Editorial / He Whakaaro nā te Ētita

COVID-19's missing heroes: Nurses' contribution and visibility in Aotearoa New Zealand

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Introduction

Although COVID-19 caught almost all countries unprepared, each country has responded differently to a novel virus that has now caused the death of over five million people worldwide (Johns Hopkins University & Medicine, 2021). Prior to the Delta outbreak (August 2021), the strategy adopted by the government of Aotearoa New Zealand was elimination. This strategy effectively eliminated COVID-19 twice from the community (Stockman, 2021), leading to fewer restrictions and less impact from COVID-19 than has been seen in other countries. The message of 'go hard, go early', which encapsulated the goal of elimination, resonated worldwide for its success, and Aotearoa New Zealand became the envy of the world. Many of my own friends and family overseas would tell me, without prompting, that they would rather be here in Aotearoa New Zealand during this pandemic.

Many commentators have watched Aotearoa New Zealand's response to COVID-19 closely, looking for lessons to be learned. The success of the COVID-19 response has been attributed to the empathetic and decisive leadership of Prime Minister Jacinda Ardern; effective communication with the public; national unity; strict border-control measures, and the use of genomic sequencing for testing and tracing (Baker et al., 2020; Cumming, 2021; Jamieson, 2020). So far, decision-making at the highest levels of government has received the most publicity in Aotearoa New Zealand. The media have particularly singled out Prime Minister Ardern; the Director-General of Health (Dr Ashley Bloomfield); the Minister for COVID-19 response (Chris Hipkins); and the Minister of Finance (Grant Robertson) for their science-based and measured approach to the crisis. It is unclear whether nursing representation exists in the key policy deliberations and decision-making about the national COVID-19 response. However, the Ministry of Health, under which nursing falls, is responsible for implementing health-related decisions and policies.

The lack of nursing visibility on Aotearoa New Zealand's COVID-19 key decision-making table may have affected how the media have covered nursing. The role of nurses in the fight against COVID-19 has remained largely hidden, a scenario that is in stark contrast to the publicity that nurses have received in other countries. In countries such as Canada, Denmark, France, Italy, the UK, and the US, nurses have been elevated to heroic status (Bagnasco et al., 2020; Gagnon & Perron, 2020; Halberg et al., 2021; Hennekam et al., 2020; Jones-Berry, 2020; Sainato, 2021). Nurses in these countries have been publicly valorised through gestures such as public standing ovations, public clapping, and a Banksy artwork in the UK.

Nurses' contribution to the COVID-19 response

Throughout the COVID-19 response in Aotearoa New Zealand, nurses have demonstrated professional values of commitment and compassion, proactively responding to the needs of the communities. Articles in this *Nursing Praxis* Special COVID-19 issue are a testament to the range of work undertaken by nurses. Prior to the first national lockdown in March 2020, there were concerns about the country's capacity to contact trace, test, and manage high numbers of patients in hospital settings (Baker et al., 2020; Cumming, 2021). In response to these concerns, the Ministry of Health, through the Nursing Council of New Zealand, released a statement calling for assistance from nurses, including from those who

were inactive or with lapsed practising certificates (in this issue: Blunden & Poulsen, 2021). Many nurses answered this call and returned to the workforce, undertaking further training as required to work in contact-tracing, COVID-testing stations, testing work, and in specialised units such as intensive care units (ICUs) and emergency departments (EDs). Nurses working in general practices had to adapt to virtual consultations, losing the critical component of in-person patient-nurse interaction in their practice. The disruption experienced in nursing education, including student nurses' clinical placements, meant that nurse educators had to provide pastoral care to distressed students (in this issue: Winnington & Cook, 2021). In aged residential care facilities (in this issue: Hughes et al., 2021), where most of COVID-19 mortality occurred, nurses had to implement policies that restricted family visitations and so they became proxy family members for isolated and dying residents.

Challenges faced

In the early days of COVID-19 in Aotearoa New Zealand, there was inconsistent information about COVID-19's transmission mode. Nurses working as essential workers had to take extra precautions such as doing their laundry separately from those of their household and maintaining distance from those they lived with. Coupled with the concerns around the supply and distribution of personal protective equipment (PPE) in some settings, nurses experienced fear of exposure, an altered sense of safety and a sense of isolation, even when in the same bubble with their families (in this issue: Cook et al., 2021; Jamieson et al., 2021). This increased anxiety and fear for nurses and their families.

Alongside the unprecedented challenges posed by COVID-19, nurses also had to deal with longstanding issues of chronic nursing shortages, unfair pay, and unsafe nurse-patient ratios (Jones, 2021). The pandemic intensified these challenges, leading to industrial disputes, high workload, and burnout. The shortage of nurses across the healthcare sector has seen considerable movement of nurses and high attrition, particularly for new graduate nurses. Nurses working in publicly funded district health boards (DHBs) are paid more than those working in aged residential care, leading to high turnover of nurses in aged care settings, and burnout for nurses who remain in this sector. COVID-19 has perpetuated these longstanding issues and increased the marginalisation that exists within nursing.

Nurses' invisibility

The spectacular success of holding back the spread of community infection meant that the public discourse in Aotearoa New Zealand was not focused on the health sector, but on the whole community. The 'team of 5 million' became the heroic slogan. Compared to other countries, there was a prolonged period of normalcy in public life. The capacity of the healthcare system (at the time of writing) has also not been stretched beyond its capacity. The media's focus on the decision-making prowess of the government and the low impact of COVID-19 in the country intensified the invisibility of individual sectors such as the health sector. Nurses' contribution to the vaccination drive, contact-tracing, testing, protection of aged residential care residents, and management of COVID-19 patients was overshadowed (in this issue, Hughes et al., 2021; Smith et al., 2021).

Since COVID-19 was apparently well managed, there was limited perception of a crisis by the public. According to Franco et al. (2018) heroism narratives are commonly used during crises in relation to people who take actions to further the well-being of others, despite the possibility of personal risks. Arguably, the efforts of nurses during this pandemic meet the criteria for heroism, but this was not visible. Indeed, the only media publicity invoking hero terminology was in relation to Jenny McGee, a New Zealand-born nurse who provided nursing care in ICU to the Prime Minister of the UK (Boris Johnson) when he became unwell from COVID-19 (Moodie, 2020).

Conclusion

The visibility of nursing matters. We cannot afford to sit on the side-line on issues that affect our professional obligations, duty of care, welfare, and image. Nurses are the largest health workforce across all healthcare sectors and communities and need to embrace opportunities to provide narratives and showcase nursing's contribution to the COVID-19 pandemic in Aotearoa New Zealand. While the hero discourse portrayed has raised the profile of nursing in some countries, the context is often limited to high acuity work and vaccinations, while the work of nurses in primary health care and Māori, and Pacific, health providers (in this issue: Davis et al., 2021; Smith et al, 2021); mental health and addiction

services; and aged residential care remains invisible. Nursing now needs to use its collective voice, influence, and research to seek out and highlight the contribution of the nursing workforce; the challenges faced to maintain their own health and wellbeing; efforts and barriers in promoting equitable health outcomes for patients and communities; and their position in key policy decisions at national, regional, and local levels.

As we deal with the surging Delta variant and prepare for emerging variants (such as Omicron) the question for nursing is whether we want to continue in our roles as implementers of policies that are handed to us. Or whether we want to use our size and influence as leverage for representation in places where decision-making that affects our practice, welfare, and profession are being discussed. In part, this will depend on how much success we achieve in showcasing our contribution to the COVID-19 pandemic.

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