“The World is Stopped, but We Keep Going”: Nurses’ Processes of Emotional Labor During the SARS-COVID19 Pandemic

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Abstract

Background

Under normal conditions, nursing requires a substantial amount of emotional labor. Past studies have found that nurses hide their emotions in order to embody a professional demeanor and display competence. There is little known about the CoVID pandemic's impacts on nurses' emotional labor, so this study examines nurses' experiences during the pandemic and analyses the pandemic's effects on the nurses' emotional labor.

Results

After interviewing 15 CoVID nurses, I conclude that a majority (13/15 nurses) of the study participants felt fearful of their situation, yet they felt compelled to go to work because their duty to care for their patients. The nurses were only able to make the decision to go to work and fulfill their perceived duty because they were suppressing their fears.

Conclusion

I conclude that the nurses perform a slightly different version of emotional labor than what has been conceptualized by Hochschild (1979). In this process of emotional labor, the suppression of feelings forms the main action that is taken to meet external expectations that include a healthcare worker's duty to care. The implications of this study suggest that nurses prioritize work over mental and physical health while not having the support systems needed to help them when they need it.

Introduction

And I'm looking around, and then I peek in a window, which peers into the OR. And I see these patients, every single one of them in all four operating rooms. Everybody is on a ventilator. And I'm sitting there, and I'm looking around. I'm like, "Oh, my God. Like if this is not our war, then I don't know what it is. This is our 9/11. This the medical community's 9/11". Based on the sheer number of patients. And the fact that we had nowhere to put anybody, you know. Like it was just a scale beyond—it was a scale beyond your imagination, like anything that you can think of. I never thought in-at any point in time during my career would I ever see anything like this. But yet, here I am.

(Nurse Ryan, 35 y/o male identifying Nurse Practitioner with 11 years of experience)

*All of the names used in this study are fake names in order to maintain confidentiality

Nurse Ryan is describing the scene that many nurses faced while they were working during the CoVID pandemic. In late January, New York discovered some of its first CoVID patients. In the weeks and months

that followed, New York City and its surrounding suburbs became one of the initial epicenters of the disease (Van Bakel and Simon 2020). With CoVID patients entering the hospitals, doctors, nurses, and additional hospital staff found themselves on the frontlines of the pandemic.

Little is known about these frontline workers' reactions to the pandemic, or what their experiences of working were like. Perhaps the event most comparable to the 2019 CoVID pandemic is the Influenza Pandemic of 1918 (Webel and Freeman 2020). Yet, the scale of 1918 pales in comparison to CoVID. More contemporary but less pervasive comparisons can be found from the HIV/AIDS and SARS outbreaks that have occurred in the past few decades, but little research exists about nurses' experiences working with these diseases and risking their lives. As CoVID has spread to the far reaches of the public, nurses and other healthcare workers are finding themselves working with increasing numbers of infected patients and facing exposures from more sources.

To understand how nurses are experiencing CoVID and navigating the decisions to come to work in this unprecedented time, 15 nurses from New York City and a nearby suburb were interviewed. These interviews provided insight into the nurses' processes of emotional labor during the pandemic. The nurses revealed that they felt fear and anxiety from multiple sources, but there was often not a way to mitigate their fears. Further, though the nurses were scared of the virus they were facing at work, they felt a duty that compelled them to minimize their fears and go to work.

Literature Review

Emotional Labor in Nursing

Hochschild (1983) coined the term "emotional labor" as the management of feelings to ensure that public appearance complies with societal norms. Outside of the private sphere, the job spheres that routinely require emotional labor skills are typically occupied by females: care work and service work (Rasmussen and Sandman 2000). The most heavily studied jobs that involve emotional labor include teaching, nursing, and service work such as flight attendants and retail workers (Hochschild 1983; Bolton 2001; Hunter 2001; Brotheridge 2004; Naring, Briet and Brouwers 2006; Huynh, Alderson and Thompson 2008; Wharton 2009). Care work will be expanded upon in the forthcoming sections, but, put simply, it is the work that prioritizes tending to the emotional and physical wellbeing of others (England 1999).

In compliance with the standards of a dichotomous and gendered society, emotional labor is not compensated (Hochschild 1983; Glomb and Tews 2004) and is often made invisible (Staden 1988; England 1999; Clow et al. 2014; Crain, Poster and Cherry 2016). In addition, emotional labor is a very difficult process and often hurts the performer (Hochschild 1983; Huynh, Alderson and Thompson 2008). From their survey of graduate students and employees of a variety of sources including a hotel, a healthcare organization, an assisted living home, and a metropolitan police force, Glomb, Theresa and Tews (2004) would add that when people feel the need to act in a way that does not align with their emotions, they can experience higher levels of emotional exhaustion or burnout.

Emotional labor is typically broken up into two actions, surface acting and deep acting (Hochschild 1983). Surface acting, matching an outward appearance with societal expectations while feeling the opposite of what that appearance is conveying, is very physical and often only involves facial expressions and body language and that does not match with the internal state (Crego, Martinez, Tschan 2013). The more involved option is known as deep acting, or an attempt to match one's feelings to the feelings that are expected in a given social context (Huynh, Alderson, and Thompson 2008).

Hochschild (1983) alludes to the effort it takes to perform emotional labor: creating, hiding, or pushing down a feeling. However, she grounds her emotional labor theories on the role of performing feelings, and the element missing from her conceptualization is an expanded discussion on the *suppression* of feelings. It is often the case that a performance of feelings, whether it is surface acting or deep acting, can only follow the suppression of other feelings. Therefore, emotional labor is a two-step process. Presently, the literature on the initial step of suppression is present but lacking in nuance. This study will add to the complexity of the literature on emotional suppression and the factors influencing decisions to suppress emotions.

Most, if not all, nurses' daily routines include emotional labor in some form (Froggatt 1998; Staden 1998; Bolton 2001; McCreight 2005; MacKintosh 2007; Huynh, Alderson, and Thompson 2008). In a survey of 128 first year nursing students, Poole and Isaacs (1997) found that most nurses saw emotional labor as an appropriate and expected part of their job. Brilowski and Wendler (2005) put it succinctly when they concluded that the important components of nursing are mainly touch, presence, and competence. However, nurses are faced with conflicting values and goals. Nurses are expected to provide a comforting presence for their patients, but they are also expected to be a degree removed from their true emotions to maintain their professionalism (Bolton 2001). The stressful, demanding, emotional, and, at times, traumatic nature of nursing leads many nurses to attempt to suppress their own emotions to be able to work and maintain what is considered a professional demeanor (Staden 1998; Bolton 2001; Huynh, Alderson, and Thompson 2008; Vogus, Gabriel and McCelland 2020). Some nurses may even refer to this process as "putting on a mask" or "switching on and off" (Bolton 2001; Henderson 2001). In other words, nurses that perform for their patients must not only *hide* their feelings by wearing a "mask", but attempt to separate from these feelings when they "switch on". When nurses return home after work, they often turn to "leaving things behind" as a coping mechanism for the stressful nature of their jobs (MacKintosh 2007).

At the forefront of these decisions and behaviors are the professional expectations that inform what nurses deem to be acceptable conduct. Many of these expectations often stem from a dichotomy separating emotion and reason from each other (McCreight 2005). In other words, nurses may be perceived as acting with little logic if they allow themselves to reveal their emotions. Bolton (2008) would add that the "professional demeanor that distances them from distressing situations... simultaneously anchors their emotional presence and commitment during their caring work". In sum, nurses may choose to suppress and distance from their emotions for a multitude of reasons, and this process comprises a significant part of their emotional labor.

Nurses perform many tasks throughout their shifts. Some of these tasks can be categorized as care work. Close and intimate in nature, this work is focused on meeting the needs of vulnerable populations such as children, the elderly, and those in hospitals or rehabilitation centers (England 1999; Folbre 2006). Here, these populations assume the role of consumers of care work. Similar to other consumer focused jobs, care work tends to be an unequal relationship between the providers and recipients; where the recipient's needs are often prioritized over the provider's (Wharton 2009).

Care work differs from other forms of consumer-based jobs in that it encompasses both the paid and unpaid spheres of labor. It includes tasks done in the home such as cooking, cleaning, and childcare. In the paid work realm, care work can take the forms of teaching, elder care, and nursing, among other occupations (Folbre 2006). Folbre (2006) claims that the quality of someone's care work is directly associated with more genuine feelings towards those in their care. On one hand, Wharton (2009) argues that providing care is a satisfying and rewarding experience for the provider, and nurses do report enjoying close relationships with their patients (MacKintosh 2007). Yet, contrary to Folbre's (2006) claims, nurses will perform emotional labor and use suppressive and distancing techniques on their own feelings to best ensure the physical and emotional well-being of their patients (Henderson 2001). The literature has yet to reach a consensus on whether best nursing practice involves a calculated aloofness or a personal involvement (Bolton 2001).

Much of the literature on nurses and care work fails to recognize the scope of medical knowledge that is needed for optimal nursing. Instead it focuses on the emotional stakes of care work. For example, in the literature exploring what nurses think it means to be an "ideal nurse", many of the conclusions are founded solely upon a nurse's emotional presence: helping, caring, empathizing, a "giving of self" (Brilowski and Wendler 2005). While medical knowledge and competence are not necessarily omitted, it seems that a larger weight is placed on the more emotional components of nursing. Some may argue that the studies focused on care work in nursing are intentionally omitting the medical knowledge component as these studies are more interested in the emotional and metaphysical aspects of work. On the surface, this logic is sound. Upon closer examination, there are two large flaws in this line of thinking. The first is that the emphasis of emotional work coupled with the invisibility of technical knowledge and skills is further reproducing the gendered nature of care work. Secondly, it seems shortsighted to withhold an examination of the intersection of nurses' care work and performing medicine with competence. Given the vital role that medical knowledge plays in everyday nursing and many studies' previous disregard of this nursing component, this study is attempting to close this gap by examining nurses' duty to care and the pressure to perform medical procedures in the face of a pandemic.

The theories from emotional labor are based on societal expectations and the belief that workers perform the emotions expected of them in their workplace despite their feelings. Attempts to operationalize emotional labor in jobs have not been sufficiently holistic (Wharton 2009). There are complexities in the emotional labor of nursing that are missed when scholars have generalized findings from other occupations. Further, in existing research, emotional labor is often broken down into distinct categories (i.e. professionalism, suppression, acting, hiding emotions, and burnout) that attempt to silo the

subtleties of this process (Bolton 2001; Naring, Briet and Brouwers 2006; Crego, Martinez and Tschan 2013). As a result, many of the nuanced facets of emotional labor, such as the differences in a nurses' approach to emotional labor in various situations, are lost. To expand the conceptualization of emotional labor, its intersection with care work must be examined. This study explores how the emotional labor of preparing for care work is made complicated by the contextual expectations of working with CoVID patients during the pandemic.

Duty to Care in Crisis

In past public health crises, medical professionals were often faced with difficult dilemmas about risk, sacrifice, and moral responsibility. When a surge in AIDS cases plighted U.S. hospitals in the 1980s, nurses found themselves at the frontlines of a sparsely researched and, at the time, deadly disease. As Sherlock (1983) describes, nurses were largely motivated by their fear of AIDS; even if this fear was, in Sherlock's (1983) opinion, largely unfounded per the guidelines given by the Centers for Disease Control and Prevention. Like past outbreaks and public health scares, HIV/AIDS complicated the notion of a healthcare provider's "duty to care" because their own lives were at risk (Reid 2005). SARS is another example. The 2002-2003 SARS outbreaks put healthcare workers face to face with a highly contagious and potentially lethal disease (Johns Hopkins Medicine). Emmanuel (2003) concluded that healthcare workers responses to the SARS outbreak were partly informed by decisions made during the earlier HIV/AIDs epidemic of the 1980s; when healthcare workers risked their lives in order to treat their patients.

For healthcare workers, the decision to care for patients is complex process in a pandemic setting. There are social elements and pressures influencing the duty to care, and the biological component of working with and possibly contracting and spreading a potentially deadly disease works synchronously with the socially situated components of fear and duty (Reid 2005). This study attempts to unpack nurses' experiences upholding duty to care in a pandemic and the roles of fear and sacrifice in this experience.

There have not yet been many studies on healthcare workers' experiences during CoVID. Kabir, Boström and Kondrasen (2020) conducted a case study of a nurse working at a Swedish care home with CoVID patients. Like many healthcare workers in the U.S., Swedish care workers faced difficulties accessing personal protective equipment, or PPE (Bowden, Campanile and Golding 2020; Kabir, Boström and Kondrasen 2020). Their management had promised adequate PPE deliveries in a timely fashion, yet these promises were not consistently met and left many of the healthcare workers in dangerous situations. Without the proper PPE, nurses were risking their own lives and some, similar to the HIV/AIDS epidemic, were too fearful to enter CoVID patients' rooms. Like HIV/AIDS and SARS, CoVID is putting healthcare workers on the frontlines of a crisis, and with that, many questions arise about their well-being and experiences being in direct contact with the disease.

The notion that, as Mauss (1985) claims, "extreme events are marked by an excessiveness which allows us better to perceive the facts than in those places where, although no less essential, they still remain small-scale and involuted" cannot be overlooked in the context of nursing during the CoVID pandemic. As is evident in prior literature, nurses have been performing emotional labor long before CoVID hit U.S.

hospitals, and they will continue to perform it after the pandemic is over. Mauss' (1985) conclusions are relevant to today's CoVID crisis provides a magnified and intensified insight into the labor performed by nurses. The nurses and their stories provide information paramount to understanding how nurses experienced working during the CoVID pandemic. To further this exploration, the researcher must ask how nurses experienced making the decision to *go* to work in a pandemic.

Methods

The goal of this study was to gain insight into the experiences and perspectives of nurses working during the CoVID pandemic. Given the novelty of the virus and the lack of theories surrounding it, a qualitative, grounded theory approach allows for the development of new conclusions and findings. Each nurse brings their own positionality into their experiences with CoVID. The subjective nature of the experiences thus encourages a qualitative method to aid in an unhampered conception of the neoteric conclusions warranted from such an unprecedented time (More and Field 1996).

There were 15 practicing nurses interviewed for this study. Fourteen out of the 15 were registered nurses (RNs) and one was a nurse practitioner (NP). As the study's scope included any nurse who was working with or had worked with CoVID patients, the NP was included in the study. For the purpose of this study, the perspectives offered by the NP supported the findings from the larger study sample.

The nurses were recruited with a combination of convenience sampling and snowball sampling. A majority of the nurses were recruited through two of my close ties. These contacts were nurses in two different New York-based hospitals. One nurse was a nurse manager in a Manhattan-based hospital. The other nurse was an RN working in a hospital in a suburb close to Manhattan. They both asked coworkers if they would be willing to participate in a study about their experiences during CoVID. Those who communicated an interest in taking part in the research provided their contact information. I then texted them to confirm their interest and schedule the interview. The remaining 4 nurses were recruited through the snowball sampling from these initial nurses.

All of the interviews began in a similar way. With multiple family members and friends in the medical field, I was familiar with many of the experiences that the nurses communicated, so I knew how to focus my probes to extract the rich detail I was hoping to find. A majority of the contacts were established through my close ties, so it was relatively easy to establish a comfortable rapport with most of the nurses. However, I did note that many of the nurses commented on my age and young-sounding voice. While my medical contacts and public health experience equipped me with the appropriate background knowledge and medical jargon to build a rapport, the age differences may have influenced the interview relationship with some of the older nurses.

This study succeeded in recruiting and interviewing 15 nurses. Recruiting nurses would have been a difficult task without the added stress of a pandemic, and this task was made more difficult by CoVID. This hard to reach population has valuable insights on the experiences of a pandemic and accessing such information in the midst of the CoVID waves will help lay the foundation of the sociological-pandemic related research to come. The nurses' work experiences ranged from less than a year to over 30

years of nursing experience, so there is a variety of perspectives present in the study. These perspectives were encouraged through the study's qualitative, semi-structured interviews that allowed participants to share their personal experiences with rich detail.

While convenience sampling does allow easy access to participants, it can lack in holistic representation. Many of the nurses worked in one of two hospitals in New York; either at a large level 1 trauma center in a suburb close to Manhattan, or at a large teaching hospital in uptown Manhattan. The overall findings of the study were potentially swayed by the overrepresentation of nurses at these two hospitals. Two of the other nurses in the study were traveling nurses that worked at multiple hospitals in New York City, and these participants did mitigate a degree of the lacking hospital diversity.

Another strength of the study's population was the location of the hospitals. All of the hospitals represented in the study are based in either New York City or a suburb near Manhattan; places that were severely hit by the first wave of the pandemic (McMinn 2020). By targeting these hard-hit locations, the nurses' experiences with CoVID were potentially amplified and easier to obtain from interviews. It is important to note that the findings from this study were informed by the volume of cases in the areas of the nurses' hospitals. The study sample may have experienced more stress from patient numbers or increased intensity in their daily tasks. Fortunately, given the study's focus on emotional labor and nurse experiences, any chances of increased intensity in the nurses' reactions will provide a richer set of findings. However, it is possible that similar findings may not be seen in areas that had lower caseloads. Interviews were semi-structured with open-ended questions about the nurses' experiences working during the pandemic and their understanding of the phrase essential worker; giving the nurses the agency to discuss what they personally deemed to be important. The themes of importance in the interview guide were mainly (1) nursing before CoVID, (2) reactions to CoVID, and (3) conceptualizations of essential workers. Most nurses focused on the themes without prompt. If that was not the case, I would use a natural point in the conversation to change topics.

The aforementioned themes were largely influenced by informal discussions that I had with healthcare workers prior to the start of the study. The healthcare workers would express their anxiety about going into work while their hospital was inundated with CoVID patients, or they would reveal how they were not being supplied with adequate PPE. Even before this study began, the healthcare workers in my lifewere discussing how their hospitals were giving them one N95 mask per week (for reference, the CDC suggests that N95 face masks lose some of their protective ability following 8 hours of use) (CDC N.D.). Initially, the interview guide was almost solely based on these discussions. I was looking to explore and build off of the reactions and perspectives shared by the healthcare workers that I had spoken to. As the study progressed, additional literature about past epidemics, care work, and emotional labor were used to modify and develop new interview questions. The interview questions were used as a loose guide for the interview, and the gathering of rich detail was prioritized and often achieved with probes.

Lengths of interviews varied; ranging from 30 minutes to over 1.5 hours. Nurses have incredibly busy schedules, so it was imperative for me to fit the needs of the nurse's interview availability; even if that

meant just 30 minutes of their time. Participants were given the choice of a Zoom interview or phone interview. All 15 interviews took place over the phone and were recorded on two devices. One recording took place on Audacity, a computer recording and editing software. The other recording was done on a second phone. A majority of the interviews took place over the course of the 2020 year (April 2020 through October 2020). For the interviews that occurred later in the year, participants were asked to base their answers on their experiences in the March through May timeline.

All but one of the interviews were subsequently transcribed. There were 10 interviews transcribed by hand (used for the interviews lasting 30 minutes), and there were 4 interviews transcribed using an online transcription platform, Otter.ai. One interview lacked the audio quality necessary to transcribe the interview. Once the 14 transcriptions were completed, all transcripts were reviewed for accuracy. The final interview that was not transcribed was listened to carefully, and its important themes were written down and organized into the larger themes of the study. However, there were no quotes used from this interview in the findings section. Throughout the transcription and interviewing process, potential codes were created and modified. The final list of codes included descriptions of the mindset needed to go into work, feelings of stress and fear, essential worker, personal protective equipment (PPE), and mistreatment. After the transcription of the first 12 interviews, the coding process began.

The 14 interviews were coded on NVivo12. Each interview was read over once before coding began. Interviews were then read two additional times while being coded. There were two interviews that lasted well over 60 minutes. These interviews were read and coded three times. Once 12 of the interviews had been coded, more prevalent themes began to emerge such as nursing mindset, lack of PPE, conceptualizations of essential workers, and reactions of stress and fear. After all 14 of the interviews had been coded, prevalent themes were picked out and included in the final findings set if at least 12 out of the 15 nurses had mentioned it in their interview. For the interview without a transcription, it was counted as part of a code if one of its main themes was in accordance with a certain code. For example, this interview had a main theme of fear because the nurse discussed her fears about going into work, so that interview counted towards the “fear” code. The nurses who were not coded with the main themes were then reexamined and discussed in the findings section as a counterexample if their perspectives largely differed from the main themes.

Findings

The pandemic impacted the way that nurses performed emotional labor. This process of emotional labor was two-fold. The first step involved the nurses experiencing different manifestations of fear: feeling threatened, uncertain, worried, and out of control. By working during the pandemic, they were knowingly risking their own health and the health of their families. Regardless, the nurses still chose to go to work with CoVID patients. This next step was informed by the nurses’ perception of their duty to care. The nurses felt as though they needed to go to work. A pressure to work existed despite the risks, and the nurses often acted on this pressure despite how they might have been feeling. The nurses were only able to make this decision and fulfill their perceived duty because they were suppressing their fears.

Fear

There were 13 nurses out of the 15 that experienced fear from the virus. The following section details the different iterations of fear that were commonly expressed. The nurses communicated different sources of their fear: (1) anxieties about the uncertainties of the virus, (2) fear of the virus itself and the threat it posed, (3) and worry for their families.

In the beginning of the pandemic, perhaps the most stressful aspect of nursing was the lack of tangible certainties about the virus. Many nurses were facing constant stress from not knowing whether they had been infected. Nurse Annemarie, a 57-year-old female-identifying RN with 34 years of experience, works at a large, level 1 trauma center in a New York suburb, and she spoke about the weekly testing that the nurses go through.

You know, so you will have to wait days to find out if you have this virus or not, and like another nurse described it: it's like each day is day 1. You know, I could be negative yesterday and be exposed an hour later, and each day is day 1 for us. And now I worked yesterday, I'm gonna have to wait until next week to find out if I'm infected or not

In her description of waiting to find out if she had been infected the previous week, Nurse Annemarie describes feeling stress each day. There was very little that she could be certain about. Nurse Ryan, a traveling nurse practitioner who worked at two hospitals in Manhattan during CoVID, felt similarly. He also describes how the invisibility of the virus added to his fears.

Like, you were right in front of it, you were face to face with it. You know? And it was scary because I'm like, it's nothing I can see. It's nothing I know that's there. There's nothing tangible to it, right? ... When I first got down there, I'm like "well shoot if I got sick on my first day down there, I wouldn't know for four to five days", then four to five days would pass and like "all right, I didn't get infected on my first day there. I didn't get affected on my second day. Great". And like, that's how it was. So every day, you're looking for days backwards saying, "okay I didn't get it, and everything's good".

For the nurses, this source of stress did not wane. Even if they were not on a CoVID floor that day, there was still a chance of exposure at work from a coworker or an asymptomatic but positive patient. In the quotes above, both nurses are expressing a sense of a daily renewal of this particular stressor. While they were working, there was no relief from this source of stress.

In addition to the chronic stress of catching the disease, the nurses were equally concerned about the virulence of the virus. During the first leg of the early surges, around March and April, there was very little known about CoVID. Many of the nurses reported that there was no specific pattern to disease severity. As Nurse Ryan, the traveling nurse that worked in two Manhattan-based hospitals, discussed, there was no knowing who exactly would have a particularly virulent case.

I mean, I think generally speaking, I had the worry going down there. I knew that, you know, if I got sick... you just didn't know what it was going to do and... you didn't know what it was going to do, and who was going to do it to. You could have been fine and healthy and be sick as a dog in the ICU on a ventilator and knocking on Death's doorstep, or you could be totally fine. You just didn't know where it was gonna go. You still don't know what it's gonna do.

Similar to the previous stressor, there was little relief from this source of fear. The nurses had no way of knowing how they would react if they caught the virus.

What weighed the most heavily on nurses, more so than the chance of getting the virus themselves, was spreading CoVID to others, and in particular, spreading it to their families. Since the nurses would have days before knowing if they were positive, there was a very real possibility of them infecting their families. Nurse Tabitha, an RN with 9 years of experience, worked in a suburban hospital near the city during the pandemic. She was also pregnant during the first CoVID surge. Unlike many of the other nurses who only had to worry about infecting their families once they came home from work, Nurse Tabitha constantly agonized about exposing her child to CoVID while she was working.

I would say that, the thing that was weighing the most heavily on me is, you know, putting my unborn baby at risk and putting the rest of my family at risk because the thing is, it was everywhere. So no matter whether you were working on a CoVID floor or not, here you are walking into the hospital, exposing yourself and bringing it home.

Even with heavily stringent precautions, the chance of infection remained. Like the two other sources of fear, this source of stress could not be mitigated by anything short of stopping work. The majority of the fears felt by the nurses originated in the private sphere. They wanted to protect their families and themselves, yet the uncertainties of the situation made this goal very difficult to achieve.

Families caused an additional source of worry for the nurses. What would happen to their families if they did catch the virus? Outside of infecting their family, the nurses were very concerned for their family's wellbeing; more so than their own health. For example, Nurse Annemarie is worried more about her family's wellbeing than the prospect of her own death. When I asked her what she was most afraid of, she spoke about her family.

So of course I'm so scared. It's not for me, but I have a family. I have two little kids and I just, I don't fear for my life anymore. I'm scared because I have two little kids. What's gonna happen to them if something happens to me?

While she is still experiencing fear about the virus, Nurse Annemarie's fear is no longer directed at her safety. Rather, she realized that her family could be in trouble if she got sick from CoVID. Nurses are care givers both at work and in the home, and Nurse Annemarie displays her priorities as a care giver in her quote. Nurse Ryan had also thought about the possibility of dying. He details his worries about his wife below.

If something bad happens to me? Forget it. It's a good thing I have a good life insurance policy, but, I can't-I have to go home. There's no... I have to come home. I cannot get sick. I cannot. You know? But yeah, I mean, the anxiety. I mean, I have my own anxiety. And at one point, I literally wrote a paragraph in my phone, where the medical ID is, you know... it was like a fight like last words to my wife: "Know that I love you. And I'm sorry, but you'll be fine. Don't worry".

Their quotes suggest that the nurses, in addition to not knowing whether they would contract CoVID, felt another area of uncertainty in how their families would fare if they died from the virus. Both Nurse Annemarie and Nurse Ryan communicate desires to ensure their families are taken care of. Nurse Ryan even mentions his life insurance policy because the economic stability it offers assuages some of his anxiety for his family. A majority, if not the entirety, of the sources of anxiety mentioned thus far were unavoidable and uncontrollable when working face to face with the virus if the nurses were coming home to their families every day.

Out of all the nurses in the study, two were traveling nurses that lived in hotel rooms during their time as CoVID nurses. The rest of the nurses were living at home with their families. Nurse Mirabelle is a 49-year-old, female identifying nurse who was a contracted travel nurse during the first CoVID surge in March through May. In that time period, she worked as a medical surgery nurse at a medium-sized Manhattan-based hospital. She did not experience additional stress when she was working with CoVID patients, and she attributed her lack of anxiety to two things: (1) living in a hotel room away from her family and (2) seeing most of her patients, many of whom had mild cases of CoVID, recover. Nurse Mirabelle did not worry about infecting her family because she only saw them three times in the two-month period of her contract. Under normal pre-pandemic circumstances, much of her daily stress came from family care and living in a hotel room eliminated this source.

I had no outside stress. My kids were with their dad. He was taking care of everything. I didn't have to go food shopping, I didn't have to cook, I didn't have to clean. I didn't have to pay bills. So all that stress was taken away from me. So it was literally work and sleep, work and sleep. That was it. So it was, like I said, manageable. And most of my daily stress wasn't there.

Nurse Mirabelle's lack of fear and anxiety could perhaps be stemming from her normalization of her very atypical way of living during her tenure as a traveling nurse. As she describes "it was literally work and sleep, work and sleep". She was as removed from her emotions about working as she was from external sources of stress once she ended her work day and left the hospital.

Nurse Mirabelle also emphasized how, as a medical surgery nurse, the nature of the work she was doing with CoVID patients differed from the experiences of Intensive Care Unit (ICU) nurses. There was a lack of morbidity and virulence in the daily care of her patients, and this impacted her opinions of the virus. Namely, she felt that she was not as fearful of the virus as her ICU counterparts.

The entire hospital was COVID positive. The entire hospital. Every floor was 100% positive, though. Yeah. I was on a med surg floor. I wasn't in ICU, though. I saw a different side of COVID than my friends that were

in ICU.

How do you mean?

I saw people recover and get discharged. They almost never did. Because by the time they got to ICU, they were... they had taken a turn for the worse and were already intubated. And once you got intubated, it wasn't very good. So they saw a different side where most of their patients did not make it. I saw many patients recover and go home. So it's a different aspect of it for me.

The main factors in Nurse Mirabelle's experience that contributed to her lack of fear and stress were living alone and working on a less critical floor. Out of the nurses, she was an anomaly because her CoVID experience was overwhelmingly positive, but her outlook could have been impacted by her lack of stressors. In her interview, she explained that she had gained a sense of confidence and assurance in both her skills and her identity as a nurse while working during the pandemic. While future research should continue to explore the different reactions and attitudes nurses held towards work, for the purposes of this study, Nurse Mirabelle's interview will be analyzed as an outlier.

Duty

The concept of duty to care was so innately intertwined with the nurses' decision-making process that their perception of their duty took precedence over their feelings of fear. The nurses would find ways of making the decision to actually come to work less of a choice. In other words, the nurses would not and, at times, could not give *themselves* the liberty of considering whether or not they would go to work. Even though the nurses felt fear and anxiety about going to the hospital, the pressure to fulfill their duty often overwhelmed these feelings. In many ways, the duty to work became a larger concept with different implications for every nurse. They internalized the obligation of work and afforded themselves less control over the situation by citing the nurse's oath, their duty to their patients, the necessity of work, and their increasingly recognized and vital role in society.

A couple of the nurses brought up the Nurse's Oath; also known as the Florence Nightingale Pledge (VUSN 2010). In many ways, their sentiments about the oath and its commitments to providing patient care were reminiscent of discussions about healthcare professionals' duty to care in past healthcare crises such as the SARS outbreak and HIV/AIDS epidemic (Emmanuel 2003; Reid 2005). For the nurses, it was almost as though the presence of the oath removed any possibilities of refusing to work during the pandemic. Nurse Catarina, a 39 year old, female-identifying RN with 12 years of experience, describes how she embodies the nurse's oath below after I asked her how she felt about going into work.

I have to tell myself that this is something that I have to do... we cannot refuse to take care of these patients because we took an oath to care for these patients regardless. We still have to do this, so that's what I tell myself 'I'm gonna go in today. I don't know what's gonna happen, but it is what it is regardless of the assignment they give you; regardless of where they put you. You gotta do it because someone has to do it...'

Nurse Catarina felt compelled to provide care for her patients. Her agreement to uphold the oath is unconditional. Nurse Penelope, a nurse who works in a large teaching hospital in uptown Manhattan feels similarly about the oath.

We are called for this, and we took oath for this, so we have to keep what we have cause for. So, yeah, we gotta keep going. And I know one day, when all these things are over, I will be standing proud, and I'll say "hey I survived. I survived this pandemic".

Both Nurse Catarina and Nurse Penelope communicated ways in which the nurses' oath compelled them to work. The oath's promise to care for patients regardless of their condition outweighed the personal risk to the nurses. It is this particular facet of the oath that should be highlighted: a duty to care *regardless* of the patient's condition. The duty to care was more important than the risks or conditions of the disease. CoVID, like the SARS outbreak and the HIV/AIDS epidemic that came before it, had solidified and made clear the nurse's understanding of where their priorities lay and what they were willing to sacrifice. Namely, their priorities were fulfilling their duty to their patients, and they were willing to sacrifice themselves.

As Nurse Catarina and Nurse Penelope alluded to in their previous quotes, many of the nurses cited a duty to their patients. They needed to prioritize coming in in order to prioritize the wellbeing of their patients. When I asked Nurse Jamie, a 24-year-old female-identifying RN with 3 years of experience, if her mindset had changed during the pandemic, she communicated a similar attitude about her patients.

Now like I've kind of had to take on the mindset of "I'm just gonna do the best that I can. It is what it is". There's not too much that us on the low level can change about things, so I'm just like "I gotta do what I gotta do" and make sure my patients are okay and they're safe and... and that's all I can try for at this point.

Nurse Jamie articulated that her duty as a nurse and duties to her patients were more powerful than she as individual nurse. Another nurse, Nurse Carrie, recounted her experience with her first suspected CoVID patient (after this incident, the nurses found out that the patient, who had been exposed to CoVID, had tested negative), and she explicitly names the sacrifices that she and her fellow nurses made when they treated this patient despite knowing that they did not have the proper PPE:

So we were going in and out of the room; knowing we didn't have the proper equipment but knowing that we had to take care of the patient. And I think that's the thing unique to health care workers is you're going to do what you need to do at your own risk, knowing that you need to take care of that patient.

Nurse Jamie and Nurse Carrie communicate values that are inherent to care work. They and the other nurses were very focused on the wellbeing of their patients and are willing to sacrifice themselves in order to achieve that. While working with CoVID patients, the nurses acknowledged that they were putting themselves in danger, but their duties as care workers and their duties to their patients outweighed these risks.

The nurses felt a duty to society. Out of the general public, they were some of the only ones who could take care of patients with CoVID and, in a sense, take care of society. When describing this new role, nurses used words like “elite” and “powerful”. When I asked her what her definition of essential worker was, Nurse Catarina answer captured this shift in perspectives as:

In the hospital we always knew we were essentials. We were essential workers, and I've always said that. If there is a code in the hospital, we run the code better than any doctors. So we've always been an essential part of healthcare, but now I think we're an essential part of society.

Society needed nurses, and there were not many others that could fill such a niche. Nurse Jamie summed this sentiment up as “the whole world is stopped, but we keep going”. Through the pandemic, the nurses recognized that their duty extended beyond the walls of the hospital to the reaches of society.

The duty that compelled the nurses was difficult to refuse. Most of the nurses communicated that they did not necessarily *want* the role of caring for CoVID patients, but they felt as though they could not reject this responsibility. Whether they were working out of necessity, duty, or social pressures, the nurses' wishes had little influence in their decisions to come to work. Duty took precedence over the nurses' desires. When Nurse Annemarie was answering a question about her mindset going into work, she explicitly stated that she did not want to go to work but felt forced to.

It's not something that we want to do. It's something that we have to do. And you know, and all we have to do is do it and stay alive... Nine people-ten people on my floor got sick. (pauses) And so you're looking at each other 'so who's next'? You know, and we're like 'you wanna be a hero'? We're like 'I don't wanna be a hero. I wanna be alive. I just want this to end'.

This quote communicates the collective attitude that many nurses felt about working during the pandemic. Many of them did not want to take on such responsibility and risk. As Nurse Annemarie put it, she did not want to “be a hero”, but she did not see that she had any other options. Nurse Catarina expanded on this idea when she was answering a question about inadequate PPE.

When it comes to me being in the hospital [and] taking care of these patients, I have to mask, gown and everything, and [if] I can still be contaminated then I don't wanna be essential... We don't even have the adequate PPE. We're still working. They tell us now we have to go downstairs to get our N95 in the morning. We go in with this flimsy gown. Does it even protect you? It doesn't, but we don't refuse to go into a CoVID room. We go in, we do what we have to do... Taking care of CoVID patients is not fun. It's something we wouldn't do if we had a choice, honestly. But we do it cause that's what we signed up for.

Nurse Catarina knew that she was possibly getting exposed to CoVID with her lack of proper PPE. However, she states that she cannot refuse to work because this situation is what “[she] signed up for”. She also explicitly says that she had no choice. She had to go to work. Her duty as a nurse was one that, as much as she wanted to, she could not refuse, even if it meant putting herself in danger.

Aside from the duty to care and their duty to society, some nurses also felt a duty to their family. They needed to provide for their families, so giving up work during the pandemic was not an option. Nurse Tabitha would feel nauseous and anxious before going to work because she was worried about infecting her baby. However, she directly states having no other choice besides working.

So I basically had no options except to work. And I just had to say to myself: “OK well, I have to take care of my family. I have to take care of myself, but I have to take care of my family” ... I had to just kinda find a way to be strong about it and say “I really don’t have any options here. I have to just take care of my family”. You know, it was-it was definitely very scary... it took a little while to accept; I’ll be honest with you. But you know, when you have a family and a mortgage, it’s just kinda like “this is what I have to do”. And I just had to suck it up.

The nurses explicitly stated not wanting to go to work due to fears surrounding the virus. Yet, they communicated an obligation to nursing that felt almost impossible to refuse. These three quotes poignantly sum up the main relationship between the fear of the disease and duty to care: fear, in various forms, was ever present, but the nurse’s duties to their patients, to uphold their oath, and to provide for their family were the more influential and compelling factors in their choices to go to work.

Mindset

In order to suppress their fears and meet their duties, the nurses adopted a mindset that forced courage and detached them from their fears. The nurses would perform deep acting by internalizing a brave attitude about going to work. Once they were at work, the nurses would remove their emotions from the situation by depersonalizing many parts of their daily routines and tasks.

Many of the nurses mentioned bravery in their interviews. They discussed the need for strength, courage, and fight to work with CoVID patients. Yet, most of them underwent a process of actually forcing themselves to feel brave because, as detailed by the earlier sections, they initially were very scared about going to work. Nurse Tabitha put it succinctly when she was talking about her decision to go to work even though she was pregnant and scared for her child’s health: “For me I had to just kinda buck up and be like ‘okay’”.

Nurse Tabitha had just finished recounting her fears about going to work and explaining why she still needed to go to work despite those. By telling herself to “buck up”, she was invalidating her fears, minimizing them, and forcing herself to adopt and perform with a brave mindset.

Once the nurses had taken on this mindset, they would put it into action by compartmentalizing what they were doing and removing their emotions from their tasks. Nurse Mark, a male-identifying nurse with 1.5 years of experience, works at a large level 1 trauma center in a suburb near Manhattan. He describes his process for shifting his mentality below.

And it was scary at first cause we were all like “what the hell. No one knows anything about this. What’s-what are the treatments supposed to be like? What’s going on”? But yeah, I guess for me it was kinda like

“alright gown up and put your PPE on like we’re supposed to” and kinda do what we’re supposed to do I guess”. (Laughs).

Nurse Mark details his process of putting his responsibility before his fears about work. He removes himself from the situation by telling himself to focus on his duties. He also does not give himself the option of feeling his anxieties about the uncertainties of the disease.

In a similar fashion, Nurse Sam, a nurse with less than 1 year of experience at the same hospital as Nurse Mark, spoke in his interview about his task-oriented mindset that he took on while caring for CoVID patients. Nurse Mark had been a firefighter and had worked in emergency medical services before going to nursing school, so he spoke about how these experiences informed his approach to working in the pandemic.

[It] definitely takes time to get used to; like, slowing down and controlling your emotions and everything... I would say just the... anxiety, and then you definitely get the little, like, the little adrenaline kick. That little... like a little pucker factor. You’re like “Oh this, like, this is bad” ... And then you go back to your training. Like “I have this”. You kinda break it down into the facts. So you’re kinda fact oriented. Like “I need to do, like, I need to work on the vent. I need to work on the drips. I need this. I need this. I need that...”, and then you make a little mental checklist that you go through each step, each step, each step. And if you find yourself overwhelmed, take a second, breathe and then, refocus on what you’re trying to do.

Nurse Mark acknowledged his anxiety and adrenaline but chose to focus on his training and ignore his emotions. The nurses needed to frame the situations they were facing in a way that made them less overwhelming. At the same time, they also needed to ensure that they were performing medicine with competency. To accomplish these tasks, they would remove their personal feelings from the situations and compartmentalize them.

There were two nurses that did not experience any drastic change to their mindset. Nurse Mirabelle, who had not felt any increased anxiety, did not report actively changing her mindset when she started working with CoVID patients. Nurse Jeremy, a male identifying nurse with 5 years of experience at a large level 1 trauma center in a suburb near Manhattan, felt similarly and believed that he received adequate protection and was therefore not worried about working. Here is what he said when I asked him if he had ever been scared to go to working during the pandemic.

I mean I could tell that some people when they first started they were like ‘This is not what I signed up for,’ you know, ‘I don’t have a problem taking care of sick people but not necessarily putting my life at risk doing so’. But I never really looked at it that way. I mean I.... I always felt protected. I mean it was a little bit sketchy in the beginning when they kept changing PPEs and what we had to wear and stuff like that. You know I-I never really felt any different about it.

Nurse Jeremy did not feel particularly scared of the virus because he felt adequately protected, so he did not need to change his mindset or perform emotional labor to feel able to go into work.

Discussion

The nurses' performance of emotional labor was largely used to suppress their fears about CoVID. Their main impetus of performing emotional labor was to fulfill their duties as nurses, as family members, and as essential members of society. They cultivated an attitude of courage and separation from their tasks to fulfill these duties.

Emotional labor in nurses still has many facets to be studied, but this research revealed that the process of emotional labor is more complex than previous studies had concluded. This process actually began with the original feeling or thought that the nurses in the study experienced: fear. Then, when the nurses contemplated the responsibilities they had to fulfill to their hospitals, patients, families, and society, they felt that these duties were of more importance than how they felt. Even when the nurses felt strongly about not *wanting* to put themselves or their families in danger, they still felt as though they needed to go to work. This process involved, in large part, a suppression and detachment from their fears in order to meet their duties.

Emotional labor has thus far been conceptualized as a performance done in order to meet external expectations of some kind (societal, workplace, etc.). I would like to expand this definition by noting that the nurses in this study were motivated to perform emotional labor not by an expectation of appearance, but by a socially constructed sense of responsibility. They were still suppressing their feelings and crafting attitudes of courage to perform their jobs with competence and professionalism, but, in larger part, they were suppressing their feelings to meet the expectation of actually showing up to work in the face of danger.

The duty to care is a concept with little existing research, but it had mainly been examined in doctors prior to this study. These interviews revealed that nurses experience a similar sense of duty in their line of work. Further, as was present with research on SARS and HIV/AIDS, the duty to care was seen as a difficult path to navigate during a pandemic. The nurses in this study revealed that the duty to care encompasses a much larger sphere than previously theorized. The duty to care existed as a force within the hospital and took the form of the nurse's oath and in the nurse's feelings of responsibility for their patients. However, it also existed as a duty to provide. The nurses fulfilled their duty to care to meet the needs of their family. In an even larger sphere, the nurses felt a duty to care that was directly connected to their feelings of responsibility to society because they were some of the only people who could fill the niche that had been intensified by CoVID.

While this study was conducted during a pandemic, the implications of the research should not be limited to that context. From the nurses' experiences and stories, it is clear that the culture of work that had existed prior to the pandemic informed the mindsets of the nurses. There was a prioritization of work over physical and mental health. Perhaps the nurses were informed by their duty to care, but this culture of sacrificing the self to work, which had been present in society before the start of the pandemic, was exacerbated in the context of CoVID.

This study provides additional implications for nurses. Though this is an examination of 15 individual nurses, the individual level of analysis should not cloud the necessity of creating the structural change and support systems for nurses that were clearly lacking when the pandemic hit U.S. hospitals; including changes in the norms of care work in nursing and cultivating a larger focus on the mental health of nurses.

The nurses in this study comprise a difficult to reach population, and the rich detail achieved from the interviews provides some of the first findings about nurses during the CoVID pandemic. By conducting the study in the midst of the pandemic, information and perspectives from the nurses were collected while they were happening or close to when they happened. Thus, the groundwork for future research about the pandemic has already been laid with this study along with others of a similar nature.

As this study was only conducted in a few hospitals in New York, there is still a need to investigate nurses from other states and hospitals. Perhaps different hospital policies will be found to have drastic impacts on nurses' reactions to the virus. Additionally, there is a lack of research examining the concept and practice of duty to care. While this study develops this idea in the context of nursing, future research should also prioritize doctors, first responders, and other hospital workers such as CNAs to examine these populations' embodiment of their duties in the context of a pandemic.

Abbreviations

PPE, RN, ICU, SARS, NP, HIV/AIDS

Declarations

Ethics Approval: All nurses that participated in the study read, discussed with the researcher, and signed an informed consent that detailed the study's scope. This study was approved by the IRB of Colorado College (IRB00005077). All of the methods used were performed in accordance with the relevant guidelines and regulation of the Declaration of Helsinki and the Colorado College IRB.

Consent for Publication: N/A

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Tables

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Supplementary Files

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