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Uncertainties and Coping Strategies among Nurses During the First Wave of Covid-19 in Germany – Nursing Students' Use of Diary Entries to Document their Experiences during the First Wave of Infections in the Covid-19 Pandemic

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Abstract

Background: In March 2020, German hospitals were preparing for the first major wave of Covid-19 infections, implementing crisis management procedures without precedent or prior testing. At this time, we asked student nurses in their eighth semester of study to complete a nursing diary for a period of four weeks. The aim of this research was to ascertain students' perceptions of the constantly evolving crisis and retrace their reflections on the situation on the basis of the knowledge they had at the time.

Methods: Eleven students completed a nursing diary, which entailed writing entries on the care they provided on the wards to which they were assigned. They added images such as pictures, screenshots and drawings to their diary entries. We analysed the data using ethnographic methods as follows: a) categorisation of the entries in accordance with general thematic similarities; b) comparison of the entries with published nursing literature from this time period, with the aim of identifying possible gaps in the content of our data.

Results: The student nurses worked on different wards; some volunteered to staff the newly established Covid-19 wards. Nursing students felt the unfolding crisis to be defined by a sense of uncertainty and potential threat, associated with various fears. The students described their own actions and behaviour in specific situations and outlined observations of others. We categorised our findings in four sub-topics: a) crisis management; b) the invisible crisis; c) a sense of crisis; and d) coping with the crisis.

Discussion: In giving insights into the day-to-day work of nurses under extreme conditions, the diaries collected and analysed for this study highlight experiences of ambivalence and uncertainty during the first wave of Covid-19 infections. Specifically, the students' reflections on professional responsibility point to this principle's importance within the system of values espoused by members of the nursing profession.

Keywords: 1st Wave of COVID-19 Pandemic, Student Nurses, Experience, Qualitative Empirical Research, Germany

1 Introduction

The impact of the Covid-19 pandemic on medicine, nursing, policy, the economy, cultural life and ethical reflection has been a dramatic one.[1] In March of 2020, Germany, like other countries, found itself facing a level of crisis not seen since the end of the Second World War. Task forces came into being at local, regional and national level, charged with drawing up emergency and infection control plans for in- and outpatient healthcare.[2] Preparatory action in-

1 Coronavirus Disease (COVID-19) Pandemic, https://www.who.int/emergencies/diseases/novel-coronavirus-2019.

2 Giese 2020, pp. 103–105; Petkovic 2020, pp. 41–43.

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cluded arrangements for the distribution of personal protective equipment (PPE) and the conversion of hospital wards into 'Covid wards'[3], on which, at this stage of the pandemic, nursing staff volunteered to work.[4] During this period, it was impossible to predict the effects of this first wave of Covid-19 infections on the working situation for nursing staff in Germany, or the potential risks to them.[5]

The serious, long-term staff shortage in the nursing and care sectors exacerbated the pandemic's impact on these areas in Germany.[6] The country's hospitals attempted to respond using crisis management procedures never previously put into practice.[7] As the pandemic gathered pace, reports of PPE shortages, a lack of psychological support for hospital staff, and incidents including the theft of disinfectant and sanitiser fed into significant levels of uncertainty and anxiety among those working in these settings.[8] Social media served as a catalyst for the frustration experienced by numerous nurses at this time, and the increasing severity of staff shortages in all areas of care for seriously ill Covid patients engendered a sense of overwork and overwhelm.[9] Recruiting staff for Covid wards proved no easy task; financial incentives were unable to resolve this issue in areas where staffing levels were already strained.[10] Ward teams were split up or their composition changed, losing the cohesion they had maintained up to this point.[11] The pandemic highlighted a notable lack of support for nursing staff in Germany as they sought to manage the risk of collapse in the health sector, conscious of the severe shortage of nursing staff. It further demonstrated and considerably amplified the urgent need for reform in the German healthcare system.[12]

Notwithstanding structural problems in hospitals, the ethical challenge of 'stepping up' in uncertain times such as a pandemic situation remains one faced ultimately by nurses themselves; moral stress may ensue if they find themselves unable to take on this responsibility. This phenomenon remains observable despite the social change continuously in progress since the 1980s, with its concomitant crises and corresponding impact on the societal handling of risk.[13] Crises of all kinds carry a threat to the structures underlying the societies that undergo them. Failure to manage such exceptional situations will deplete public trust in the ability of institutions to solve problems that arise, an effect in which the Covid-19 pandemic has provided an object lesson.

The status of the nursing profession as a distinct group in its own right[14] is a necessary aspect of its professional identity and entails the exercise of responsibility in a number of contexts

3 Garbe 2020, pp. 32–34.
4 Fromm 2020, pp. 106–108.
5 Hellige 2020, pp. 15–17; Giese 2020, pp. 103–105.
6 Fatke et al. 2020, pp. 675–681; Stetzenbach et al. 2020, pp. 4–7.
7 Hunlede et al. 2020, pp. 10–14.
8 Ernst et al. 2020, pp. 57–59.
9 Wöhlke/Hartwig 2020, pp. 123–126.
10 Jansen 2020, pp. 53–56; Gundolf 2020, pp. 27–32.
11 Garbe 2020, pp. 32–34; Fatke et al. 2020, pp. 675–681; Begerow/Gaidys 2020, pp. 33–37.
12 Giese 2020, pp. 103–105; Klie et al. 2021; Ullrich 2020, pp. 8–11.
13 Beck 1986; Ullrich 2020, pp. 8–11; Pelz et al. 2020, pp. 38–40.
14 For the purposes of this article, we define 'nurses' as nursing professionals who have completed either a course of vocational nursing training lasting at least three years (as remains the most frequent case among qualified nurses currently working in Germany) or a nursing degree.

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and arenas.[15] This responsibility stems from the nursing profession's collective commitment to and adherence to a specific set of values, enshrined in the ICN Code of Ethics, which govern nurses' actions at work and which require nurses to uphold, simultaneously, the principles of empathy and professional distance; altruism and self-care; and critical reflection on their work, alongside efficiency. The high standards inscribed in these demands find explicit expression in legislation, regulations and guidelines and take implicit form in the particular trust people place in the work nurses do. Such professional values, of course, form only part of what the nurse's role entails; a further core component thereof is the increasing expectation on nurses to possess, apply and reflect on up-to-the-minute specialist knowledge in their field.[16] 'Responsibility', in the sense of accountability, thus attaches fundamentally to all nurses; its facets encompass causal responsibility (i.e. who has caused a particular problem), responsibility for the consequences (whose 'fault' it is), the attribution of responsibility (who is made accountable for what has happened), and distributed, organisational responsibility (how responsibility is shared among the actors involved).[17]

Responsibility, of course, also has a moral aspect; it references concepts such as commitment and duty, as well as engaging the process of arriving at a moral decision. Professional responsibility, thus conceived, incorporates a duty to care for oneself and others, yet extends far beyond this intra- and interpersonal level, encompassing an obligation to other professions to account for one's actions. Professional responsibility, then, rests on the basis of a collective and organisational responsibility.[18] In light of the situation in which nurses found themselves during the first wave of Covid-19 in Germany, the moral decision to acknowledge professional responsibility and act accordingly raises issues around how we conceive of what is morally 'good', around how we define the principles which we set to govern our actions, and around the extent of our – or specifically, nurses' – freedom to take our (their) own decisions, which, even prior to the pandemic, had been subject to severe limitations imposed by structural conditions. This article will explore nurses' perspectives on the principles affecting their professional radius of self-determined action in their care for acute Covid-19 patients. In an exploratory study that took place at the outset of the first wave of Covid-19 infections, we sought to ascertain the extent of practising hospital nurses' preparedness to work in the extreme conditions presented by the pandemic situation; specifically, we were interested in nurses' reflections on their professional responsibility in this context and setting. Our work has an expressly experimental character, having taken place during a period of time unlike anything we have seen since the last major pandemics of the 1950s and 1960s. Viewed from today's vantage point, our approach reveals limitations in the depth of the data our participants generated and, ultimately, in their capacity to stand as representative of the situation at the time. Our intent in this article is therefore not so much to present a definitive portrait of nurses' experience in this period, but rather to cast light on the promising potential of a participatory, stakeholder-based methodological approach to empirical research around matters of ethics.

15 Ulrich et al. 2010, pp. 2510–2519.
16 Wöhlke/Leinweber 2022, pp. 117–131.
17 Tronto 1993.
18 Responsibility thus defined entails a professional's awareness of their own spheres of responsibility, including their boundaries and limits, in clinical interaction with members of other professions and within hierarchically defined distributions of tasks and roles. Cf. Gastmans 2006, pp. 135–148.

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2 Methods

At the outset of the first wave of Covid-19 cases in March 2020, we asked students in the eighth semester of a cooperative degree course in nursing, who were taking a course module on 'extended reflective practice', to complete a nursing diary over a period of four weeks.[19] The purpose of this task was for students to document their experience of the emerging crisis situation, which at that time was evolving daily. The use of diaries for data collection is currently on the rise in empirical research on health, most typically for recording information on working practices.[20] Asking research subjects to complete diaries is a method that has found little use in nursing research to date; it is nevertheless, in our view, eminently suitable for collecting information on participants' views, subjective emotional states, and experiences of specific situations. Diaries, as qualitative data, can serve to record people's thoughts and feelings, particularly in highly personal, emotionally charged, or challenging situations. Recent work taking a phenomenological approach provides exemplars of the capacity of diary writing to generate substantial and illuminating insights on the relationship between emotion and self-reflection.[21] Potential drawbacks of the method include its dependence on participants completing the diaries regularly and comprehensively, and variance in subjects' ability to express themselves in writing.

We employed this method in the context of structured reflection conducted over a four-week period, with the aim of documenting and exploring the incipient first wave of Covid-19 in March 2020 and the response to it in terms of infection control. Eleven students on a cooperative nursing degree programme[22] completed a nursing diary over a period of four weeks, from mid-March to mid-April 2020. We asked them to make an entry daily, specifically from a nursing perspective, and set no maximum or minimum length for entries.[23] The diaries constituted a requirement for successful completion of the module.[24] Students submitted them to us at the end of the four-week journalling period, enabling us to review the data and devise a rough set of thematic categories. We observed considerable variation as regarded the length of the diaries (between 12 and 68 pages of A4) and the depth of reflection in evidence. In the final session of term, we discussed and evaluated our pre-analysis with the students. All participants gave written informed consent to the publication of their diary entries under pseudonyms. This exploratory study has not been through an ethics committee approval process.

19 Diary writing as a method of collecting empirical data should not be confused with the 'care diary' (*Pflegetagebuch*) completed by people requiring care and their relatives for the purpose of documenting their needs, as provided for in Book XI of the German Social Code.

20 Jones 2000, pp. 555–567.

21 Bedwell et al. 2012.

22 At the time of data collection, the student body of this cooperative degree course comprised both those taking the degree to complete their initial nursing training and vocationally qualified nurses studying for the degree alongside their position as a nurse.

23 Ross et al. 1994, pp. 414–425.

24 The module was assessed through a number of different types of assessed task. One of them entailed completing the diary and giving a brief presentation to the class on its content. We were aware of this study's experimental character and of the fact that participants were simultaneously completing an assessed part of a course module. We communicated all this candidly to students at the outset and permitted anyone who did not wish to participate to complete a written paper for their assessment instead. The institution was likewise aware of these arrangements.

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The phenomenological analysis of the diaries, in line with the nursing-based methodological approach taken, centred the participants' lived experience and their perceptions of the situations in which they found themselves.[25] We sought above all to identify and ascertain the reality of the Covid crisis as our participants viewed it during this period, with the ultimate aim of recording their experience of the events, objects and phenomena that comprised their professional lifeworld.[26]

The initial stage of the analysis entailed us reading each of the eleven diaries. During this, we identified common factors and divergences, which a second reading subsequently examined more closely and critically in the context of nurses' reports[27] from this period, with the aim of revealing any aspects of the crisis which the diaries omitted.[28] Four central thematic categories for analysis emerged from this stage of the work: 1. Crisis management in the hospital setting; 2. The 'invisible' crisis: the unknown threat posed by the pandemic; 3. A sense of crisis: how participants perceived people around them (colleagues, patients, relatives) in the changed clinical setting; 4. Coping with the crisis. The participants further described a variety of ways in which they relaxed and decompressed outside of work. Following this stage of the work, we set out these initial findings to the students and engaged in a critical discussion of them. Each participant chose an excerpt from their diary to read to the group and assigned it to one of the four categories, with help and advice from us, where required. The findings we will discuss below consist largely of participants' descriptions of their experiences and perceptions.

The open approach required by our method of phenomenological observation, and our commitment to deriving our categories from the empirical data, debarred us from including the concept of responsibility as a distinct category in the analysis. To do justice to the centrality of responsibility to nursing ethics,[29] we incorporated the concept into our considerations via Joan Tronto's work (1993) on responsibility and the ethics of care, on which we drew for our ethical and empirical analysis[30] of the participants' experiences and views.[31]

3 Results

The nursing profession is inextricably intertwined with the principle of care work. Nurses' experiences of the pandemic's early stages, as set out in our participants' nursing diaries, point to aspects of this period, and of its significance, that the rapid pace of events makes it difficult to access retrospectively. The diaries detail nurses' reflections on the value of nursing as providing various forms of care and caring in times marked by profound uncertainty, in which it seemed almost impossible to maintain authentic relationships of caring in the day-to-day provision of nursing care. Further, the diaries uncover the ethical considerations that nurses view as having relevance to healthcare. The participants' sense of being in a situation where 'care' was regaining its core, now somewhat archaic, meaning of worry and concern, left them

25 Schütz/Luckmann 2003; Raab et al. 2008.
26 Thomas/Pollio 2002, pp. 183–184.
27 These reports related exclusively to nurses' experiences in Germany; an example of their sources is the journal *Pflegewissenschaft*, which has published special issues on the pandemic (2020).
28 Van Manen 2022, pp. 77–79.
29 ICN Code of Ethics 2021.
30 Wöhlke/Schicktanz 2019, pp. 424–427.
31 Vosman/Nortvedt 2020.

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feeling, at the outset of the Covid-19 pandemic's first wave, that their lives consisted in a complex moral and emotional relationship with their professional responsibility.

In March 2020, the students were working on various wards in a large acute hospital. Some of them volunteered to staff the newly established Covid wards, while others remained where they were. The participants described numerous situations that were new to them and frequently associated with uncertainty and a sense of potential threat. The diaries consisted of descriptions of their own behaviour and actions and those of others, reflections on events, fragmented thoughts; they had a collage-like character, incorporating visual means of communication such as pictures, screenshots and drawings alongside text.

Our analysis of the diary entries identified four key themes, which we have outlined above and which we will refer to, in short form, as 'crisis management', 'the "invisible" crisis', 'a sense of crisis', and 'coping with the crisis'. In the period from mid-March to mid-April of 2020, nurses, including our participants, found themselves on unprecedented alert for a degree of threat not experienced since the major pandemics of the 1950s and 1960s, although Germany was ultimately spared the feared worst-case scenario – the collapse of its health system due to factors such as overwhelming patient numbers entering hospitals.

3.1 Crisis Management: The Unsettling Disruption of Routine Work on the Wards

The category of entry most frequently in evidence in our participants' diaries is that of 'crisis management'. The students recorded an 'inside view' of life in the hospital as it struggled to contain an unknown virus. In the period between 15 and 30 March 2020, the entries principally describe an atmosphere of teams trying to 'keep it together' (as the structures around them changed, dissolved or fell away). The previously established principles of order and structure on the wards, such as working routines, rotas, hospital hierarchies, care procedures and assigned areas of work, were disrupted. Rotas could no longer be relied on, exposing nurses with children to a particular level of additional emotional strain. Patients were transferred to other wards; planned admissions did not take place. Wards were rearranged and rededicated; tasks redistributed; the offer of risk supplements to wages sought to motivate nurses to work on the new Covid wards. One entry describes a conflict between the nurse's family responsibilities and the professional responsibility of someone working in the healthcare system:

> A lot of nurses are staying at home for safety, for fear of putting themselves at risk. On the one hand it's understandable, but on the other it's a systemic and attitude problem. After 4 nightshifts, I'm sitting here today logging straight back into my online lectures. I'd been looking forward to a sunny weekend to decompress. But no, yesterday already I got the call to say that I had to go in. Of course I thought briefly about saying no. But I can't, my responsibility to my patients and colleagues wins. (9FN)

A nurse at the beginning of her career described leaving the children's wards and starting in intensive care:

> "We'll train you up this Monday and Tuesday and then you can start – don't worry, it'll all be fine." [words of the charge nurse to the diarist] I think, yeah, sure, of

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> course it'll all be fine. Like everything has to be fine in hospitals. I wrote down every part of every task on a piece of paper I had with me. Hoping I hadn't forgotten anything important. Am I ready now? No; I knew full well that I actually hadn't a clue. (7FN)

Further uncertainties arose from working in newly formed or rearranged teams whose members' roles and remits were not clearly defined:

> On late shift today (…) 2 staff from theatre, 1 staff member from dermatology, and a nursing assistant [from another different ward]. Nobody on the late shift has had [the new documentation system] explained to them (…) I have to show 3 colleagues how to use the telemetry system. (1FE)

As the diaries indicate and our students confirmed in reflection sessions in class, 'keeping it together' includes maintaining emotional composure and resisting the urge to run away. The diary entries on this topic are ambivalent in character, revealing a mixture of astonishment at what is happening to the diarists' familiar working environment before their eyes and a mounting sense of unease at the 'invisible' threat facing them. One entry notes:

> Now there's security at all the entrances to the hospital, and they're only letting members of staff in, who show their ID. The hospital's closed off to everyone else. (11FE)

Signs and notices appearing daily on the ward detailed the infection control requirements: "There's info up everywhere" (11FE). By the end of March, masks had become mandatory for all staff and patients at the hospital; the lack of adequate amounts of PPE to cover all areas and wards posed a fundamental threat to the nursing staff. Issues and dilemmas arose in the matter of interactions with patients, with nurses experiencing the continuous mask-wearing as highly limiting in this regard. They report constantly weighing up whether to break the rules and conduct specific nursing interactions without a mask:

> I even have time to wash a patient's hair, and I think about wearing a mouth and nose covering, because I'm working so close to her… but I don't want to unsettle her and decide not to [wear one]. (11FE)

This lack of structure that characterised the pandemic's initial stages was likewise evident in the logistics surrounding resources, provisions and procedures for infection control. At this time, alongside insufficient numbers of masks for staff and patients, a shortage of sanitiser was making itself felt: "There's a spate of sanitiser thefts; I heard that security even had to intervene." (6FE)

Adding to these structural deficits that the crisis inflicted on the running of the hospital, a shift in workloads was in evidence, with a greater burden falling on wards and units that were in place pre-pandemic:

> The ward is full to bursting with patients. One patient is dying, and there's another who we'll probably have to transfer to intensive care. This shift's nothing but rushing around; I haven't had breakfast, I haven't been able to go to the toilet. I can't even say right now whether it's because of the Covid situation or because of the high levels of staff sickness and how frightened some staff members are. It'll soon be over and the late shift will come on. I hope! (9FN)

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The nursing management in the hospital had delegated medical students to the wards to help relieve the staff shortages caused by sickness and quarantining. The newly established Covid wards were not full at this point, giving rise to various different perceptions among our diarists:

> Nightshift. There are three patients. And there are two of us working. There's nothing to do. Weird phenomenon: I look at the clock every 15 minutes, and each time only 2 minutes have passed… I'm too tired to think about it any more, I just hope that this night will be over soon. Thursday, 26.3.2020. There are only two patients tonight. I think of my colleagues on my usual ward, who can hardly manage their workload. I'm ashamed of feeling bored. (4ME)

Another entry notes:

> I'm on a non-Covid ward looking after a post-operative patient who is due to be transferred at some point during the shift. Rarely have I been able to give a patient such extensive care in accordance with what he wanted, and during this I also had time to have discussions with my colleagues – their experience is the same. The care that people on my ward are getting has rarely been as good as it is now. (3FN)

The uncertainty intensified in the first week of April, with the emergent sense of threat filtering through from media reports about the virus. Up until this point, the latent risk of infection had stemmed from patients; now, however, numbers of staff with proven or suspected Covid were on the rise:

> Today I'm disinfecting handles of doors and other things, my blood pressure monitor and the phone receiver especially often; I remind the doctors to [do the same] – they hadn't thought of it before… . (11FE)

The participants experienced having a suspected Covid infection as shaming and stigmatising; they sought to avoid this stigma by not telling anyone they had done a test until the result was available. Alongside shame towards colleagues for supposedly having infringed infection control procedures stood the potential exposure of nurses' families and friends to stigma or even discrimination. This was a period in which the immense level of flexibility required of nurses had an invasive impact on their personal lives. Participants became increasingly concerned about catching the virus: "When I get home from work, I go and take a shower before hugging my children. The worry about passing the virus to them is always with me." (11FE)

Amid evaluation of the infection control procedures that had been in place up to this point, residents of care homes were arriving in the hospital, being admitted to Covid wards and tested. The rapid spread of the virus permeated all areas of life in the hospital. During all this, some diarists noted exhaustion among their colleagues, one indicator of which was an increase in verbal disagreements around crisis management matters. Some of these incidents took place in interactions with patients' relatives:

> A nurse 'bites a relative's head off', [saying] how did that happen – a relative accompanying a patient. There was no need for [the nurse] to speak [to the relative] like that. The relative doesn't even get asked about the situation. While this goes on, I personally feel sort of ashamed for my colleague. I resolve to mention this, perhaps, at an appropriate moment. (6FE)

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Alongside this, disillusionment and discouragement were beginning to weigh on the participants:

> I have to admit that at the moment, it's not the Covid crisis that's my main stress factor, but the sickness absences on my ward. It's the conditions in which we nurses do our jobs that push us to our limits, and that was the way it was before Covid too. (9FN).

Our findings in the category of 'crisis management' point to a sense of uncertainty affecting nurses during this period, an uncertainty in matters organisational and staffing-related, but also in their personal lives. Amid this uncertainty, the participants attempted to do justice to their professional commitment to being a source of stability and security for patients, while enduring the chaotic conditions engendered by the pandemic's advancing first wave. Here we note the emergence, as indicated above, of a sense of 'care' as worry or concern, with participants seeking to establish their boundaries and to work out for themselves whether and when they can, are allowed to, or indeed have to 'be strong for' their patients despite their own uncertainty.

3.2 The 'Invisible Crisis': The Strained Intimacy of the Caring Relationship with Patients and their Families

This second category of our analysis encompasses data that points to the day-to-day impact of the loss of routine outlined in the previous subsection. The participants found themselves facing situations that placed them under moral stress. Similar perceptions emerge from their reflection around their self-care, particularly in relation to their own families. During this period, the aspect of nursing that gives patients stability and provides a consistent and calm presence and support in their suffering appeared to be impacted, to have itself declined in stability and security, in consequence of the falling away of familiar routines.

Nurses' interactions with patients rely on direct physical contact, facial expressions, and other non-verbal and verbal communication. One student diarist observed, in relation to the care he provided for the handful of patients infected with the SARS-CoV-2 virus at this time, that "my PPE has the additional effect of making it considerably harder for me to form a relationship with the patient" (4ME). One of his entries relates to a Covid-positive dementia patient:

> I'm with the patient again. [Her] symptoms are still only mild ones. However, the isolation is taking its toll. She barely speaks any more, and is increasingly withdrawing from interaction. The thing that's occupying my thoughts most of all is that this doesn't seem to be important at all in this situation. But I can't see that I have any way of bringing about change here, and this is making me more and more frustrated. (4ME)

Some days subsequently, he stopped writing about this particular patient: "Suffice to say the case is still on my mind." (4ME)

Our participants appeared to expect and wait for the hospital to present solutions to the difficulties encountered, which they could try out and put in place. The use of a vocabulary typical of crisis situations, redolent with the imagery of disaster and war, has the effect of amplifying the impression of this cautious, reticent behaviour: "In the last few days, I've been hearing

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[people using] these metaphors: 'Calm before the storm'; 'it's like waiting in the trenches [to go over the top]'; 'the tsunami is ebbing away'." (11FE)

Participants kept a close eye on themselves and the risks they were exposed to, alongside the concomitant potential harm to themselves and their families:

> At home, the children want to hug me. I keep them at arm's length until I've been for a shower; I feel dirty somehow. We – the nursing staff – should really be being tested as well [as patients]... I'm worried about my children; would they perhaps be better off in key worker childcare? Are they more likely to get infected at home? (11FE)

The first week of April brought an increase in the frequency of entries revolving around the students' fears about becoming infected with the virus themselves and the associated risk of long-term sequelae. The diarists attempted to pay close attention to themselves and their physical state, with the aim of identifying a Covid-19 infection at an early stage:

> This morning, I had this feeling of not being able to breathe freely again; I needed to cough; it felt as if I'd done a sprint... I'm glad to have the day off, think, what if I have Covid. Always had these thoughts when this weird feeling came back. It feels a bit like asthma...before going to bed, I check my emails again, the result is negative...phew...all the strange feelings are gone at once. (6FE)

3.3 'A Sense of Crisis': Public Perceptions of the Pandemic

Mass media reporting, social media, and the daily case figures from Germany's core epidemiological organisation, the Robert Koch Institute (RKI), powerfully influenced people's experience of the Covid-19 pandemic. Panic buying of flour and toilet paper illustrated the level of public fear at its outset. In March 2020, the media in Germany, as elsewhere, were showing images of exhausted medical and nursing staff in neighbouring European countries whose health systems had collapsed under the pressure of the pandemic. German hospitals were only just beginning to draw up their emergency plans at this time. This notwithstanding, nurses in Germany felt safe and were glad to be working where they were, a sense of relief that served briefly as consolation for poor pay and chronic staff shortages.

Participants in our research noted their unease with the praise and applause showered on nurses at this point in the pandemic:

> So how believable is all the talk about the great importance of nursing ... especially in the media? (5ME) But what'll happen when the crisis is over? Will nurses still be as important as everyone is writing that they are right now? (...) It would be a good idea to [talk] about adequate pay for nurses in the near future. At the moment, almost every politician is lamenting how badly paid nurses and carers are. Well, yes! Even so, I don't believe that this insight will be followed by an improvement of any kind. (5ME)

On 23 March, unprecedented legislation in Germany partially banned physical meetings between people from different households. These restrictions on people's personal freedoms exacerbated nurses' sense of uncertainty. Entries made by our participants indicated agreement with the enforcement of these rules: „A police car stops ahead of me. In my rear view

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mirror I see three police officers walking towards a group. They haven't kept the minimum distance and there's a ban on gatherings; they have their ID checked… good." (11FE)

During the second week of April, we observe a degree of 'pandemic fatigue' towards media reporting on the situation. At this point in time, the pandemic's development and the associated debates around freedom, autonomy and their loss were inescapable parts of public discourse in Germany. One diarist observes:

> I avoided the news today. (…) Yes, OK, I just can't take any more of it. The death rate is going down in Italy. Germany had almost 260 deaths today and the figures are going through the roof in America. There's a 'Covid special' on every TV channel. I've had enough for today and don't want to hear another word about it. (9FN)

3.4 'Living with the Crisis': Strategies for Managing the Unseen Threat

Participants recorded their strategies for recuperating from the strain they were under at work. These included spending time with their families or engaging in solitary hobbies; „being in nature" appeared to be particularly highly valued. Participants still found, however, that the pandemic, with all its associated issues, permeated all areas of life, adding to the stress they experienced. One entry describes the jarring moment of re-realising the situation:

> Sometimes I feel like everything's normal, the atmosphere around me feels that way, the sun's shining, the trees are in blossom, the birds are singing – then I think, who could I go and see after work - and I remember that I can't. Can't sit with friends or go out in the evening after work. (All the stuff we can't have at the moment). (6FE)

Alongside the changes in the once-familiar structures at work, participants faced the challenge of reorganising their home lives, with particular difficulties for nurses with children:

> I'm sending the children to key worker childcare, (structure is important…) the [childcare] workers know that I'm not scheduled to work today and am studying alongside my job. They're happy to have any children in at all (today: 5/40 from two groups). (11FE)

Some participants attempted to use the experience of spending time in nature as a positive counterpoint to the emotional strain and difficult situations at work and the events that are the subject of media reporting:

> Mowed the lawn today. I never knew how relaxing mowing the lawn can be … (4ME). Today I spent the day in the garden, planting flowers. I avoided switching the news on or clicking on articles about Covid online. (5ME) (…) the weather is amazing, so off I go into the woods, away from people, to enjoy nature. I have the feeling that nature is recovering and I am seeing and feeling the landscape, the weather and the air differently from how I used to. I'm taking more notice of what's in bloom, how animals are behaving, and rediscovering the world. (9FN)

Germany's first Covid lockdown, which commenced on 22 March 2022, imposed numerous restrictions on people's movements and interactions in public. It is imperative to read our diarists' comments in the context of the exceptional and, as far as their generation goes, entirely

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unprecedented situation that prevailed at that time. The strict limits on travelling that were in force left the students compelled to focus on home and the natural world, a reorientation we can regard as a self-care strategy and therefore as an assumption of responsibility for their wellbeing.

3.5 Discussion

The diaries completed by our study participants provide us with multifaceted insights into nurses' experience of the first wave of the Covid-19 pandemic in Germany. The entries, documenting day-to-day work and life in conditions far beyond the ordinary, reveal ambivalent and paradoxical emotions and views, states of uncertainty and a sense of confusion and disarray. Nurses found themselves facing feelings of overwhelm as predictions of a first wave of Covid infections with a rapid rise in cases precipitated a range of infection control rules and procedures. As the threatened tsunami of cases failed to materialise to the extent feared, nurses were left with a sense of emptiness and deflation; their responses to the potential for worse to come included uncertainty and, in some cases, a feeling of resignation.[32]

In their diary entries, the student nurses in our sample explored various facets of their moral responsibility as nurses. We will discuss three examples in this context: professional responsibility specific to the work of nursing; the responsibility of the hospital in which they work; and societal responsibility.

Nursing-specific responsibility: The diaries strikingly illustrate the intensity of the workload faced by nursing staff in all areas of acute care, with the general exception of the Covid wards newly set up at the time of data collection. Covid permeated the nurses' view of their patients, raising a fear that the patients might infect them and they might subsequently pass the infection on to others, with the concomitant risk that these 'others' could include the nurses' own families and especially vulnerable family members. The participants were simultaneously aware that, in the conditions that were in force at that point in the pandemic, the PPE they were required to wear, such as masks, represented a serious barrier to the process of forming a relationship with the patient. The ensuing conflict between the distancing that was an integral part of 'correct' infection control procedures and the value nurses place on creating a positive nurse–patient relationship was, at this point in time, irresolvable, leaving nurses forced to essentially suppress it and placing them under moral stress. An ambivalent perspective emerges in relation to the hospital's clinical management of the crisis. As well as giving rise to uncertainty, the emergency procedures, which were evolving day by day, provided nurses with guidance on the standards required of them at this time, bolstering their professional role in the setting. The participants valued rules for the new routines and procedures that entered their working lives, finding that they helped guide their work and supplied a new, albeit initially unfamiliar, structure in what had suddenly become an unstructured space. Their focus was on doing everything right within the newly prescribed structures and strictures, on being able to resolve instances of ambivalence, and on reducing the moral stress to which they were exposed. Some nurses took and defended decisions to prioritise the nurse–patient relationship over the infection control procedures in place,[33] thus successfully resisting the dominance and authority

[32] Petkovic 2020, pp. 41–43.

[33] Mask mandates in hospitals were coming into force during the data collection period; it took some time for full compliance to be established. Many people were wearing cloth masks (for instance) at this time.

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asserted by medics on the basis of a biomedical perspective encapsulated in the so-called 'AHA' rules,[34] predicted case numbers, and physical distancing requirements.[35] Our findings indicate that, in the four weeks commencing the initial wave of Covid-19 infections in Germany, nurses found themselves confronted with the task of restoring an order that had been severely disrupted as the pandemic began to unfold. The complex landscape of rules, regulations and information around the virus presented a severe challenge to the practice of empathetic and compassionate nursing care. The fear and the all-encompassing sense of unease felt by many during this period left nurses in various settings unable or struggling to find creative ways of continuing to provide such care, to improvise and identify alternative paths to restoring to themselves the stability they had lost at work.[36] None of our participants' diaries recorded an instance of a problem solved in such a way; this crisis situation appeared instead to cause people to fall back on conventional, inflexible ways of handling the issues arising in their day-to-day working practices. The attempt to create the impression that the desperately struggling health system was coping with the pandemic certainly had the purpose of managing societal fears. This optimistic view evidently also had a part in the rigidity with which actors within the system sought to regulate their own fears and worries by relying on tried-and-tested approaches amenable to a hierarchical implementation and thus generating a sense of security amid the crisis.

Our diarists reflected on various dilemmas they encountered during this period, one example being considerations around whether to wear a mask when interacting with a patient and accept the barrier to relationship that it presented. With regard to this aspect of professional responsibility, participants apparently considered the risk of infection with Covid-19 as justified in view of the principle of providing empathetic care. This perspective emphasised the vulnerability of the other party to the relationship more strongly than the risk to the nurses themselves. Nurses seeking to assess the implications of a distanced nurse–patient relationship regarded infection control procedures with a critical eye, revealing a distinct and marked professional ethos.

Our findings suggest that nurses approached the pandemic situation from a point of view that placed the vulnerability of the other and their own vulnerability centre stage – a perspective of care as concern. Underlying their actions was the knowledge that, while Covid-19 had the capacity to kill, a comparable level of potential harm could arise from nurses' inability to provide patients and their relatives with compassionate, empathetic care, and from the obstacles to their professional practice of caring presented by the lack of supportive resources that was a consequence of policy-level decisions at that time.

The responsibility of hospitals: Nursing takes place within spaces structured and defined by fixed roles and accompanying responsibilities, and undergirded by a specific system of values. During these early weeks of the pandemic, as existing structures fell apart and actors within the hospital system attempted to restore order in a context newly marked by uncertainty,

[34] 'AHA', an acronym targeted at the general public in Germany and representing rules intended to limit the spread of SARS-CoV-2, stands for Abstand (distancing), Hygiene (hygiene; infection control) and the wearing of an Alltagsmaske (that is, a face mask, which at this point was not required to be medical grade). Cf. https://www.bundesregierung.de/breg-en/news/meeting-with-state-premiers-1792296; https://www.bundesregierung.de/breg-de/themen/coronavirus/aha-a-formel-1774474

[35] Klie et al. 2021, p. 12.

[36] van Heerden 2021.

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nurses sought to provide their patients with compassionate care in accordance with the values and ethos of their profession. What also emerges from our data, however, is that this focus on care was very closely intertwined with direct, individual relationships, blocking nurses' potential to come together to assert their personal and professional interests within the hospital. None of our diaries contained first- or second-hand accounts of nurses' involvement in working groups or emergency task forces. The hospital setting is a highly complex sphere of nursing work whose facets and implications extend far beyond the responsibility to the patient within the nurse–patient relationship. Knowledge of how pandemics unfold and advance was crucial to the ability of those working on the 'front line' of the Covid crisis to cooperate multiprofessionally in finding ways of meeting infection control stipulations that did not infringe patients' dignity. In this light, a nurse's professional responsibility appears as an ambivalent space of care-driven relationships, attitudes and values; one example of this from our data is the diary entry, cited in our analysis above, made by a nurse noting the tedium of a nightshift on the Covid ward, earning a supplement, but without any Covid patients to care for. This nurse found himself feeling ashamed of having left his colleagues on his usual ward coping with a heavy workload. In view of these conflicts of responsibility and ethos, we consider it vital to encourage nurses to engage with and act in accordance with their professional responsibility in the sense of protecting the interests of their patients alongside their own. Professional supervision, to this end, needs to extend beyond its use for theoretical 'reflective practice' and find a firmly rooted place in nurses' working lives.

Hospitals, as complex organisational systems, are sites of divergent sets of values, where biomedical conceptions continue to predominate, and economic notions of value have come to attain an equal influence. In this preponderant, scientifically-driven system, the values underlying the nursing profession exist within a niche that shrinks in direct proportion to the emergence of crisis within the healthcare system. This situation leaves a professional ethos of nursing care without the ability to flourish.[37] We are of the view that urgent action is required to enable nurses to establish and protect their professional system of values, allowing space for answers to questions such as "What shall/can I do with my newly acquired knowledge and skills?" and "What career paths, or routes to greater responsibility and control of my work, are available or can become available to me in my department/profession?" and thus uncovering scope for autonomous action as nursing professionals.[38]

Societal responsibility: News headlines are a pervasive presence in our participants' diary entries. The diaries often included screenshots, primarily showing graphs and charts issued by the Robert Koch Institute. During this period, the media frequently featured members of the public applauding nurses and other workers – in Germany as elsewhere. Nurses and carers expressed vehement criticism of this gesture on social media. We would note at this point the importance of distinguishing between the self-sacrificing ethos that society ascribes to nurses and members of other caring professions, alongside correspondingly high expectations of these workers, and the perceptions and positions which members of these professions ascribe to themselves – encompassing structural altruism, but not necessarily implying a heroic willingness to lay down their own lives. Our participants reflected on these issues in their diaries, without engaging critically with the actual or desired role of the nursing profession's representatives in the policy sphere, particularly after the designation of nurses as 'key workers'

37 Isfort et al. 2018; Aiken et al. 2013, pp. 143–153.
38 Giese 2020, pp. 103–105; Stemmer et al. 2020, pp. 116–117.

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(the German term is *systemrelevant*, meaning 'relevant/vital to the system [of society]') at national level.[39] We are of the view that empowering nurses to represent their interests to national policymakers is a task for society at large. The pandemic, on top of exacerbating existing difficult conditions on hospital wards, has left nurses struggling to gain appropriate recognition for their adherence to their distinct professional system of values.[40] As the first wave of Covid-19 infections ebbed away, large numbers of nurses, driven by frustration over the demands placed on their profession and the perceived lack of genuine societal support underlying them, left their roles in Germany's hospitals. It has historically been, and remains, the case that few in society, at individual level, are willing to enter into a profession such as nursing, with its tendency to impose workloads far beyond the contractual, and few, at collective level, are prepared to support pay, conditions and societal appreciation that would do justice to this commitment. Genuine recognition of nursing as a 'key' profession would require extensive redistribution of financial and human resources.[41]

The Covid pandemic was an object lesson for our societies in the vulnerability of their reliance upon mutual solidarity. Those working in healthcare received insufficient recognition and appreciation for their professional contribution to the stability and security of our society in times defined by uncertainty. The nursing and medical professions are responsible for caring for the sick and bearing witness to vulnerability, old age, and death, and they fulfil this responsibility. During the pandemic situation, however, members of these professions found themselves compelled to deliver ritualised forms of care, distanced from people in life-or-death crisis, if they were to cope with the levels of suffering they encountered in their day-to-day work. Nurses in Germany are in urgent need of greater understanding of their present situation, which many of them experience as a diffuse sense of powerlessness. The extreme staff shortages and inadequate working conditions plaguing the profession are the result, in part, of its limited political power and influence in German society – power and influence which nurses need if they are to make the point that societal assumptions and ascriptions around them, far from reflecting the reality of their work, effectively promote professional identities which are unhelpful in the practical discharge of their duties.[42]

4 A Look Ahead

In this exploratory study, conducted at the outset of the first wave of Covid-19 infections in March 2020, nursing students on a cooperative degree programme kept diaries in which they described a variety of new situations, procedures and events that engendered a profound sense of uncertainty, fear and threat. The crisis took a marked toll on their sphere of professional action, characterised hitherto by care- and compassion-driven nurse–patient relationships, established routines, and nursing-specific values. These student nurses found themselves required to refigure and reconfigure their professional responsibilities in accordance with the dual interests of their patients and their own physical and mental wellbeing.

In our view, the study has shown that professional and ethical reflection, by means of keeping a diary of day-to-day life on the wards, is a promising method through which nursing research

39 Hunlede et al. 2020, pp. 10–14; Fromm 2020, 106–108; Roigk 2020, pp. 47–48.
40 Edward 2011, pp. 184–191.
41 Reiber et al. 2021, pp. 197–208.
42 Giese 2020, pp. 103–105.

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can bring practitioners on board in participatory designs and encourage them to take a more active role in interpreting their experiences. We further believe that this method may provide a new approach for ethics advice and support for nurses, in formats such as regular ethics discussion groups. This practice could empower nurses to articulate both their experience of incapacity to effect change and the authenticity and integrity of a successful, caring and empathetic nurse–patient relationship in day-to-day nursing, and to reflect on these considerations in the teams they work with. During the first and second waves of the Covid pandemic, it became apparent that nurses did not engage with the ethical and psychological support which numerous settings put in place rapidly and in extremely easy-to-access formats; it therefore seems imperative to identify ways of providing this support that work for nurses in the current structures of their roles.

As a final thought, we would suggest that our findings call for fair and just participation for nurses in hospital structures – participation that goes beyond a putative 'equity' and enables nurses to engage fully in shaping their working conditions. Achieving this will entail forging new paths in the organisational structures of hospital wards and creating ways to help nurses understand and maintain their resilience and attain the skills they require to manage the situations they face today.[43]

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[43] Giese 2019, p. 321.

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