

Speak truth to power and consolidate the nursing visibility gained during COVID-19

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Abstract

Aim: To provide a perspective on the visibility of nursing gained during the COVID-19 pandemic and propose strategic options for nurses to consolidate their expanded roles and influence.

Background: The COVID-19 pandemic has exposed long-standing inequities across the world. Factors preserving discrimination weakened during the emergency are now being re-established by neo-liberalist influences that dismiss the true scale of the disaster and shape the narrative in ways that increase public risk and render nurses invisible.

Sources of Evidence: All evidence drawn from publicly available sources is presented through the lens of the authors' nursing, management, education, policy and research experience.

Discussion: Nurse advocacy will be needed during future decades of pandemic control and recovery and be in a position to deliver appropriate care and services.

Conclusion: For nurses at all levels to remain visible, important, valued and respected, they need to be informed, engaged and willing to make a stand to preserve the hard-won reputational gains of the last 30 months of the COVID-19 pandemic.

Implications for Nursing Practice: Nurse advocacy and engagement are needed to maintain public awareness of the ongoing risks and safety options associated with the pandemic.

Implications for Health and Social Policy: Nurses and other health practitioners need to reveal the true level of devastation that continues to occur and guide the focus of political and administrative strategies in response to COVID-19 impacts on services and public health orders.

KEYWORDS

Capacity building, COVID-19, nursing role and scope, power, visibility

Picture of Dr Tracey McDonald AM PhD FACN taken December 2021 (see over)



INTRODUCTION

The COVID-19 pandemic has disrupted the status quo in every country. As occurs with all disasters, local and international power has undergone significant redistribution of wealth along with a re-shuffling of social values, relationships and reputations. The pre-2019 social and industrial inequities exposed during this pandemic have alienated many people who must now rely increasingly on charity and welfare agencies for basic provisions (Power et al., 2020). Nurse advocacy during this time has helped families and others to find ways to adapt to their changed situations and minimise COVID-19 transmission while supporting those in isolation and misery.



The frontline of national responses to the pandemic continues to be populated primarily by nurses, with episodic, valuable contributions by other health professions and support staff. The significant contribution of nurses has become too obvious to be ignored. From a standpoint theory perspective (Borland, 2020), nurses and midwives have greater access to insights and information about human relationships and the natural world of the society in which their patients live, than those in more esoteric circles. Such expertise alone presents opportunities for nurses to get involved with public health and hospital policies, implementation protocols and strategies around screening, limiting transmission, managing quarantine and building immunity. Nurses' input has been pivotal to good health policy, job and service context redesign, setting research priorities, research translation for producing and refining guidelines and protocols for nurses and colleagues responding to pandemic-related emergencies.

First-generation vaccines (those developed for the first-generation variants of the SARS-CoV-2 coronavirus) have helped to reduce the seriousness and duration of symptoms and curtail coronavirus transmission. In the latter half of 2022, it is anticipated that more significant control over the morbidity and mortality associated with COVID-19 will occur as second-generation vaccines are made available, and provided that coronavirus antigenic shifts do not produce other more lethal variants. Widespread media speculation is that the pandemic will soon abate and the world will return to the way it was pre-2019. Such media and political commentary refers mostly to the reported numbers of cases and hospitalisations, the desire for economic recovery, and the previous social stratification of work and power hierarchies. The core ideas appear to resurrect policies that maintain those social disadvantage factors that move wealth to the upper 5%–10% of societies, while lower paid workers subsidise national productivity by accepting lower wages in fragmented, risky and uncertain employment (McDonald, 2017).

Opportunities arising from the disruption caused by the pandemic need to be grasped before they are lost. Long-standing inequities, weakened during the emergency, are currently open to change and the implementation of more fair and equitable systems and policies (The Smith Family, 2020). It is these opportunities and strategic options that are canvassed in this article.

CONTRIBUTORY FACTORS TO INEQUITY

An understanding of factors that promoted inequities in the pre-2019 environments helps when thinking about nursing relevance and visibility as a consolidated asset going forward, and the need for nurses to remain active and visible on the front-line of the pandemic response.

The COVID-19 pandemic has triggered a resurgence of neoliberalism (Vincent, 2009), which is associated with capitalist economic principles where market forces dominate. It is an ideological framework ostensibly set up to build interna-

tional prosperity, but in reality, since the 1880s, it has operated as a mechanism for polarising wealth and poverty and exploiting the many to serve the few (Bloom, 2017). The emphasis on protecting entrenched pre-2019 financial and industrial mechanisms that favour elite groups became apparent during the pandemic, and have influenced pandemic response policies and resource distribution decisions by various levels of national governments.

Many governments appear to be complicit in normalising inequities and maintaining market levers that advantage one end of the spectrum, for instance, taxation systems and industrial regulation that have made no long-term adjustment for changed conditions (Haymes et al, 2015). Other government controls include participation in shaping market demand, such as identifying and mandating a commodity that advantages one supplier over another, for instance, approving vaccines produced by particular companies. Governments also endorse some professions while excluding others from consultation and technical advice on science, health, services and safety. For example, physicians are invited to publicly support government communication about pandemic issues, yet advice from nurses and allied health practitioners is dismissed as irrelevant or subsumed under medicine.

INVISIBILITY

Nurses provide the major portion of direct health services and coordinate other patient care and services in precarious workplaces. Their innovations in protocols and treatments keep the health care system operating and up to date with the science of COVID-19 as it becomes available – yet they are rarely visible in pandemic response forums. Nurse visibility in data collections is often aggregated within categories such as 'multidisciplinary teams' or 'health workers' rather than specifying 'registered nurses', 'nurse practitioners', 'advanced practice nurses', 'midwives' etc. Even in pandemic mortality data, nurses are not always visible as a category and nor are the consequences of high nurse mortality presented as an issue of concern other than as a prospect of service failure due to lack of staff (McDonald, 2020).

Any group of the population that is invisible to the public and to government is vulnerable. The circumstances that produce vulnerability stretch back over many years of accumulating disadvantage to the point where group invisibility becomes normalised within a society. Darab and Hartman (2013) describe the situation of entrenched invisibility in data, understanding, programming and policies around a particular situation. Their theory is useful when analysing how nursing has endured generations of similar invisibility despite being central to public health success and national productivity. Various descriptive efforts to define nursing as a disadvantaged group have produced some visibility within the health workforce, but while we remain under-resourced and managed by other professional groups, that vulnerability will continue. As an editor, I notice that some authors refer to these highly qualified, skilled and experienced nurses as 'staff', 'nursing staff'



and even 'our staff' rather than to acknowledge their professional titles of nurse, nurse practitioner, midwife etc. Self-aggrandising writers who refer to nurses as a homogenised group help to solidify our status at a low level. It is interesting that the medical profession delineates itself according to medical specialisations and practice contexts, whereas nurses are more often treated in policy, management and education decisions as standardised and interchangeable.

The gendered nature of rationales used by various government and industry bodies to resource nursing practice, research, innovation and education also contributes to the silencing of nurses (Aslan, 2021). Justification for limitations placed on professional nurses and their practice scope often includes economies of scale issues and also planned substitution of parts of nursing work. Nurses and midwives form 60% of the health workforce across the world (World Health Organisation, 2020), and 50% of the health workforce shortages are nurses and midwives. If the Sustainable Development Goal 3 on Health and Well-Being is to be reached by 2030, an additional 9 million nurses and midwives will be required in the next five years.

Cuts to health services invariably include cuts to nursing personnel because of the large employment numbers involved where reductions are less visible in the budget. Also, the lack of detail about the identities, personal expertise and professional profiles of individual nurses contributes to their 'invisibility' within the system. In financial administration terms, nursing is usually considered as one budget line referring to nursing services rather than to the different nursing specialisations and qualifications. Population health and well-being has little to do with these administrative choices. Decisions about the number and remuneration of nurses employed contribute significantly to the administratively planned restrictions on the number of qualified nurses across the globe, a situation crying out for scrutiny and accountability regarding the negative impact such decisions have on public health outcomes and national productivity.

SYSTEMATIC EXPLOITATION OF NURSES DURING A CRISIS

During the pandemic and throughout the ages, nurses have shown their determination to work in the best interests of the general public, and a willingness to adapt their interventions to provide support to people in need. Internationally, 70% of the health workforce are women. Nursing and midwifery account for a major portion of the female labour force (World Health Organisation, 2020). Since the beginning of the pandemic, a groundswell of public awareness has supported the ascendancy of work traditionally taken for granted, predominantly performed by women in nursing, child care, aged care and other support services crucial to the survival of all. A resounding example of exploitation is the gender pay gap. Over the past two years of pandemic, the gap between remuneration of men and women for the same work has widened (Payscale Research, 2021)

Evidence of nurses being exploited can be found around the world. The list of anecdotal incidents below is but a small part of what is happening in many workplaces across the world:

1. Real wages have not been increased and no hazard pay offered for COVID-19 direct care work
2. Workers' compensation access has been tightened because of higher risks of pay-outs during the pandemic
3. Substitution of nurses with lower paid, less skilled personnel and students
4. Demands by employers for nurses to use their accumulated recreation and long-service leave for COVID-19 furlough and illness
5. Employer demands for nurses on COVID-19 furlough to return to work before the recommended safety period
6. Nurses expected by their employers to pay for own PPE, vaccination and antigen tests
7. Poorly managed health services resulting in nurses being coerced into working unpaid overtime, double and triple shifts at short notice and for no extra pay
8. Nurses being fired because they would not comply with unreasonable directions that increased their risks of infection and injury
9. Boards of management not being held accountable for their resourcing policies and workplace safety decisions.

It is not surprising that nurses are resigning in large numbers because of the risk of working in under-resourced and often mismanaged health organisations. In the United States of America, the health care sector has lost around half a million workers since February 2020 (Young, 2021). Similar stories abound in other countries that transparently report what is happening locally. Vacuous displays of gratitude by political leaders and administrators have done little in terms of redressing previously entrenched disrespect for nurses and other front-line workers.

DATA, MEDIA AND POLICY VISIBILITY

Undignified haste by international governments and global industries to restore equity barriers weakened by a few years of emergency measures is occurring. Tactics to re-establish power and vulnerability relativities and achieve a 'snap back' to pre-pandemic inequities are underway. Already, nurses are beginning to disappear from view as advisers and spokespeople for providing updates to the general public on COVID-19 issues, immunisation, quarantine and public health order protocols. Politicians and elite medical and academic voices are replacing nurses in high-profile forums and bulletins.

Nurses everywhere must resist being relegated to sentimental 'hero' status or as 'warriors' protecting their communities. Such tactics are manipulative in encouraging nurses to accept less remuneration, to work without complaint in unnecessarily precarious working conditions and to forgo financial acknowledgement as a measure of respect shown by employers, governments and colleagues. While public perception of



nurses and nursing has been positive, the professional standing and image of nurses as skilled clinicians has not advanced in any permanent way. Nurses have gained little recognition in the areas of pandemic management, scientific advice or information on pandemic issues, nor have many nurses been welcomed into health policy or service planning and evaluation forums.

In policy visibility terms, clinical nurses need to capitalise on their current media visibility and their clear relevance to public health, and clinical leaders need to be more active in demanding the review and renegotiation of past policy and employment frameworks. For instance, nurses everywhere could initiate or review local regulation and legislation to ensure their workplaces and work systems are reasonably safe. Nurses are justified in insisting that their remuneration be geared to the importance of the work undertaken, that is, fair remuneration for skills, experience and risks associated with work. They need to ensure that workers' compensation guarantees are strong, and that access to individual and collective promotion is based on merit and experience. Nurses' individual and collective employment contracts could be reviewed and strengthened against unfair and unconscionable demands, and that employment certainty is made more stable.

POST-PANDEMIC VISIBILITY

The current pandemic statistics are catastrophic, with over 6 million reported deaths – despite the real number being estimated at many times greater. Wang et al. from the COVID-19 Excess Mortality Collaborators have exposed the extent of under-reporting of mortality statistics across the globe, re-setting the total estimated mortality from COVID-19 at 18.2 million so far. This equates to around 120 deaths per 100,000 of the all-age population. The largest numbers of unreported pandemic deaths were in India, the United States, Russia, Mexico, Brazil, Indonesia and Pakistan. The highest gap in under-reporting was in Russia at up to 378.4 deaths per 100,000 population, instead of the 228.1 per 100,000 population reported (Wang et al., 2022).

Nurses have been at the forefront of pandemic responses, but when the magnitude of the challenges faced by front-line health professionals and service managers during 2020–2021 is not accurately reported, the work and effort of nurses and all health workers is hidden, some might even say trivialised. As a general rule of thumb in disaster management, for every death there will probably be around ten people who are left injured or otherwise traumatised. On this general calculation, we could be looking at almost 182 million people worldwide who are currently suffering and living with damage caused by the pandemic. In addition, nurses expect to remain available to assist non-COVID-19-affected patients with all of the other health conditions that occur.

Recent evidence that COVID-19 causes cerebral deterioration adds to the concerns about ongoing morbidity associated with the pandemic (Bernhard, 2022). Results from

that recent Oxford University study indicate that even mild cases of COVID-19 can result in grey matter damage in memory and emotion centres as well as sense of smell (Reuters, 2022). Nurses know that the long-term sequelae of COVID-19 includes chronic conditions acquired through this disease, cardiac, endocrine and other system deteriorations, mental health breakdowns from the stress endured, social deterioration for vulnerable people and groups displaced by the pandemic, and potentially a global surge of people suffering post-infection cognitive decline even from mild COVID-19 cases. Projections of demand for long-term care and support will depend on whether these brain changes are progressive and if they can be minimised with treatment.

While this impending burden of demand for care, support, treatment and protection may be less than in early years of the pandemic, any effective response will need nurses as clinicians, researchers, clinical managers, educators and policy-makers if it is to be brought under control. In each of these areas of practice, nurses must ensure that contemporary clinicians and credible leaders consolidate nursing relevance and leadership in relation to public profile, practice scope and transferrable skills gained during the pandemic response.

We cannot allow our profession to be designed and managed by others who have shown little appreciation of nursing's fundamental roles and value and who undermine nursing status as clinicians and innovators by starving us of essential resources and acknowledgement of nursing's contribution to public health and national productivity. Together, we can stop further encroachment on the gains made in health impact and ensure that nurses' contribution is acknowledged in ways that assist their ongoing efforts to develop and extend the scope of nursing practice to meet the health and well-being needs of our societies.

To achieve these goals, we need new thinking such as a policy framework that will focus on 'the principles of visibility, capability and accountability' (Darab & Hartman, 2013, p. 33). The starting point has to be truth-telling about the extent of the pandemic and the death and damage it is causing – and accurate reporting about the work nurses and their colleagues are doing against overwhelming odds. In this way, we can consolidate visibility gains made in policy, public health data, program funding and positive health gains for patients and societies throughout the pandemic. Returning silently to the invisible and mostly unnamed, substitutable cohort of underpaid and underrated workers who permit gender and work pay gaps to continue as if normal, is not an option. The general public relies on nurses to speak truth to power to ensure that those who are in dire need of the full range of nursing services have access to them.

CONCLUSION

Nurses have responded to the pandemic with skill and determination, and their efforts to protect and health their societies



have not gone unnoticed worldwide. While the personal cost for many nurses has been high, they have endured the hardship for the benefit of their patients. It is now time for nurses to consolidate the visibility and respect, earned over the past few years of the pandemic, and ensure that previously inequitable systems and policies are not reinstalled along with entrenched inequities of the past.

If we want our profession to remain visible, important, valued and respected, we must all be informed, get involved and take a stand to preserve the hard-won nursing visibility gains of the last 30 months of the COVID-19 pandemic. Part of that effort will be to maintain public awareness of the ongoing risks associated with the pandemic and to reveal the true devastation that continues to occur when political will and focus becomes distracted. Nurse advocacy will be desperately needed during the decades of pandemic control, recovery and adaptation that lie ahead. Global pandemic recovery depends on ensuring that nursing is in a strong position to deliver appropriate care and services in partnership with many others working towards this goal.

IMPLICATIONS FOR NURSING PRACTICE

Nurse advocacy and engagement are needed to maintain public awareness of the ongoing risks and safety options associated with the pandemic. Nurses also need to ensure that they have the authority and influence to be able to deliver nursing care to the required patients. Nurses, in their own right, need to pursue nursing visibility in data, media and policy so that they can set a strong direction for their own profession.

IMPLICATIONS FOR HEALTH AND SOCIAL POLICY

Nurses and other health practitioners need to speak truth to power and clearly reveal the continuing devastation. The focus of political and administrative strategies in response to COVID-19 impacts on services and public health orders. Nurses as the front-line implementers of this public policy need to be aware, visible and outspoken.

AUTHOR CONTRIBUTIONS

Tracey McDonald is the only author involved with the development of this paper.

ETHICS STATEMENT

The article adheres to the ethical principles of the Declaration of Helsinki. All information has been taken from publicly available sources.

AUTHOR QUALIFICATIONS AND HONOURS

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