

EDITORIAL

We're on mute! Exclusion of nurses' voices in national decisions and responses to COVID-19: An international perspective

Nurses are the largest healthcare workforce and have had direct, intense and sustained contact with COVID-19 patients throughout the pandemic playing an essential and frontline role in the COVID-19 response. Nurses have worked tirelessly and undertaken multiple roles during the pandemic including education, treatment, prevention, vaccination and research often in uncertain situations and to the detriment of their physical and mental health. They have also managed and cared for distressed patients and their families, and many have been redeployed to other roles often outside of their usual duties, all factors which have affected their well-being. They have publicly been lauded as 'heroes'. Yet, their voices and perspectives are seldom heard or included in COVID-19 decision-making and in the development of interventions and responses at all levels from individual health services to national policymaking. Indeed, it has felt like these voices have been muted and excluded. Nurses' unique knowledge, expertise, needs and lived experiences are vital to the COVID-19 response. Without their inclusion, COVID-19 decision-making and initiatives are unlikely to be successful and patient outcomes poorer.

1 | THE PSYCHOSOCIAL IMPACT OF THE COVID-19 PANDEMIC ON NURSES

We work clinically and conduct nursing and health services research in several high-income countries (Australia, Denmark, Sweden and the United Kingdom) which have relatively high COVID-19 vaccination rates by world standards but have reported varying numbers of COVID-19 cases and deaths and implemented diverse responses to the pandemic. At the end of January 2022, the total confirmed COVID-19 deaths per million people in Australia and Denmark were below the world rate compared with higher rates in Sweden and the United Kingdom. Sweden has implemented fewer and less stringent restrictions than the other countries in which we work. The Swedish response was based on pragmatism, 'common sense' and personal responsibility. Schools and borders remained open, and no 'lockdowns' were implemented. In contrast, Australia, Denmark and the UK introduced many initiatives to limit or slow infection transmission. These included stringent 'lock-downs', 'social' (physical) distancing, remote working for non-essential workers and remote

learning for school-aged children and university students, the closure of international borders and restrictions to visitors in healthcare settings including hospitals and aged care. Additional income support was provided by government for those unable to work due to COVID restrictions. COVID-19 vaccinations for healthcare workers such as nurses were also mandatory in Australia. In the UK they were mandated for social care workers, but this requirement was dropped for NHS staff in early 2022.

Nevertheless, our research demonstrates the universal and considerable psychosocial impact of the COVID-19 pandemic on nurses internationally. About 20%–30% of the nurses we surveyed during the first wave of the pandemic reported mild to extremely severe psychological distress (Couper et al., 2021; Holton et al., 2020; Holton, Wynter, Rothmann, et al., 2021). Nurses also appear to have experienced greater psychological distress compared with other healthcare workers. Our study of hospital clinical staff conducted in Australia found that nurses and midwives were significantly more likely to experience symptoms of anxiety than doctors and allied health staff (Holton et al., 2020) and this association remained as the pandemic continued (Wynter et al., 2022). In Sweden, registered nurses reported more negative effects of the pandemic on their working conditions and ability to recover than other professional groups (Alexiou et al., 2021). This high level of psychological distress may have been exacerbated by reports of nurses dying due to COVID-19 estimated in October 2020 to be 1500 across 44 of the world's 195 countries (International Council of Nurses, 2020).

As well as high levels of psychological distress, the pandemic has also had a negative effect on nurses' work and personal lives. Nurses in all countries have reported concerns about contracting COVID-19, putting colleagues and family members at risk and caring for infected patients; the challenges of wearing and lack of access to personal protective equipment; the stress of being redeployed to other areas and undertaking different duties than normal; difficulties managing paid work and family responsibilities, including supporting children with remote learning; and experiencing moral distress when they are unable to deliver the care they wish to (Couper et al., 2021; Holton, Wynter, Trueman, et al., 2021).

2 | 'ON MUTE': WHERE ARE NURSES' VOICES IN THE COVID-19 RESPONSE?

The media and others have highlighted the important and life-saving work of nurses throughout the pandemic. Boris Johnson, the UK

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prime minister, paid special tribute to the nurses 'who stood by [his] bedside for 48h when things could have gone either way' when he was hospitalized for COVID-19 early in the pandemic (Booth et al., 2020). In Denmark, Her Majesty Queen Margrethe II paid tribute to healthcare workers including nurses in her 2021 New Year's Address: 'many people must again make an extra effort. This applies in particular to those who help trace and limit infection, and to those who treat the sick' (HM The Queen of Denmark, 2021). In Sweden, nurses were recognized with 'official national applause' (as in the UK) and Swedish nurses received additional salary payments during different waves of the pandemic. Yet despite their raised profile, nurses' voices are seldom heard or considered in COVID-19 decision-making and responses.

2.1 | Nurses' voices in the media: limited appearances and narrow portrayals

Despite an increased positive focus in the media on nurses and their work during the pandemic, there are few instances of senior nurses sharing high level COVID-19 response information with the public or represented as leaders in COVID-19 decisions. Although chief health or medical officers have regularly attended government media briefings, chief nursing officers are seldom in attendance. For example, in Australia, Victoria's chief health officer, Professor Brett Sutton attended daily media conferences with the premier, Daniel Andrews, which were held for the first 19 months of the pandemic and provided updates about the number of COVID-19 deaths and cases, latest restrictions and decisions, and vaccination targets. Yet nurses have made limited appearances at these daily media conferences with the discussion mainly focused on their experiences of caring for COVID-19 patients or urging people to be vaccinated. England's chief medical officers were present at every briefing, yet the chief nurse only appeared twice at the daily briefings in 2020/21. In Denmark, the COVID-19 response has been managed by the Danish Health Authority and its director general, represented by medical professors in virology, epidemiology and infectious disease; not nursing.

2.2 | Nurses' voices in COVID-19 decision-making: organizational and national deafness

Nurses have had limited representation in high level government and advisory group decision-making and planning about the COVID-19 response, particularly in comparison to members of the medical profession and public health experts and academics. The International Council of Nurses recently surveyed its 130-member national nursing associations (NNAs). Less than half of the NNAs reported that their government chief nurses had been involved in national health decision-making (41.5%) and similarly less than half of infection, prevention and control nurses (44.4%) or senior nurses (40%) had been involved in government decision-making about COVID-19 (International Council of Nurses, 2021).

Nurses in the UK have voiced concerns about their lack of involvement in key parliamentary discussions about protective personal equipment (PPE) and representation on official scientific advisory groups (e.g. SAGE) which provide advice to the government about COVID-19. A lack of nurses' voices was also evident in the establishment of the 'Nightingale Hospitals' in England during the first wave of the pandemic. Seven facilities were built at a total cost of £530M and later all decommissioned with the exception of one, with very few patients ever admitted. Nurses' involvement in the decision to build these facilities appears to have been minimal although the Chief Nursing Officer for England did visit the London facility during its construction and opening. Staffing these facilities was problematic and calls were made in each National Health Service (NHS) region for volunteers from in existing nursing workforces; further stretching already strained and scarce resources.

There are some rare exceptions. In Denmark, the Danish Nurses Organization was invited to several working groups, meetings and negotiations to discuss the COVID response and workforce. Whilst in Australia, the Infection Control Expert Group which advises the Australian Health Protection Principal Committee on infection prevention and control including community transmission of COVID-19 is chaired by the Chief Nursing and Midwifery Officer and senior nurses are members. Nevertheless, the exclusion of nurses from decisions about the COVID-19 vaccine rollout in Australia has also been noted. Our recent study of Australian nursing and midwifery educators (Wynter et al., 2021) highlighted the lack of input that many nurses feel they have in COVID-19 decisions. One participant commented: '*Feeling like things are being planned behind the scenes that will perhaps affect us but perhaps we're not included during the planning stages...*' (Wynter et al., 2021).

Our research in the UK identified that nurses frequently tried to raise concerns during the pandemic but an 'organizational deafness' existed which meant that their concerns were ignored (Adams et al., 2020). Many of the nurses we interviewed spoke about their moral distress at being ignored and silenced and some left the NHS as a result. One very senior nurse reflected on her experience of being redeployed to a national role during the pandemic. She stated that the government paused the interventions she had been involved in recommending and as a result, she stepped down from her role. She stated: '*I didn't even get a thank you for what I'd done for, in the national [role]. It's never been acknowledged. So, I sent the emails that went to very senior people. I didn't get a response. Not even a reply*'. Similar to other nurses we spoke to who did not hold such senior positions, she felt ignored and undervalued (Maben et al., [under review](#)).

3 | WHAT ARE THE POTENTIAL CONSEQUENCES OF IGNORING NURSES' VOICES?

As highly educated and skilled health professionals, who spend most time with patients and are critical to patient safety, it is vital that nurses have a voice in high level decisions about the response

and planning for not only the COVID-19 pandemic, but also future health crises and adverse events. Nurses have unique healthcare expertise, intimate knowledge of healthcare systems, work in a variety of healthcare settings, are powerful patient advocates and have unique perspectives of patients' experiences. They need to be actively involved in the COVID-19 response, and response to other health challenges, to ensure effective decision-making, better patient outcomes, high quality and patient-centred care, and more robust healthcare systems.

4 | WHAT NEEDS TO BE DONE?

We need to value and empower nurses, recognize the important role they play, and ensure their voices are heard and their recommendations are acted on, not ignored. To raise their voices, nurses need to work collaboratively to value, empower and learn from each other and take actions towards systematic organizational changes which includes nursing representation and leadership positions in healthcare settings, government advisory groups and committees; actively involving nurses in the development of health policy and practice similar to other groups of health professionals; appropriately supporting and resourcing the nursing workforce including education, recruitment, pay and working conditions; and providing appropriate and effective support for nurse well-being.

Nurses from different countries can learn from each other and strengthen their voices at individual, organizational and government levels. A unified, evidence-based nursing voice is critical and requires ongoing inclusive research at local, national and international levels.

5 | CONCLUSION

Nurses around the world have made a considerable and valuable contribution at the point of care delivery during the COVID-19 pandemic, often at significant cost to their own psychological well-being and personal lives. Yet overwhelmingly they have had a limited voice in the national and regional responses to the COVID-19 pandemic in our respective countries. We believe nurses' can, and should, play an integral role in driving the conversation about the management of and response to the COVID-19 pandemic and other future adverse health events. A diversity of voices and expertise is critical for effective decision-making in times of crisis, benefitting collective action and ultimately patient care. It is time to make sure our mics are on and to turn up the volume!

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

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