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The Dual Epidemics of 2020

Nursing Leaders' Reflections in the Context of Whole Person/Whole Systems

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The Greater Boston Nursing Collective, a consortium composed of university nursing deans and chief nursing officers within academic medical centers and specialty hospitals in Boston, Massachusetts, was formed in 2014. Since the group's inception, our mission has been to create and reinforce whole-person/whole-system healing environments to improve the health of all

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communities. Through our collaboration in navigating the dual epidemics of COVID-19 and structural racism within our respective organizations, and across the United States and the world, we share experiences and lessons learned. Our common mission is clearer than ever: to create safe and joyful work environments, to protect the dignity of those we are privileged to serve, and to generate policies to advance health equity to rectify societal forces that have shaped this dual epidemic. We are humbled by the many who persist despite limited rest and respite, and whose stories, innovations, and leadership we are honored to witness and share. They have defined our generation, just as nurses in earlier crises have done: leading through service to others as our purpose and privilege. **Key words:** *COVID-19, epidemic, nursing leadership, pandemic, structural racism*

2020 PRODUCED a convergence of the coronavirus disease-2019 (COVID-19) global health care crisis and numerous law enforcement actions nationally experienced by many as evidence of structural racism. Structural racism is defined as "... a confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial and ethnic groups."[1] As the year unfolded, these 2 challenges were increasingly conceptualized as a "dual epidemic" of historic proportions. Particularly impacted were those leading both academic and health care delivery settings. To quote author and actor Denis Leary, "Crisis doesn't create character, it reveals it."[2] The dual epidemics have revealed the character of nurses, and indeed the profession of nursing, in profound ways during this World Health Organization's Year of the Nurse.[3] These revelations are not surprising, given the public consistently ranks the nursing discipline as the most trusted in the nation.[4] As leaders of a discipline grounded in reflective practices to develop and advance the science associated with our profession, we are obligated to examine our responses to better understand our impact during this tumultuous time.

The Greater Boston Nursing Collective (GBNC) was established under the leadership of academic deans and senior patient care operational leaders serving as chief nursing officers (CNO) within specialty and acute care hospitals and health systems in the metropolitan Boston area.[5] As the COVID-19 pandemic evolved, GBNC members provided leadership not only within our respective institutions, but also to regional, national, and global strategic planning efforts.[6] Dissemination of new knowledge varied, though broadly included research related to caring for caregivers, ethical challenges, and responses to health care disparities made manifest by the interaction of the pandemic with preexisting societal structures.[7-13]

As health care institutions struggled to stabilize acutely ill patients, our members were intensely aware of the needs that existed in hospital, ambulatory, and community health care settings (Tables 1 and 2). We also had to mitigate numerous stressors associated with guiding students and safety within academic nursing programs (Table 3). As leaders, we witnessed the extreme demands placed on all health care delivery team members, including most specifically members of our hospital and command centers. Related stressors intensified as the pandemic accelerated in complexity and duration. There was little respite to be found in our communities, workplaces, and even our own homes—increasingly stressed by child care, home schooling, and multigenerational care-taking challenges.

Concomitantly, the COVID-19 crisis dramatically increased our collective awareness of the wide health disparities among marginalized populations, including a substantial number of nursing students, clinical team members, and support staff within our hospitals and universities. Data by race/ethnicity indicate that African Americans and Latinx individuals bear a disproportionate burden of COVID-related outcomes. Hooper et al[14] note that while health disparities are complex, underlying causes are rooted in social and structural determinants of health. Our economic, social, and financial systems contain fundamental barriers to care. The healing of our

Table 1. Clinical Challenges and Responses

No visitors/family presence	Leverage technology
• End of life—inhumanity of dying alone	Ensure widespread signage so staff are not only form of communication
• Beginning of life—laboring women alone	
• Maintaining family presence in pediatrics	Visitation exceptions—follow nursing science
Less than adequate PPE—staff fear for self/family	To become a never event—political advocacy/PPE policy development, planning analytics and advocacy
	Visible leadership and authentic listening
	Extra-long IV tubing
	Include family members in care of staff (ie, COVID testing)
Resources reallocation	Conceptualize skill set as porous, less geographical
	Develop rapid educational offerings
	Competency validation
	Overt and active expressions of gratitude from leaders to all staff
Patient conditions	Implement proning practices
	Heightened communication shift to shift regarding: changes, clinical and social
	New and extra-communication pathways
	Remove barriers to innovation (curling leadership)

Abbreviations: COVID, coronavirus disease; IV, intravenous; PPE, personal protective equipment.

city, nation, and world will necessitate the creation of new, more equitable systems. Academic and practice partnerships such as the GBNC offer a cross-system foundation to accelerate change, stimulate collaboration, and impact the design of essential national and global health care and societal transformation.

A UNIQUE VANTAGE POINT

As leadership expert Michael Porter states, "Good leaders need a positive agenda, not just an agenda of dealing with crisis."[15] The dual epidemics of 2020 provide an opportunity to highlight the impact of nurses, as they lead strategic change throughout public health, academic, and acute care environments. From our unique vantage points, we challenged ourselves to understand the impact of nurses in health and healing during a complex global health crisis exacerbated by historical inequities.

The GBNC exists to promote the health and well-being of those in the Boston metropolitan community, with an intent to disseminate empirical outcomes nationally and globally. Our mission is to advance the science and practice of integrative nursing, inclusive of a principle focusing on the well-being of caregivers and those they serve.[5,16] In studying nursing's impact during the dual epidemics, we dedicated our Spring 2020 board meeting to reflect on the degree to which our respective organizations prioritized healing environments, adapted relationship-based care initiatives, and sustained whole-person and whole-system care. What did we get right despite time, knowledge, and resource constraints? What would we do differently with the benefit of time, resources, and pooled insights?

CONFRONTING ENTRENCHED DISPARITIES

As nurse leaders in academia and service, grounded in knowledge of the biopsychosocial impacts of health, we recognized COVID's impact on both the vulnerability of direct care clinical staff and the broader hospital community. This included low-income

Table 2. Leadership Challenges and Responses (Practice and Academia)

Extreme stressors for staff and students	Prioritize healing environment for staff • Visibility • Authentic listening • Time outs/highlight what went right • Honest conversations about current state and projections Staff wellness and resiliency offerings
Students and staff do not have level-playing field	Education was customized as needed for students to meet expectations, as detailed in Table 3 Rapid HR policy adaptations in context of public transportation and community resource constraints coupled with complex personal demands
Disproportionate impact on workforce as family members	Recognize household risk—provide education on safe practices Prioritize engagement in public support of health equity (eg, White Coats for Black Lives) Lead policy change and education to reduce structural racism Create opportunities for alternate housing/transportation—relax absenteeism/lateness policies Flexible scheduling wherever possible
Multigenerational care taking Schools cancelled for children Communal living Public transportation	Creative HR policies and approaches as government shutdown options Institutional alternatives and HR policy considerations

Abbreviation: HR, human resource.

essential workers, often people of color, who were more likely to rely on public transportation or live in multigenerational housing, making them disproportionately vulnerable to infectious disease transmission. A subset of nursing students lacked access to technology and privacy to support successful remote learning. As leaders, we addressed these disparities as

Table 3. Academic Challenges and Responses

Clinical time was put in jeopardy for virus containment	Partnering with practice leadership facilitated parity of clinical time among varied disciplines in interprofessional environments
Technology was not equally accessible	Faculty and universities provided loaner laptops and confirmed Internet access
Privacy was not equally accessible	Faculty employed virtual modalities to stay in touch with students and customize their experience
Different students have different levels of personal obligations	Customized experiences so students could succeed
States varied in requirements of clinical time	Innovations created to conceive learning from international pandemic as a clinical opportunity

operational challenges in our respective institutions, while as nurses, we were challenged to address the pandemic's ubiquitous health impact on our communities and country.

Across the United States, racism and health equity are inextricably linked. Racism, both individual and structural, is deeply ingrained in the social, political, and economic fabric of our society with adverse outcomes to individuals and communities of color. This fosters unequal access to social and economic opportunities such as quality education, livable wages, employment, healthy food, stable and affordable housing, and safe and sustainable communities. Through a concerted effort encompassing multiple sectors, nurse leaders are changing the fabric of structural racism by leading change within governments, health care systems, and other community-based organizations. Reform areas of significance include:

- Educating health professionals on the intersection of social, political, economic, and environmental factors on health and illness.
- Creating multisector, place-based partnerships with community organizations to amplify the voice of citizens to drive meaningful, system-level change.
- Leading development of policies and programs to eliminate barriers to community empowerment in low-income neighborhoods, especially around economic opportunities, education, and housing.
- Building supportive structures to increase access to health care, healthy foods, and safe neighborhoods, and decrease exposure to environmental pollutants.
- Building trust by enhancing residents' ability to communicate their health care needs and improving the capacity of health systems to effectively respond.

As the most trusted profession in the United States,[3] nurses have a great opportunity and a responsibility to leverage this trust and lead key reform at the local, regional, and national levels. Change leadership should focus on an essential core principle: structural racism, not race, is the principal determinant of disparities in health access, services, and outcomes. Reforming policies that perpetuate racism is essential to alleviate critical gaps. We translated our whole-person, whole-system commitment into action in public venues such as "white coats for black lives"[17] events, knowing the added stress, anxiety, and vulnerability of this moment requires pauses, reflection, and being present to truly lead.

LEADERSHIP IN PRACTICE SETTINGS

The metaparadigm of nursing consists of 4 components—person, health, environment, and nursing—spanning scientific, technical, and humanistic dimensions.[18] As we responded to the pandemic, GBNC's executive nurse leaders managed the environment in academic and practice settings. For hospital and health system-based leaders, this included critical decision-making roles as members of executive leadership, safety, and quality teams, as well as significant operational roles within the Hospital Incident Command System (HICS) structure, including HICS Incident Commander and Operations Branch leaders.

While most senior leaders transitioned to remote work, the nature of the nurse executive as both the leader of a clinical discipline and patient care operations leader required a strong on-site presence. We direct rapid changes in care delivery and support middle managers who were translating complex infection control and prevention protocols for direct care teams. We make strategic decisions, while also being present and visible for the clinical teams. Rounding and listening and being present for nurses around the clock, every day of the week, made a difference and is a distinction in our roles from those of other executives. The HICS structure facilitated swift and hierarchical decision-making. Yet even in this context, senior nurse leaders sped the process further with "curling"—engaging with direct care nurses to sweep away barriers to rapidly conceived care delivery innovations.[19]

Resourcefulness and creativity saved lives. With COVID disrupting every aspect of the care environment, nurses responded with tailored innovations for patients, families, clinical and support staff, and community members. Nurses had to innovate across multiple practice domains, including direct patient care, infection control, occupational health, and patient and family emotional support practices.

In the intensive care unit (ICU), nurses introduced the evidence-based practice of proning—administering oxygen and continuous positive airway pressure to rapidly deteriorating COVID-19 patients placed in the prone position.[20] Proning not only lessened the immediate effort of breathing for these patients, but also mitigated long-term respiratory distress that might require the use of ventilators. To create proning teams, leaders redeployed nurses from areas of reduced activity, such as the operating room, to critical care. Redeployment required rapid education, training, and competency validation among nurses and other care team members. Nurse educators developed curricula almost overnight to provide just-in-time orientation to a wide range of new roles. New operations were established, such as hotlines and employee/patient screening programs, to provide information and keep practice environments safe.

Direct care nurses and their first-line leaders also identified the critical need to reduce staff exposure to COVID-positive patients and those awaiting test results. They innovated team-based care delivery models and technical interventions, including extra-long intravenous solution tubing reaching from outside the patient's room. In many cases, HICS incident commanders facilitated staff redeployment and associated supply procurement to support these local innovations.

The pandemic created a significant barrier to one of the most important emotional supports for acutely and terminally ill patients: the presence of their loved ones. Government mandates required hospitals to implement restrictive visitation policies. Consequently, nurses were most likely to serve as liaisons between patients and families. Direct care nurses designed, implemented, and improved processes around care team communication, interprofessional rounding, and patient-family/care team interaction.

Executive nurse leaders collaborated with HICS leaders to develop and implement programs that stretched beyond hospital walls to meet community needs. This included expanded occupational health support; patient, parent, and employee testing; housing for employees; and education for school nurses and day care personnel. They worked alongside executive leaders to address employment continuity and workforce financial support, particularly among vulnerable employee groups.

LEADERSHIP IN ACADEMIC SETTINGS

The dual epidemics of 2020 presented equally daunting challenges to nursing deans and faculty. The rapid move to online learning led to equity concerns, with variations in socioeconomic status creating unequal access. Colleges and universities hurried to provide loaner computers to students who needed them. Nurse educators also confirmed Internet availability for students who suddenly found themselves back home with limited online access. All spring, academic deans and faculty worked with students to navigate these challenges. We learned not everyone had space or time to study at home. Many students prioritized care for siblings so their parents could go to work. We used a wide range of virtual modalities to stay in touch with students, helping them succeed academically, as well as learn from their unique opportunity as nursing students during an international pandemic. We also supported clinical faculty who were juggling new responsibilities at work and home. They were often the sole source of family income as job losses accelerated.

A major challenge was a rapid pivot to virtual simulation environments to ensure all students had sufficient clinical hours to meet national licensure and certification

requirements. The National Council of State Boards of Nursing helped by collating information.[21] We also worked closely with the Massachusetts State Board of Nursing to ensure virtual simulation was an acceptable alternative.

The dual epidemics provided a critical opportunity to reaffirm practice and academic partnerships. CNOs and practice leaders collaborated with deans and academic leaders to modify student placement planning and consider learning innovations. GBNC efforts over the last 6 years had strengthened relationships, which enhanced a shared commitment to patient, staff, and student safety and well-being. Through shared leadership, access to clinical rotations was considered across all disciplines to promote equal access to in-person and virtual learning. Likewise, despite significant shortages of personal protective equipment (PPE), health care organizations extended "PPE equality" practices to assure one common, high-quality standard for both workforce and students. These actions highlighted our shared values and commitments as senior nurse leaders.

To prepare for the fall semester, nursing deans, CNOs, infection prevention specialists, laboratory leaders, and others shared expertise across institutions. Health care organizations shared testing protocols with academic institutions, especially around sensitivity, specificity, and cost. Public health experts also contributed.

Cross-organization communication fostered a uniform voice and fundamental values, reflecting GBNC's whole-person, whole-system philosophy. We anticipate the same high level of collaboration guiding COVID-19 vaccine distribution and administration sequencing moving forward.

NURSING CARE: CHALLENGES AND SOLUTIONS

Nursing leaders and direct care nurses balanced the care of COVID-19 patients with other patients and families across settings. Nurse leaders played a significant role in translating national and state visitation guidelines. Immunosuppressed oncology patients receiving care in designated cancer treatment settings required strict visitation controls to mitigate risk. Specialty quaternary ICU pediatric care was consolidated regionally throughout New England to one primary children's hospital where complex cardiac, neurosurgery, and oncologic services were provided. Often 2-parent visitation was deemed essential to provide meaningful family-centered care. This required nurse leaders and direct care staff to continuously adjudicate complex visitation planning to balance physical and emotional well-being with increased visitation risks. In cases where loved ones were not permitted to visit, nurse innovations fostered connection. At one of our institutions, they purchased a color printer where families could send photographs directly to post in patients' rooms.

Visitation policies were acutely felt at the beginning and end of life. Nurses supported laboring women and their newborns, sustaining the family unit, and ensuring new mothers remained healthy and able to assume parenting demands. With many unanswered questions about COVID-19's influence on pregnancy, delivery, and newborns, nurses scoured the literature on mother-infant dyads related to other infectious diseases such as HIV.[22] Fortunately, following further scientific review, it became clear the risk to mothers and infants was less than initially feared.[23]

Nursing and consumer activism jointly changed essential practices related to family presence during labor. Nurses noticed that expectant mothers with adequate resources and flexible insurance plans were selecting hospitals that allowed a support person in the room. In New York, Governor Cuomo declared, "Women will not be forced to be alone when they are giving birth," leading hospitals to expand visiting privileges.[24] Allowing labor partners became an established practice in many settings nationally. Research has long associated support in labor with improved birthing outcomes[25] and patient satisfaction.[26]

At the other end of the lifespan, stricter visitor restrictions remained. Nursing leaders

have called for an examination of how we allowed people to die during the pandemic.[27] We learned COVID-19 is more likely to kill the elderly and those with preexisting conditions. As the number of cases rose, emotional support and family presence for vulnerable elderly individuals remained low, including at the end of their lives. GBNC members reflected on this phenomenon in the context of the inhumanity inherent in solitary death. How do we make equitable and ethical decisions about how many visitors can come and go? What do we need to change to ensure that patient, family, and community voices are integrated into our care delivery models? Not only now, but also for future epidemics and emergencies.

CARING FOR THE CAREGIVERS

In the words of Max de Pree, "The first responsibility of a leader is to define reality. The last is to say thank you. In between, the leader is a servant."[28] Embracing servant leadership, especially during crisis and uncertainty, is a way to care for and build strength in others. Servant leaders demonstrate and encourage listening, empathy, healing, foresight, and stewardship. In the age of COVID-19, servant leadership became more important. The pandemic has elevated the urgency and need to care for caregivers—nurses as well as other members of the health care team.

In addition to the usual stressors of patient care, nurses faced uncertainty about their own safety and well-being.[29] At the onset, it was unclear whether nurses might transmit COVID-19 to their families, especially the elderly or chronically ill. As conditions escalated, nurses and care team members faced the unimaginable: a worsening national shortage of PPE and other critical supplies. Fear for their physical safety added to nurses' near-constant stress.

"Moral distress" is a term commonly used to describe these struggles.[30] Over time, many caregivers found a way to compartmentalize personal and professional stressors. COVID-19 erased those boundaries. Where caregiver stress and burnout have historically existed as chronic undercurrent themes exposed via surveys and studies, they now manifest as acute issues among health care workers in a wide range of sectors.[31]

Acknowledging these unique circumstances is the first step to build appropriate support. Defining reality through authentic, frequent communication and expressing gratitude are critical. Many of us encourage staff to end their days with pauses of gratitude or happiness. As a community, GBNC members routinely share emails celebrating joy in our practice. Many of us in academic institutions have designed curricula focused on self-care.

CONCLUSION

The COVID-19 pandemic has exposed the need for the nation and world to strengthen emergency management readiness, supply chain preparedness, and essential health care workforce skills. The need for health care leaders in practice and academia to advance health equity was made explicit by the pandemic's predictable and disproportionate impact on the poor and indigenous, and people of color. The GBNC served as a force to marshal resilience through regional, national, and global collaboration. Amid tremendous personal and societal suffering, we offered new practice and education linkages to improve systems of care and examine ways in which society could protect those most vulnerable.

Increasingly, the transformation of moral suffering to moral resilience is understood as a key imperative in health care. Nursing ethicist Cynda Rushton posits a path forward noting, "Multifaceted approaches must harness the commitment and moral fortitude for system change that takes into account the need for mindfulness, resilience, and joy."[32] Building or enhancing resilience programs, offering meditation, structured peer support programs, pastoral care, employee assistance, and mental health support are needed.[33] It is also important that executive nurse leaders sustain their visibility on patient care units and use appreciative inquiry methods to understand staff

needs, address questions and concerns, and reinforce to staff that they are not alone. As we weather this pandemic, strong leadership will guide organizations through the uncertainty so we emerge with a renewed ability to thrive. Perhaps this is an opportunity to transform compassionate care for caregivers from a concept to a fundamental commitment.

The GBNC commitment to relationship-based healing environments was both challenged and reinforced by the magnitude of the crises. We believe nursing can lead our country to a healthier state through stronger advocacy addressing health disparities as an acute public health crisis. Our reflections elucidate we must never let staff or patients make do with less than that which science informs us is essential for safe environments. We embrace that now as a leadership action item.

One of our nurses reflected, "COVID has shaken us to the core. We summoned the courage and strength to care for patients who entrusted us to comfort and heal them when they were too weak or frail to care for themselves. I can say we did our best and pray that was good enough." Committed to a whole-person, whole-system approach to health care, knowing we are at our best when academia and service partner, we believe we owe our staff reassurance their care was "good enough."

Our collective experience solidified 4 tenets of our collaboration, which we believe are key takeaways from 2020 for nurse leaders. First, academic/practice partnerships strengthen nursing responses to clinical, academic, and societal problems. Forums that existed prior to crises were essential to build relationships and exchange expertise that minimized negative impacts in practice and academia. There will always be a next challenge for both to manage and we do that best with both lenses. Second, approaching problems from a whole-person/whole-system framework, for communities, patients, and staff, facilitates nimble clinical adaptation and strengthens inclusivity, ethical underpinnings and sustainability of culture changes desired. Third, transformational leadership, which is visible and attentive to mindfulness, resilience, and joy, is our best path to a healthy workforce, future workforce, and community. Fourth, there is a vital role for nursing to lead strategic public health, acute care, and academic environments.

We move forward as nurse leaders in hospitals, communities, and academia, recognizing our inner Florence Nightingale, who said of her nurse colleagues, "I do not pretend to teach her how, I ask her to teach herself, and for this purpose I venture to give her some hints."[34] Every conversation, thought, and reflection evokes the deepest admiration for the millions of courageous, relentless, and innovative nurses who continue to serve—in command centers, as infection prevention and control specialists, executive and first-line leaders, and most significantly, direct care nurses. We admire our colleagues in academic nursing programs, as they persevere in preparing the next generation of nurses, refusing to sacrifice future patient needs to the demands of today.

Our common mission is clearer than ever: to create safe and joyful work environments, to protect the dignity of those we are privileged to serve, and to generate policies to advance health equity to rectify societal forces that have shaped this dual epidemic. We are humbled by the many who persist despite limited rest and respite, and whose stories, innovations, and leadership we are honored to witness and share. They have defined our generation, just as nurses in earlier crises have done: to lead through service to others as our highest calling.

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