurse)
	Yes, at the beginning of the pandemic … Many people limited their interactions with me, did not want to date me, did not want to get together, etc. I understood these reasons, but it still stings when people were willing to interact with others because they didn't work in healthcare. The double standard was always present … I just did not like the double standard of people choosing not to see me but then still going out to parties, meeting with others, not understanding that just because they didn't work in a hospital doesn't mean they couldn't spread the virus either. (#91, Nurse)
Feeling Ostracized by Strangers	Then, when they asked us not to wear our scrubs in public if we can help it because, like, people in public get freaked out by seeing healthcare workers ... I don't know, it's kind of frustrating because, I mean, I need to run and go to the grocery store before I go home, and if I had to take care of COVID patients, like, who cares? But yeah, people do say things to you in public if you're wearing scrubs, and they don't appreciate it. (#2, Nurse)
	I've seen people give me faces when I have my work shirt and my badge and my mask on when I go to the store to get supplies or whatever. I feel I've seen people look at you like they want to go away from you because they're worried that they're going to get a disease from me. (#35, Housekeeping Supervisor)
	If I stopped by the gas station on my way to work, are people wondering, and they shouldn't be, but it's just like, I feel like I'm walking around with a big, you know, road cone on my head, like, "Stay Away!" (#48, Nurse)
Avoidance & Concealing	I avoided things like shopping or interactions where people would be around. I would not go out in my scrubs. It is also very hard in a small town when everybody knows you are a healthcare provider. (#19, Nursing Home Administrator)
	I feel like for a little bit, we were getting a lot of praise and all this stuff, and now I feel like you have the other side of people that feel like everything's kind of a hoax or everything's kind of fake, and so I feel like they kind of look at you like if you say anything, then you're on one side or the other I guess, if that makes any sense so I try not to talk about it too much, honestly, I just try to stay in my own little bubble and have my opinions in the back of my mind. (#76, Nurse)
	And now, I don't want to be identified as a nurse in public. Often, I'd rather people not know because people might have a reaction like, "Oh, gross. Oh, you're dirty," or whatever. (#84, Nurse)

social distancing, it was understandable how many individuals became skittish around healthcare workers. Even within healthcare facilities, such protocols seemed to articulate a sense of taint among the more highly exposed versus those less exposed. For example, we heard from many workers like a nursing home administrator (#9) who labeled the quarantine unit versus the non-quarantined unit in how they divided his skilled nursing facility: "We had … our quarantine unit … a 'dirty half' of the building and a 'clean half' of the building … [marked] literally, quite literally, with red tape … we call it the 'Mason–Dixon Line'" (full quote in Table 2).

Informedness. The second criterion we observed was the participants' requirement that social evaluations and those making them be broadly informed. When workers thought evaluators were informed, they seemed happy to accept the evaluations. Admin #96 said, "I really liked it … It's hard, especially during COVID. People who understand it are like, 'Wow, that's amazing what you do.'" To be informed, evaluators did not have to be medical professionals, but the more informed they appeared, the more participants seemed to internalize the evaluations. However, while *informed* (like all of our theoretical codes) should not be considered binary, according to our participants, the majority of positive and negative social evaluations that emerged during the pandemic were by outsiders who did not sufficiently understand healthcare work and, according to our participants, often made ignorant and illogical evaluations that did not cohere with their own self-evaluations. With both positive and negative social evaluations, many outsiders believed healthcare workers were engaged in novel, pandemic-related work. In response, we often heard our participants complain that they were engaged in the *same work as always* and that they *signed up for this*. When a nurse's (#6) sister, who also worked in healthcare, had a baby, her in-laws told her, "They wouldn't come see the baby because the baby might give them COVID … It's just kind of hurtful things like that. Like we're not, we don't carry the plague" (full quote in Table 3). In coding our memos and interviews and member checking, we identified this cluster of informed-related criteria as the most common reason our participants rejected evaluations. One nurse (#48) told us why she would "never call myself a hero," explaining, "It was a job before a pandemic; it's been the same job. We bring the same value systems with us to work every day since even before" (full quote in Table 3). Hence, we discovered an important discrepancy between the workers' perception (i.e., "this is how it always has been") and outsiders' perception (i.e., "the job is different now"). In fact, the workers' sentiment was strong enough that when some of our participants perceived other healthcare workers as accepting the hero moniker, they challenged whether or not they were a "true" healthcare worker:

> I think if you ask any true healthcare worker, they will always say they don't see themselves as a hero because that's what we're trained to do. If that was your calling, if you're a true nurse, it's what you wanted to do. (#57, Nursing Home Administrator)

We found that many of our participants intuitively, though not explicitly, commented on the differences between core stigma and event stigma (Hudson, 2008), as well as positively valenced job characteristics brought to the fore by the social evaluation event of the pandemic. In both cases, the pandemic had not changed the core attributes of their job. Thus, outsiders calling attention to or conflating core-based versus event-based characteristics disqualified them as legitimate evaluators. In participants' minds, for better or worse, they have always been around patients with transmissible diseases, and these duties always had the potential to be seen as altruistic and important. Our participants, in other words, were very aware of the core elements of their work. They were sensitive to breakdowns in the logic of their work being celebrated and idealized for characteristics and duties they had long performed. When workers were stigmatized, they were often frustrated by the ignorance of outsiders who did not understand the nuances or even major features of their unique positions and responsibilities (Vough, Cardador, Bednar, Dane, & Pratt, 2013). Even though our subjects used personal protective equipment (PPE) and other safety measures at work—which the media described in detail—outsiders remained ignorant and discriminant, according to our interviewees. As part of this focus on core characteristics of work that were unchanged by the pandemic, it was very important to many of our participants that they were paid for their work. When outsiders called them heroes, many of our participants countered that one who gets paid for doing something is not a hero. As one nurse (#16) lamented, "I think it's so stupid 'cause if I wasn't getting paid, I wouldn't come to work. That doesn't make me a hero. I go to work because it's my job."

Meanwhile, other participants had job responsibilities that took them nowhere near patients with COVID-19, situations we coded in vivo as *I'm not the hero*. These workers felt "lumped in" with both hero treatment and stigmatization for equally uninformed

and illogical reasons. Healthcare workers thus saw clearly the discrepancy between how they were being evaluated as heroic figures battling COVID-19, for example, and their specific roles and duties. Many of them had not been exposed to patients with COVID-19 or were lumped in erroneously with those who had. The incongruence of their self-evaluations and the idealized and uninformed evaluations of outsiders bothered them and made them feel unseen, misunderstood, and even guilty. A nurse (#4) working in a large children's hospital who had not admitted any patients with COVID-19 reported that the hero treatment made her and her coworkers feel guilty and uncomfortable with being grouped together with what she saw only on the news:

> As a whole, it felt really silly to go to work and have nothing to do for the middle hours of my night shift and just sit and literally watch *Seinfeld* for hours and wait for something to happen, and then leave work and see those big banners all the way down the university drive. "Heroes work here. Thank you so much!" You're just like … Our hospital has not dealt with any of these horrific COVID cases that we keep hearing about, so to hear people say we're heroes, it makes a lot of people feel guilty …. So much stuff being brought in for us to eat while we sit around with our lower patient load.

Conversely, other healthcare workers did care for COVID-19 patients but, because they were not seen as central actors, were *excluded* and discounted by outsiders. These groups included workers in hospice and home health, nursing homes, and other settings outside of traditional hospitals. A hospice nurse (#33) expressed her frustration, "I'm a nurse too. Where's my free water bottle and lunch? People are like, 'Do you ever wish you were a real nurse and worked in the ICU?' and it's like, 'Oh, ouch.'" Many of our participants felt that being called heroes or stigmatizing evaluations came from people who were inadequately informed, and thus workers felt they could largely ignore them.

Authenticity. The third and final criterion concerned whether an evaluation was made by a source with authentic motives. Our participants believed that outsiders now had a convenient but often *disingenuous* reason to publicly thank healthcare workers for a job these outsiders knew healthcare workers had long been doing. In other words, participants like Nurse #56 felt that much of the "healthcare heroes" campaign had "turned into a marketing thing" and contended that the evaluators were motivated to recognize the sacrifices of healthcare workers more "to maintain a pristine PR image" than out of genuine regard. Physician #77 reduced much of the attention to "signaling … with all sorts of like political social movements" and added that while it may be "something that they believe … I don't feel like the thoughts necessarily represent actions." Nurse #4 described the efforts as "a cheap vote by a lot of businesses and opportunists" and complained the attention "make[s] us look pitiful and I don't like it."

At first, we were surprised that our participants saw the hero treatment as disingenuous, but we learned that many perceived a sense that such labels and attention engendered manipulative, even sinister, expectations of self-sacrifice. As a neonatal intensive care unit nurse (#16) told us that being called a hero "felt hollow, just a way to appease the public while giving an excuse to overuse and abuse healthcare workers." We label this sense of an excuse or justification for negative treatment as *hero-washing*, which was perceived by our participants as coming either from their own organizations or from the public at large. We define hero-washing as a practice of collective idealization that occurs around occupational members who are not adequately supported. Nurse #56 made an interesting observation of collective focus with regard to calling healthcare workers heroes, telling us:

> So, the "healthcare heroes" movement, I feel like, again, is just kind of a marketing thing to be used to remind people to thank your local nurse or thank your local doctor dealing with this pandemic while other people are really *focusing* on other topics that are going (emphasis added).

We see this quote as an example of how hero-washing allows the collective to justify how it cannot or will not give greater levels of focus to complicated and difficult situations. A physician (#36) in Chile wished her employer would offer more support and safer conditions instead:

> I don't know, the word "heroes," I think you say doctors are heroes … like that gives you reason for not paying well and the bad hours and all the sacrifice, all because they're heroes. Maybe we could have better conditions and just not the heroes and do our job, you know? If they cared about you, they would give you better conditions.

Many participants saw the hero treatment not only as a justification for a lack of focus or resources but for more sinister intentions to extort or otherwise harm them. Nurse #47 summarized this sentiment, noting (full quote in Table 3), "If you call someone a hero, then all of a sudden, it's okay to mistreat them or expect them to make major sacrifices." One nurse

(#16) passionately rejected what she saw as manipulative hero banners from her employer and reported that she wanted to "rip them all down," adding, "It really pisses me off. I hate it." As she saw things, the attitude of organizations was: "We know that we're making you do a lot of crappy stuff … So, we're going to say all these nice things to you." But, she concluded, it was "all a means to an end." We were surprised by how often we heard such affective responses to positive evaluations. Nurse #84 also suspected that strings were attached:

> It also felt like if we accepted all of this, then we kind of owed it back, like it wasn't just that they're giving this to us to show kindness and thankfulness. They're giving it to us because they're almost trying to buy us into doing this and making it okay to put us in a really dangerous situation … and it felt like by them giving us these gifts and giving us free food and whatever else that companies were doing that like, "Okay, well, we're going to give you this and then in return, you're going to go into the front lines of this pandemic, and you're going to take care of us regardless if it puts you at risk or not." When all of this started, and everyone was like, "Oh, you're a healthcare hero," that felt really, really wrong to me. Like, why should we be? Why should we be held to that? Then it makes people feel like we should be doing things that maybe we didn't want to do in the first place because people are calling us heroes.

Respiratory therapist #45 compared healthcare hero-washing to how people treat the military and highlighted the feeling that their services were only desired at safe distances:

> That's kind of irritating a little bit. I guess you see that with military-type stuff as well … like they want us there, they're happy with us doing our work, but they don't want to interact with us. I think it's just, "Stay in the hospitals and keep everyone safe but please don't leave. Please don't leave the hospital or go anywhere near us." That's annoying.

We detail how some participants objected to the hero treatment because they *signed up for this* (covered in the previous section on being *informed*). We also heard the complaint, paradoxically, that healthcare workers actually *did not sign up for this* in that they did not sign up to be a proverbial submissive and sacrificial lamb during a dangerous pandemic, especially because many felt *poorly treated*. Nurse #86 discussed this frustration (full quote in Table 3):

> We didn't come in here to, like, sacrifice ourselves to, like, for the greater good, you know? We're not like soldiers in a battle. We're, like, paid professionals, which, I think, may be in the hero talk. People could say a lot of these, you know, soldiers, people who have been to war, people have done good to, like, protect their cohorts, and in war, those people get called heroes, and I'm not one of those people. That's not me. Don't do that.

Nurse #62 similarly articulated this sense of not signing up for the implied sacrifice that hero-washing seemed to expect:

> The part that I've warred with and had a hard time with was the "healthcare heroes," because "hero" to me just says they have to be this person that sacrifices themselves to help others, and I don't think that that is necessarily what you should do as a nurse. Especially because when you hear "healthcare heroes" … "They have to deal with it because that's what they signed up for." And I think that I've had a hard time with the heroes message because … it's like they don't have to give us adequate PPE. They don't have to give us adequate breaks or anything because if you label somebody as a hero, "Well, you know what? They're okay with sacrificing themselves to help others," and I think that that's been a hard line to hear because … I didn't sign up for a pandemic, and I didn't sign up to maybe sacrifice myself to help others. I mean, of course, health care is a certain amount of sacrifice, but we still need to be adequately cared for.

Nevertheless, when participants perceived organizations as authentic, they noted and seemed to internalize such positive affirmations. In an anonymous member check, one participant said a lasting impact of the healthcare heroes campaign was that "providers showing genuine gratitude has gone a long way." Physician assistant #81 commented similarly on the public displays, concluding, "I think it's genuine. I think it's the community genuinely wanting to show appreciation towards healthcare workers that are treating COVID patients."

Finally, it is important to note that the social evaluation event of the pandemic brought a number of varying social evaluations toward healthcare workers. Thus, healthcare workers did not go through the *evaluating the evaluator* process just once but many times and often within a short period of time. Thus, our interviewees occasionally spoke of single evaluations, but other times seemed to consider them together, which meant scrutiny of whether the evaluator was proximal, informed, and authentic based on the collection of evaluations. Collective evaluations being considered together allowed for inconsistencies to be more easily perceived. For example, Nurse #62 considered the collection of contradicting evaluations that we cover in this manuscript:

> It's definitely hard because you're hearing people [say], "Oh, look at these healthcare heroes," and then you get treated like dirt at the gas station. It's so odd to me that, you know, that you can have that, and I've definitely heard people like, "Oh, thank you so much for all you do," … and I'll see them like on Facebook or something like, "We need to open up, it doesn't matter." And I'm thinking, "Wait, hold on a second. You thanked me *like two minutes ago*, and then you're calling me a liar online, saying that healthcare people are blowing this out of proportion. *Which way is it?*" I don't know; it's frustrating. I mean, for some people, you know, like it's super nice of them to say, but it's also really hard to see the *opposite reaction* where it's like, "*Man, you're calling me a liar online, and then thanking me for all that I do* and I don't understand how you can be okay with that *hypocrisy*" … I have a hard time with it … and it's just bizarre to me that they get so aggressive and then thank us so hard. (Italics added for emphasis)

In the end, the social evaluation event of the pandemic generated a multitude of mixed social evaluations that healthcare workers seldom found acceptable. Next, we outline the last stage of our process model by illustrating how healthcare workers internalized and acted upon the "evaluating the evaluator" process.

Internalization Outcomes

In this final section of the findings, we highlight interesting patterns out of the spectrum of outcomes reported according to how our participants evaluated their evaluators. Whereas the previous section covered the evaluation process, here we summarize the outcomes our participants reported for how they ultimately responded—generally inwardly, though occasionally outwardly too. The quotes and vignettes above have already provided numerous examples of these outcomes. Still, we wanted to formalize this part of the model with additional data because it provides important nuance and theorizing for how stigmatized workers respond to supporters and condemners. See Table 4 for additional quotes.

Supporting supporters. When participants found positive evaluators to be proximal, informed, and authentic, they supported their supporters in ways that follow previous findings of stigmatized workers (e.g., Heinsler et al., 1990). Specifically, they reported *pride* and *gratitude* in being lionized as emergent heroes. Nurse #13 talked about how healthcare workers being celebrated as heroes influenced her own self-evaluation, explaining, "I just was hit differently by it because I was like, 'Oh, this actually, this is a big deal to people,' and I didn't realize that, and it's definitely changed the way that I've felt about [being a nurse]" (full quote in Table 4). A physician assistant (#23) in New York City warmly described her experience walking outside after work where she would encounter supporters: "People, random strangers, walking home from the subways, they would be like, 'Thank you for your work' if I was wearing scrubs, people are so nice and appreciative and a lot of clapping." Nurse #21 offered an example when she wore scrubs to a local fast-food restaurant and was treated to a free meal by another customer in line, and how this stood in contrast to other circumstances of the pandemic:

> I cried when that guy paid for our food … that was amazing that he did that, and it just showed me that … even though there's like a lot of not great feelings going around during this time, there's, like, a lot of people that are really appreciative.

Condoning condemners. The literature has generally found that stigmatized workers will condemn their condemners and support their supporters (Ashforth & Kreiner, 1999). However, we discovered nuanced examples that break this mold—instances where workers condoned their condemners by *empathizing with stigmatizers* or *blaming other factors.* Admin #35 said people in his life were avoiding him but that he did not mind, adding, "I understand why people are afraid of getting it because so many people have gotten really sick and so many people have passed away." Nurse #13 articulated her recognition of how much uncertainty existed during the pandemic (full quote in Table 4), which was a factor to blame: "I can understand both sides. I really can. It is a scary thing, I think, to people, and they feel like there's something out there that they can't see or feel or control." Physician #83 similarly recognized the uncertainty and related what she and her husband did, since both worked in the emergency room:

> I'm not surprised that people would be nervous, especially when we still didn't know a lot about what was happening and how bad it was going to get and who it was affecting. I mean, honestly, I live with an emergency medicine doctor, and I felt afraid of him touching me before he changed when he got home, and we made a rule … you had to shower before you touch the baby or touch each other.

A physician (#43) in Chile did not blame the stigmatizers but local civic leaders and social media for spreading misinformation and failing to communicate correct information:

> You feel sad obviously because you're giving everything in the hospital and you're exposing also your family, and you receive bad words or [attacks]. It's not

> good for anybody, but I repeat, the people are not responsible for that. I think they don't receive the information that they need. Social media also plays a big role in this because they have a lot of misinformation, and they respond. I think the problem is communication.

Nurse #51 articulated a nuanced belief that, given the risks of the virus, if outsiders are *informed*, each person should be able to make their own choices in response to the risks:

> I don't think anyone should put themselves at risk or outside their comfort zone, just to help me out. Like, it's fine. I wasn't that worried about it. If I were a more cautious individual, I maybe would make a similar decision if I wasn't in healthcare, and wasn't like a problem-exposed person to begin with … I think everyone should, especially right now, be practicing within their own comfort zone, and I think everyone has the right to decide what that looks like … so I just try my best to have it not be an issue if they feel they don't want to hang out with me. It's whatever. That's totally within your right. You're telling me you're educated, and you're satisfying your risk, and I think that's fine.

Other healthcare workers encouraged others to fear and avoid them and would take the initiative to socially distance themselves even when others were not concerned about the risks. Physician (#26) commented on how he and his wife stayed in the open air outside at a family dinner because of his work with COVID-19 patients: "So we literally waited 'til dinner was over outside just because we feel like that was the right thing to do, and, outside, my wife's in tears because she can't go in."

Discounting and condemning supporters. These next two outcomes discuss what happened when participants believed evaluators were not proximal, informed, or authentic and thus did not agree with their evaluators. While the first two outcomes sections included examples of healthcare workers more or less accepting their positive and negative social evaluations, more commonly, our participants bristled when asked what the "heroes" campaign meant to them or whether it was fair for people to be nervous about being around them. Many found the heroes' treatment as simply *insufficient*, given all the negative evaluations and circumstances surrounding them (e.g., increased workload, more dangerous conditions, etc.). A COVID-testing site manager (#30, Admin) for a large hospital summarized many of our codes in explaining why workers discounted messages around being called heroes:

> This might sound bad, but like I personally wasn't impressed with [his organization's] response to COVID-19 and again, when you can say, like, "Well, our people are heroes so let's pat them on the back, give them the internal satisfaction of saying good job. Thanks for putting your life at risk." It can only go so far, right? At the end of the day, you've got to remember that these people are humans and people as well. They have families that are scared as well and just because they signed up for it doesn't necessarily mean that they don't need to be compensated. So I think while it's probably nice that we've given them the attention, I'm sure a lot of them would much rather take in hazard [pay] and different forms of compensation than just a PR stunt saying our people are heroes and they've always been heroes, right? They've always been saving people's lives, always been running into scenes when people run out, so I'm sure that they like the attention, I'm sure it's nice trying to give it back to them, but if you would ask frontline people, I'm sure that they would choose a different way to be compensated.

Discussing the widespread campaigns to celebrate healthcare workers as heroes, Admin #57 described the gulf between these distant sources and the realities "on the ground" and how healthcare workers discounted such sources accordingly (full quote in Table 4):

> The people that were in it and in the heat of it—it didn't mean a whole lot. They would have much rather preferred a body [for staffing] versus a [heroes] sign … they put their efforts in the wrong direction.

Many complained of inadequate staffing, insufficient PPE, and persistent low pay and other benefits. A housekeeping supervisor (#35) complained:

> I'm grateful that people are thankful for what we're doing, but what we need most of all is to be able to get all the PPE we need to make their work environments safe. We need that more than nice words, and we feel like the healthcare workers should have maybe gotten a little bit of a bump in pay, but we haven't.

Participants often reported that the outcome of their internalizing was resistance and a general sense that the hero treatment *did not motivate* them and, conversely, that stigma was unfounded. Left with a sense of indifference from unmet criteria, workers instead became resilient to future external evaluations. Nurse (#56) nicely summarized what we heard from many other participants about being called a hero from such distant sources for disingenuous or ulterior motives discussed in *evaluating the evaluator*:

> I'd probably say nine out of ten people would probably roll their eyes at it, knowing that they are just doing it for marketing, just to try to facilitate some feeling of loyalty in their employees. You know, it kind of loses its meaning, kind of loses its luster, and

you just get really sick of hearing it, to be honest. (Full quote in Table 3)

In the absence of meaningful impact, healthcare workers were left to confirm their suspicions that most of the evaluators calling them heroes did not actually care or were too far removed to understand or have an informed opinion. Many landed on *annoyance and anger* for their evaluators who too often contradicted themselves. A Chilean physician (#36) summarized (full quote in Table 3) that "if [supporters] cared about you, they would give you better conditions." Nurse #84 described her frustration and anger toward her father and others whose views contradicted positive views that especially had come earlier in the pandemic when narratives were stronger about healthcare workers being celebrated and supported more than the time immediately preceding our interview:

I'm angry that my dad, his political views do not align with mine, and it was really hard to talk to him because he was one of those people who was like, "Oh, this is all a hoax, and this is fake news, and I don't need to wear a mask." And even now, he's still like that, even post-stroke. He just can't say it as easily … but yeah, you just feel really angry and hurt that one month everyone's telling you, "Thank you so much," and "You've done so much," and "You're this hero," and then it's like they go back on their word.

In response to *hero-washing* and other phenomena previously discussed, our participants evaluated their evaluators and became annoyed and frustrated, like these two nurses:

I had so much frustration. I had even said to my husband, like, "I think that calling us heroes it's just really annoying because it's like telling us that we should want to run into the burning building without a fire hose, to try to see if we can extinguish flames with a pillowcase like we're not adequately armed. We can't do anything." (#47, Nurse)

Then when they asked us not to wear our scrubs in public if we can help it, because, like, people in public get freaked out by seeing healthcare workers … it's kind of frustrating because, I mean, I need to run and go to the grocery store before I go home, and if I had to take care of COVID patients, like, who cares? (#2, Nurse; Full quote in Table 4)

Although stigma seemed to drive most concealing, Nurse #86, whose quote introduces this manuscript, reported concealing because she disliked both stigma *and* the hero treatment:

I've actively changed my own behaviors. I would usually stop at the grocery store before or after work … and I just don't go anywhere in my scrubs because I'm just not trying to attract attention to myself … I don't go out in scrubs in public anymore because there's definitely been backlash, thinking we're infected or germ-infested or something … I really don't even want the "thank you" for being a hero thing, either. Like, I don't want that as much as I don't want them to be like, "I can't believe you're wearing your scrubs out in public." Like, I just don't want either one 'cause I think both suck.

Discounting condemners. Unlike previous dirty work literature, where stigmatized workers often create insular subcultures to avoid outsiders fully, our participants seemed to generally discount those who stigmatized them, as opposed to wholesale condemnation. Perhaps these changes were due to the belief that the pandemic would one day end or because healthcare workers enjoy greater institutional and occupational legitimacy. Regardless of the reasons, whether the evaluating the evaluator criteria were fully met or not, stigma left many healthcare workers *feeling ostracized*, which often led to *concealing efforts.* Assisted living administrator #29 complained of loneliness from feeling *ostracized by friends*, recalling, "Someone would ask me to do something, and I was just like, 'Just so you know, [I work in a healthcare facility],' and they would say, 'Okay, maybe next time,' and then they never reached out again." In these cases, friends of presumably low social distance chose to avoid them, which resonated more. While less socially proximal, feeling ostracized by strangers was also not an enjoyable experience. Workers often found these stranger evaluations unfounded, like Nurse #48 (full quote in Table 4), who sensed the stigmatizing signals, "Are people wondering, and they shouldn't be, but it's just like, I feel like I'm walking around with a big, you know, road cone on my head, like, 'Stay Away!'"

Many participants reported that the potential and actual negative evaluations received from outsiders impacted them enough that they practiced *avoidance and concealing* tactics by changing out of scrubs before going to grocery stores or gas stations, like Nurse #85, who said with a laugh, "I don't go out in public wearing my scrubs, my badge, or anything. You wouldn't know I'm a nurse, I don't flash that." In a short member-checking follow-up survey in December 2021 (n = 20), we wanted to know if concealing behaviors lasted after our interviews. Avoidance and concealing efforts were not only a function of lower-status jobs that may have felt invisible (Hennekam et al., 2020). A physician (#18) commented, "I would say I kept my profession rather discreet. I wouldn't mention as quickly what I did or where I worked."

Another complained, "I couldn't even do my grocery shopping after work, even if my scrubs were clean" (anonymous). Others would conceal their work identities: "I would try to always change before going somewhere to avoid making other people uncomfortable" (anonymous). Another said, "I would make sure I wasn't wearing my work badge when I went places" (anonymous). These concealing behaviors were prevalent for long periods of time and for a wide variety of healthcare workers. That healthcare workers, even at the height of the "heroes" campaign, would conceal their identity was surprising to us and helped us realize the seriousness and severity of the stigma they were reporting.

DISCUSSION

Our findings document a revelatory case of workers responding to mixed, varied, and contradicting evaluations following a disruption of the prevailing social evaluations of their occupation. The severity and urgency of the COVID-19 pandemic propelled healthcare workers to the forefront of public consciousness and, in so doing, occasioned an instance of intense public scrutiny that resulted in positively and negatively valenced evaluations. The extremity of our research context allowed us to theorize about important mechanisms influencing the internalization of mixed evaluations and, further, to abductively theorize about how such evaluations emerge. We describe our findings in a dynamic model incorporating individual and cumulative evaluations of both positive and negative valence. Overall, our work has important implications for the scholarship of stigma and dirty work and carries additional implications for the stigma identity management and social evaluations literatures more broadly.

Dirty Work, Stigma, and Social Evaluations

Illuminating our dirty heroes. A foundational supposition of the stigma literature broadly is the need to verify one's social identity (Ashforth & Kreiner, 1999; Clair et al., 2005; Ragins, 2008). Verification of one's social identity is thought to enhance self-esteem (Hogg & Abrams, 1990; Swann, 1987), while disruptions to self-verification are thought to provoke considerable stress (Pachankis, 2007; Smart & Wegner, 2000). In our context, we document the "disruption" of healthcare workers' social identities in not just one sense (as has been previously theorized; see the literature on event stigma, e.g., Hudson, 2008), but in multiple senses (e.g., "you're a hero, but don't get near me"). In this respect, we contribute to theory by spotlighting this undertheorized, yet relatively common, phenomenon within dirty work. Specifically, we illuminate the experience of workers subject to an episodic, yet extreme, case of internal–external identity dissonance and reveal, contrary to the speculations of prior literature (e.g., Ashforth, 2020), how such antagonistic evaluations did not simply cancel out or invalidate the other (e.g., a positive evaluation counteracting a negative). Rather, our findings illustrate how both positive and negative appraisals of one's "social self" are considered independently but together intensify the magnitude of the disruption and thus the experience. In this respect, we contribute to the dirty work and stigma management literatures by exposing the lived experience of "dirty heroes"—a term we use to describe an occupation's broad subjugation to intense, seemingly contradictory, social evaluations. In this sense, our findings speak to the relational, subjective, and even capricious character of stigma (for a review of the relational aspect of stigma, see Aranda, Helms, Patterson, Roulet, & Hudson, 2023). In our study, the public simultaneously (and paradoxically) occupies two of Goffman's (1963) core audiences: *the normal*—in other words, the stigmatizers—and *the wise*—in other words, the supporters. The term "dirty heroes" characterizes those occupations simultaneously stigmatized and celebrated along one or more dimensions of work. Occupations we see as particularly susceptible to treatment as "dirty heroes" include those stigmatized along physical or social dimensions of work, yet lauded, legitimized, and lionized along moral dimensions such as firefighters, police officers, soldiers, healthcare workers, and mental health professionals.

Hero-washing. Interestingly, many of our participants seemed to pick up on an implicit connection between being collectively *idealized* (DiBenigno, 2022) while also *insufficiently supported*—a phenomenon we describe as "hero-washing." We document this phenomenon in two important respects. First, as we demonstrate, many outsiders thanked healthcare workers for their morally laudable service but outwardly demonstrated that they were not welcome at close physical distances. We include examples from family members, friends, organizational policies, and strangers in public. Second, many of our participants complained that vital resources (e.g., adequate staffing, PPE, and compensation) were often lacking. In general, many of our participants seemed to sense that they were being idealized at a distance in a way that seemed like a defense compensation for outsiders not having to "get their hands dirty," so to speak, by

dealing with the actual problems of the pandemic. We see this as a transferable phenomenon where collective idealization threatens to stand in the place of the more challenging task of recognizing and appreciating both the noble and demeaning aspects of a worker's work. While hero-washing may be more common in stigmatized occupations, hero-washing likely happens in many less-stigmatized or unstigmatized work settings (e.g., teachers who are often publicly lauded but poorly compensated).

In our context, the public idealization of healthcare workers turned them from complex individuals into hero caricatures in a way not too dissimilar to how stigmatizing "reduces" an individual from a "whole and usual person to a tainted, discounted one" (Goffman, 1963: 3). Comparisons are not hard to find, such as military members or teachers being publicly thanked but then inadequately cared for or financially supported during or after their service. In the United States, as in other countries, soldiers are often sent to distant wars and conceptualized abstractly as hero caricatures who are to be supported with bumper stickers and banal slogans (e.g., "support our troops") yet often lack the physical and mental health support needed during and after their tours of duty (Hester, 2017). These "dirty heroes," as Goffman (1963: 2) would indicate, are not depicted as whole selves but instead are imputed social identities with "righteously presented demands." While military members are often celebrated at sporting events and allowed to board planes early, they are not properly supported with adequate physical and mental health services (Hester, 2017; Teeters, Lancaster, Brown, & Back, 2017).

We call on future researchers to dive deeper into the concept of "hero-washing" to explore how occupations and workers become idealized and how such idealizing interferes with how they can be better supported, and how organizations, leaders, and workers can break those cycles to advocate and receive better support and power to make changes. We hope our findings bring the paradox of hero-washing (e.g., "You're a hero but don't get near me" [#86, Nurse]) to the forefront of social evaluation research. We see potential transferability beyond the occupationally driven dirty work area to other stigmatized workers. For example, the lessons we elicit on mixed social evaluations might also be applied to neurodiverse workers who are often lauded for certain categories of skills (e.g., focus) and thus garner appreciation for getting their work done yet also stigmatized for their shortcomings (e.g., social awkwardness) by coworkers in ways that similarly keep them at a distance. Indeed, we encourage future research that showcases the complex intertwining of mixed social evaluations and identity among such workers stigmatized by neurodiversity or mental illness, given the paucity of research on those populations in management journals.

How workers experience mixed evaluations. Rather than focusing on stigma-management strategies, such as concealing, peer support networks, and social weighting, which researchers have thoroughly addressed (Clair et al., 2005; Kreiner et al., 2022; Ragins, 2008; Zhang et al., 2021), our work primarily focuses on an often overlooked but integral element of stigma—how workers evaluate their evaluat*ors* and evaluat*ions* (i.e., the process of stigma acceptance and rejection) and how this process impacts how they internalize their evaluations. We illustrate the process by which these evaluations are perceived, evaluated, and acted upon, showing that, as Link and Phelan (2001) contended, stigmatized individuals are not just passive, helpless victims. Rather, as we demonstrate, workers subject to social evaluations, stigma or otherwise, are active in the social construction process and reflect back an equal and opposite evaluation of their evaluators and their evaluations and, still further, under specified conditions, may challenge such evaluations.

Our context, wherein healthcare workers received disparate evaluations corresponding to traditional dimensions of stigma (i.e., physical, social, and moral), also allowed us to examine the internalization of evaluations in a way that was inclusive of mixed, repeated, and even contradictory evaluations. This examination revealed that, contrary to prior understanding, stigmatized individuals do not simply support their supporters and condemn their condemners as past research has theorized (Ashforth & Kreiner, 1999; Heinsler et al., 1990; Sykes & Matza, 1957). Instead, targets seek to validate (or invalidate) the accuracy and legitimacy of both stigmatizing and evangelizing evaluators with a process of logic (Ashforth et al., 2007; Meisenbach, 2010) and emotion that determines their internalization response. Indeed, we present instances where condemners were condoned (i.e., accepted) and where supporters were discounted and condemned. This insight into the internalization process resolves existing puzzles about how targets of stigma manage interactions with those who stigmatize them and how they might avoid internalizing the stigma they receive (Helms, Patterson, & Hudson, 2019).

More specifically, we demonstrate that targets of stigma consider the proximity, informedness, and authenticity of those evaluating them and thus are not merely passive targets of social evaluations but instead play a proactive role in deciding how external

assessments will or will not be internalized. When targets appraise actors as informed and authentic and interact with them at low spatial or social distances, they largely heed their evaluations, whether positive or negative, and act accordingly. However, if these criteria are unmet, targets can be expected to discount or even condemn their evaluators and their evaluations, regardless of the valence. Even positive evaluations, if given with questionable logic, half-hearted intent, or from distant sources, carry a risk of not only being ignored but of backfiring, as it invites eye-rolls, annoyance, and even anger. Our findings demonstrate that if positive evaluations like "the hero treatment" are given to workers who do not feel as if they earned such increases in status, workers will logically pick apart arguments or feel emotionally bothered. Generally speaking, our findings indicate that, when being evaluated, individuals do not simply focus on what can boost one's self-esteem but instead prioritize authenticity and coherent reasoning, turning the evaluation process around by "evaluating their evaluators." Building on this, we encourage future research to scrutinize the evaluating the evaluators process even more closely, exploring how the criteria we uncovered play out in a wider range of circumstances. There may be important differences in criteria—or in the weighting of criteria—when comparing occupations that enjoy high degrees of societal status (e.g., physicians) to occupations of significantly lower status (e.g., sanitation workers). We speculate that the broad legitimacy of healthcare workers likely impacted how logical and reasoned they were in evaluating their evaluators. This difference in legitimacy may help explain the variance in what we found versus what has been studied in previous dirty work literature (e.g., on prostitutes), where moral stigma is particularly salient and workers more commonly turn to wholesale rejection and condemnation of their stigmatizers (Ashforth & Kreiner, 1999; Hughes, 1958).

We also add to dirty work and stigma research by studying how different modes of evaluation impact stigma management (Ashforth & Kreiner, 1999). For instance, during a time when they were being celebrated on commercials and giant banners (moral dimension of work, high spatial distance), many of our participants were concealing their identity as healthcare workers (to avoid the stigma that would come along the physical dimension due to low spatial distance). While our data best addressed internalization outcomes, we also viewed some outcomes that were occasionally manifested behaviorally as well (e.g., avoidance, concealing, anger, etc.). Future research might build on our work by further examining elements in the front end of our model. It could, for example, quantitatively test how varying dimensions of stigma (and their combinations, such as physical–social) lead to different behavioral outcomes and even adaptive strategies in stigmatized workers. For instance, we noticed especially affective responses when evaluators varied within the same evaluative dimension, such as calling healthcare workers heroes and then accusing them of being coconspirators.

How stigmatizing and mixed evaluations manifest. The existing literature has focused on polarized evaluations toward occupations where divergent views appear to be relatively stable and based on longstanding prior values and beliefs. For example, Piazza and Augustine (2022) documented how abortion clinics are supported and opposed by entrenched stakeholders. Our research, however, makes important contributions to the stigma and dirty work literatures because it presents a unique exploration of the three dimensions of dirty work (physical, social, and moral) and how they vary in salience according to the social context of the interaction. The unusual circumstances surrounding the pandemic and the myriad evaluations received by healthcare workers allowed us to explore how workers can be both supported and condemned simultaneously across and even within different evaluative dimensions of work. In our example, outsiders celebrated and stigmatized them, in both cases, because of their perceived role in treating COVID-19 patients. While healthcare workers were generally lauded on the moral dimension (helping the world cope with a pandemic), they were being stigmatized strongly on the physical (e.g., direct exposure to the virus) and social (e.g., exposure to sick people) dimensions.

Our grounded findings point to an important contextual element that influenced the formation and expression of mixed social beliefs—spatial distance. In our context, evaluations appeared to hinge on how evaluative dimensions of healthcare workers were made more or less salient according to the spatial distance of the interaction. At a distance, evaluations of healthcare workers emphasized the moral nature of their work, whereas in close proximity, evaluations emphasized workers' perceived proximity to the virus and infected patients. However, we found no evidence to suggest that this same pattern must play out in all mixed evaluations. To the contrary, we can imagine a scenario wherein outsiders hold negative views of an occupation (e.g., law enforcement officers) at a distance who then, upon receiving their assistance (e.g., emergency services), express gratitude for their

service and evaluate them positively at a close distance. By illustrating the process whereby varying categories of stigma are made more or less salient according to spatial distances, we advance scholarship on the importance of social context, which can answer the puzzle of how stigmatizers might paradoxically support those they stigmatize (Helms et al., 2019).

Legitimacy. Our study offers a unique setting where healthcare workers were stigmatized and yet continued to be considered highly legitimate. Although an established field, stigma scholars have recently called for research that clarifies and relates stigma to similar concepts (Ashforth, 2019; Hudson, Patterson, Roulet, Helms, & Elsbach, 2022; Kreiner et al., 2022; Mishina & Devers, 2012). Our research responds to such calls by contributing to debates over whether we should place stigma on a spectrum with legitimacy (Ashforth, 2019; Devers & Mishina, 2019; Hampel & Tracey, 2019; Helms et al., 2019). Helms and colleagues (2019) argued that actors can be both stigmatized and legitimate at the same time but joined others in calling for research that can empirically demonstrate that legitimacy and stigma represent distinct dimensions of social evaluations. We offer a detailed examination of an occupation that carried considerable social legitimacy even prior to the pandemic. It is reasonable to speculate that our participants enjoyed higher levels of legitimacy than many prior dirty work research participants, which allowed them to utilize more judgmental, nuanced, and logically complex stigma management strategies. We believe occupational legitimacy and status empowered healthcare workers with emotional resilience that allowed them to process the sources of mixed evaluations and end up with internalization outcomes unpredicted by prior stigma literature. This resiliency, for example, perhaps allowed them to quickly discount uninformed supporters and condemners when they were suddenly valorized and stigmatized for work they had been doing all along. This example of positive and mixed evaluations answers Hudson's (2008) call to identify the boundary conditions of core stigma by looking for examples in industries with high legitimacy.

Social evaluation events. By presenting the umbrella concept of *social evaluation events* to explain how healthcare workers were seen differently after the pandemic, our findings contribute to stigma literature that has considered core and event stigma (Hudson, 2008; Hudson & Okhuysen, 2009). While the evaluations in our example were provoked by a social evaluation event (e.g., the pandemic), other occupations and contexts might evince stigma inherent to core job characteristics (e.g., sanitation workers), where workers might enjoy moral and regulatory legitimacy yet experience ongoing physical stigma for their work. Future research can test these boundary conditions and more precise relationships between legitimacy, status, and responses to stigma. We noted, for example, that physicians and other high-status workers seemed to be less surprised that outsiders were uninformed and thus seemed more open to condoning their condemners.

Practical implications and transferability. We present the idea of hero-washing as a potentially common, but harmful, outcome of occupational members being bestowed honorifics like "healthcare heroes" for their sacrifice in public but insufficiently supported (both materially and socially). We believe the collective idealization of occupational members like healthcare workers during the pandemic threatens to interfere with needed action to better support and empower them. As Hughes (1958: 64) described, "the delegation of dirty work to someone else is common among humans. Many cleanliness taboos, and perhaps even many moral scruples, depend for their practice upon success in delegating the tabooed activity to someone else." We hope that our firsthand accounts from healthcare workers during the pandemic will open the eyes of outsiders while honoring healthcare workers who endured harrowing circumstances both inside and outside of their organizations. More broadly, organizations (and society) can learn from this case study by intentionally trying to remove distances, demonstrate understanding, and display authenticity whenever evaluations are meant to be accepted (i.e., coupling cheap talk with concrete action). In general, praising an entire workforce may be ineffective because, if not followed up with meaningful measures, individual workers will undoubtedly begin questioning the proximity, precision, and motives of the sources. Instead, evaluations are most likely to be accepted if they are perceived as targeted, informed, and genuine. In this way, we hope our research evokes meaningful and impactful change in how workers who sacrifice for society (e.g., teachers, healthcare workers, mental health professionals, military members, etc.) are treated and supported and encourages more theoretical and empirical work around this phenomenon.

Stigmatization is becoming progressively problematic for an increasingly interconnected world and corresponds to real societal consequences, including polarization, fragmentation, murder, and suicide (Loyd & Bonds, 2018; Zhang et al., 2021). We heard from a number of our participants who complained that managers at work had asked them not to wear

scrubs or other occupational regalia in public. Interviewees generally saw these recommendations as largely motivated by concerns over impression management, not infection control. The goal of managers seemed aimed at concealing the occupation of healthcare workers in public so as not to instigate condemnation by outsiders. Although such efforts may have helped some workers avoid stigmatizing evaluations, they seemed to confirm suspicions in healthcare workers that they were not truly valued or supported by their employers or society but were instead transactionally needed and ultimately expendable. This example is one of many mixed messages that healthcare workers internalized during the pandemic. Mixed messages, like other dualities, can lead to ambivalence and disidentification (Ashforth, Rogers, Pratt, & Pradies, 2014; Kreiner & Ashforth, 2004). It is, therefore, important for managers and decision-makers to be aware of how mixed messages and organizationally condoned stigma management tactics may undercut the values and signals they are trying to communicate. Moreover, our findings reveal an important yet often overlooked implication for effective stigma management—alignment between the management tactic, the stigma, and the stigmatized dimension of work. In other words, when stigma management tactics (e.g., using the term "healthcare heroes") are not aligned with or targeted at the stigmatized dimension(s) of work (e.g., physical or social), then not only would we expect such management tactics to be ineffective, but they might also compound the psychological stress experienced by the worker by exacerbating the incongruence of their internal and external selves.

CONCLUSION

Despite the publicity and notoriety of the "healthcare heroes" campaign, our study documents, in dramatic detail, the experience of an occupation under intense private stigma. Specifically, we reveal how healthcare workers were subject to a mix of social evaluations, including stigma. We also reveal how these workers largely rejected evaluations that manifested during the pandemic, including being called heroes—a phenomenon not explained by the existing research on stigma and social evaluations. We illustrate how and why many healthcare workers struggled with being treated as something akin to "dirty heroes" and provide a model to understand how workers experience, process, and respond to mixed social evaluations.

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APPENDIX A
SAMPLE OF OUR PROTOCOL (INTERVIEW) QUESTIONS

1. How many years have you worked in health care, and in what roles?
2. How have you enjoyed being a healthcare worker up to this point in your career?
3. What was your level of pride in being a healthcare worker before the pandemic?
4. How have things changed since the pandemic?
5. How do you see your job differently since the pandemic? How has the pride you feel for being in health care changed? When are you most likely to notice that sense of pride (i.e., what situations or activities)?
6. There have been a lot of descriptions in mass media and social media about healthcare workers as heroes, i.e., "Heroes work here." What do you think of that?
7. When someone calls you a hero, how do you respond to that?
8. Has the "healthcare heroes" campaign changed how you view your job? How, if at all, has that changed
9. How, if at all, do you think the campaign changed the way other people view your job? Do you think they understand what you're going through (in the pandemic)? [If they don't], how do you deal with that feeling that people don't get it?
10. Since the onset of the pandemic, are there times or moments when you feel something negative, unusual, or awkward in the way people treat you, knowing you work in health care?
11. Have people displayed any nervousness being around you because you could be exposed to COVID-19 through your work?
12. Have there been any negative consequences, such as people not wanting to socialize with you or your family members? If so, what has that been like for you?
13. Have you had people treat you or your family differently because of the pandemic? What was that like for you?
14. Do you sense that there is any kind of stigma attached to healthcare workers because of their exposure to the virus? What do you think of that?
15. What, if anything, do you do in response to negative treatment? How do you respond to others when these issues come up?
16. What's the experience of potentially being around COVID-19 patients like for your family?
17. [If described, if not, skip] What's the experience been like for you to be called a hero by some, but treated poorly by others? How do you manage that duality?
18. What, if anything, have you found helpful as you cope with the challenges we've discussed? What has worked and what has not worked?

Note. Our questions evolved during data collection and analysis based on emerging themes. The questions above represent those asked in later interviews. For example, early interviews did not include questions about stigma or mixed evaluations.