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A Bleak Future Awaits Nurses in Traditional Employment Worldwide: Insights on Practice and Career Alternatives

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Abstract: The COVID-19 pandemic has tested world leaders' capacity to manage, and they have been found wanting. Traditional, institutionalised health services will shortly be unsustainable due to unconvincing leadership and inept managerial capacity to identify and alleviate risks to nurses and other workers on the pandemic front line. The aim of this paper is to share insights on nursing career and practice options to provide nursing services to our communities; and canvass anticipated resistance to nurses choosing autonomous practice models in independent business approaches to health care provision.

From analysis of the evidence and literature, it was found that the systematic ill treatment and mismanagement of nurses during the COVID-19 pandemic is appalling. Nurses are exiting hospitals and health systems across the globe. Some are leaving nursing itself. On any measure, the situation is a wholesale disaster and a wanton waste of skilled and dedicated people. When hospital and health systems become too toxic for nurses and nursing services to function fully and thrive, and when government officials and politicians trivialise and disrespect the work and value of nursing, it is time for nurses to consider other employment and practice model options. In conclusion, A groundswell of support is needed for nurses to remove normalised policies that bind them to medical control, and to break medical monopoly on universal health insurance funding to permit access by nurses to sufficient specified items to earn a wage as independent practitioners.

The implications for nursing and health policy makers are: nurse safety and practice integrity need to be central to policy deliberations that affect spending on risk management and reduction. Policies that put nurses and patients at increased risk encourage those with a choice, to abandon unsafe health system employment. Administrative accountability for staff and patient safety affected by their decisions has long been neglected in health systems around the world. It is time for a reckoning.

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Background and Context

The COVID-19 pandemic has tested world leaders' capacity to manage, and they have been found wanting. Those who know how to respond effectively to infectious diseases, often lack the positional power and authority to do so. At baseline, the global pandemic

response is compromised by leadership and management self-interest, incompetence, and a lack of political will to prioritise human life over profits or political gain. Nurses in every nation have risen to the challenge of helping people to manage COVID-19 risks and infections, recover from other health problems and survive invasive medical procedures. Recent responses from medical centre bosses canvassing the replacement of nurses with robots rather than providing safe workplaces and showing respect for nurses, is an explanatory narrative about their attitudes toward nurses and patients.[3]

For the past three years, nurses have risen to the global challenge of helping people to survive the COVID-19 pandemic and recover from non-COVID health problems and medical procedures. However, the systematic mismanagement of nurses during this period is inexcusable. Historically, the current pandemic is the most mismanaged in human experience.[1] In some countries, nurses continue to be thrown onto pandemic frontlines with inadequate safety equipment, little information and outdated or ineffective protocols.[2] Many workplace safety conditions and human health necessities that were hard-won legal rights before 2020 are being dismantled on the grounds of necessity and justified by the pandemic. Several nations are considering legislation to force nurses to remain in precarious work situations. Others plan to introduce nursing robots rather than provide safe workplaces and show respect for human nurses.[3] Nurses were hailed internationally as heroes and saviours by their patients, yet substandard management decisions continue to abuse their human rights.

By late 2021 political messaging for the pandemic had changed dramatically from 'we're all in this together' to 'the health risks are exaggerated and pandemic surveillance and public safety orders cost too much money'.[4] A year later, in 2022, the financially inspired message was, 'governments should not be involved in personal health problems, so look after yourselves.[5] Such government shifts in pandemic rhetoric justified altering policies for COVID-19 data collection to trivialise the catastrophic, worldwide impact of the pandemic[6] and reduce their reportable national numbers of COVID deaths and illnesses.[7] Accurate information about the prevalence of COVID and its variants is available only to those who know where to look for it. The aggregation of COVID prevalence information prevents deep scrutiny of the extent of the pandemic. But nurses live the daily reality of COVID. Nurse clinicians continue to help pandemic patients survive by encouraging people to protect themselves with masks, social distancing and handwashing voluntarily. At the same time, politicians and some medical commentators spruik the idea that the world is now in the 'post-pandemic' stage and even deride earlier public safety measures as unnecessary.[8,9]

Despite the scientific evidence that at least ten days of isolation is needed to prevent transmission of COVID-19,[10] some politicians in Australia and elsewhere convinced medical advisory panels to reduce the period of paid isolation for nurses (and others) to five days. Vulnerable patients consequently endure extensive self-isolation to avoid infection[11] and those still working have increased exposure to infection from those returning. Recently, when some politicians re-established pandemic transmission precautions, bypassing the medical advice to suspend public health safety measures, they were publicly attacked by the medical fraternity for 'snubbing' their advice.[12,13]

In some countries, at government hospital board and senior administration levels, action was taken to reduce nurses' access to worker′s compensation insurance if they were infected at work.[14] Nurses are expected by most employers to use their accumulated sick leave or vacation time or take unpaid leave if they 'choose′ to self-isolate for longer than five days. No specific compensation or paid leave provisions exist for nurses who develop long-COVID and cannot return to work.

Evidence is building that long-COVID, which affects more women than men, is fuelling misogynistic medical attitudes towards sufferers.[15] Simultaneously,

unchecked disinformation campaigns assure the public that COVID infections are no more than seasonal influenza. Therefore, devastating suffering and deaths are ongoing, under-reported, and trivialised.[16]

Hospital and health systems administrators worldwide seem to concur with many political leaders and medical analysts in abandoning mandated public safety measures for the general public[17,18] but not in their own workplaces. Nurses and their colleagues, who face overwhelming demands for their expertise, have begun publicly exposing questionable financial decisions by management boards. These include NOT replacing nurses and other practitioners who become infected or self-isolating to protect colleagues and patients, allowing staff attrition to erode nurse-to-patient ratios, and placing all at undue risk.[19,20]

At the time of writing, nurses in many countries are exercising the right to withdraw their labour as a last resort to draw public attention to dangerous and unjust situations in public hospitals. The disappointing efforts of trade unions to advocate for nurses and protect worker rights has placed nurses in situations with risks for all concerned.[21] In some countries, nurses who are regulated into their role have no civil right to withdraw their labour or resign[22] are compelled to work regardless of personal risks. Some Western democracies appear to be considering similar tactics where employers and governments examine legislation options to strip nurses' civil and industrial rights to strike or otherwise withdraw their labour during emergencies.

'Never let a good crisis go to waste'

The above saying, widely attributed to several political, business and industry leaders, means that a crisis, such as the pandemic, provides opportunities to transform policies and expectations in ways that would normally be unacceptable. With this in mind, we should consider the perverse economic incentives around the misery and death caused by COVID-19, and who benefits.

Pandemic-related increases in medical diagnosis and treatment demand have caused a surge in medical business income. Policy drivers for medical income streams, such as medical insurance, universal health insurance subsidies and gap fees paid directly, are controlled by doctors whose businesses benefit from increased demand.[23] A similar perverse business incentive applies to pharmaceutical companies producing vaccines, antivirals and testing kits. Medical practitioners face a classic moral hazard when, on the one hand, they are paid to generate health benefits and, on the other, they earn more if illness and disease continue and require more fee-paid interventions.

Not all medical practitioners subscribe to dubious business tactics. However, those that do often provide elite advice to governments to encourage them to open borders and admit COVID-infected travellers and convince politicians to ignore their responsibilities to protect citizens during a pandemic.[24] From my experience, many doctors appointed to policy advisory forums act as counter-revolutionaries to promote policies that ensure their profession's business success while quashing competition for funding or shared access to government subsidies and insurance payments. By controlling policy settings that regulate public access to vaccinations and advising political leaders to restrict vaccine and antiviral availability to groups identified by doctors, they guarantee medical business growth and run lucrative medical intervention programs with government funding.

Licenced physicians monopolise the pronouncement of legal diagnoses. While moderately tolerated by other professions that also diagnose and treat, there is growing concern about the medical ethics of hospital doctors colluding with officials and colleagues on policy advisory committees to mis-record the deaths arising from COVID-19 infections and manipulate tallies. Throughout the world, accurate numbers of COVID deaths are being hidden through a medical strategy of emphasising any other patient condition present during COVID-19 as the cause of death.[25,26] Just suppose older adults, who often live with multiple health conditions and morbidities, become

infected with COVID and do not survive. In that case, doctors may attribute their deaths to a previous condition that they had managed successfully. The irony, of course, is that by altering the actual cause of death, an upsurge in deaths from illnesses that had been successfully managed would, at face value, indicate alarming global medical incompetence or neglect.

Nurse mistreatment during the pandemic

Misinformation and disinformation about the COVID-19 pandemic, promoted by political, medical and economic leaders, has fuelled public confusion and naivety about whether the pandemic is real[17] despite millions of early deaths so far. Proposals to limit personal freedoms to prevent virus transmission are often met with public outrage. Nurses and their colleagues working in hospitals and clinics are experiencing increased aggression and verbal abuse from patients and families who refuse to wear masks, wash their hands, or keep a safe distance.[27] Attempts by nurses worldwide to protect vulnerable people from exposure to infection prompt resistance from some family members and other visitors who believe the 'post-pandemic' or 'living with a mild variant' rhetoric of politicians and medical commentators.

At the clinical frontline, 'good crisis' management decisions normalise draconian emergency staffing decisions while concurrently claiming that the pandemic is over. In some countries, hospital administrators expect nurses to pay for PPE, COVID vaccinations, rapid antigen tests, and polymerase chain reaction (PCR) tests to confirm their COVID status.[28] Many of these employers justify reducing supplies of nurses' work safety equipment[29] because they too believe the convenient 'truth' that the pandemic is over.

Nurses who arrive at work expecting a regular shift can be told, hours after starting work, that they are required to stay for a double shift – or in some countries, a triple shift.[30,31,32] Overtime or penalty rates may not be offered or paid, and often only limited rest time or meal breaks are allowed. Nurses are sometimes virtually imprisoned in their protective equipment (PPE). They are not permitted to leave the ward or clinical area during the few breaks they are allowed. Nurses' accounts and social media posts out of Peoples' Republic of China and elsewhere tell of nurses being sewn into their PPE and forced to use incontinence pads throughout their shifts, are horrifying indictments of callous administration and systematic denial of nurses' human rights.

Health service administrators and government health department officials are internationally lamenting a nursing shortage,[33] and many feel justified in recruiting nurses from other countries to fill gaps in their neglected domestic health systems.[34] Sufficient people qualified in nursing probably are available to meet health services requirements; however, there is a shortage of nurses and others willing to work in hazardous environments run by administrators who exploit them and mismanage pandemic risks.

Nurses are exiting hospitals and health systems across the globe for many reasons. More than usual are leaving nursing itself.[35] On any measure, this is a wholesale disaster and a wanton waste of skilled and dedicated people, especially when the world is already short of approximately 6.5 million nurses. The general public constantly identifies nursing as the most trusted profession, and nurses are ever-ready to advocate for patients in any circumstance that poses undue risks to their well-being and recovery. The worldwide health work protests about what is happening in hospitals are mainly about the safety of patients. It is devastating for nurses to see those with positional power in government and health organisations trying to manipulate public sentiment against them and their calls for fair treatment, safety and respect at work.[36] Recent government plans to outlaw future protests by health workers[37] indicate a growing ineptitude of many in possession of the power to legislate appropriately – but are unwilling to do so.

Nursing practice and career options: the way ahead

Standards established for workplace safety in public hospitals and career development are being

dismantled in many countries by health service administrators using the 'good crisis' rationale to reduce expenditure and build a surplus. Such decisions have consequences that are unfolding around the world while decision-makers act with no personal accountability. When hospital and health systems become so toxic that nurses and nursing services cannot function fully, and when government officials and politicians trivialise and disrespect the work and value of nursing, it is time for nurses to consider other practice and employment options.

In 2023, no valid reason exists to prevent self-employment for nurses in innovative practice models. These businesses would promote a more appropriate and effective model of nursing services than the current medical model offerings in public hospitals and communities. Nurses are autonomous clinicians in their own right and do not require medical oversight for their nursing practice. Nurses in most countries have the right to remove themselves from unnecessarily dangerous, poorly managed work environments without jeopardising their registration or licence to practice. Any government effort to force nurses to remain powerless or in peril would amount to civil conscription or coerced servitude of a class of workers and would run counter to the United Nations Universal Declaration of Human Rights, Articles 4 & 12.[38]

There are many income-generating options for nurses to consider that would give them control over the type and timing of work they do and the practice model they use. The business models and career strategies available to physicians provide a starting point and an equitable and useful precedent for nurses embarking on independent practice. Medical business models enable physicians to contract their clinical services to the health system, their teaching services to universities, and to be on boards of management and government committees and only accept work that meets their safety, status and remuneration requirements. Some USA nurses work to a similar business model, travelling to various hospitals and working as infectious diseases specialist nurses for defined periods or nominated outcomes such as infection control protocol reviews and medical practice audits. Many years ago, nurses at Johns Hopkins Hospital in Baltimore, Maryland, proposed a business model to supply nurses to medical treatment departments, with a budget line for nursing included in clinical pathways funding based on patient cost estimates for a standard pathway and adjusted for complications. That hospital now leads the world with clinical nurses in central financial and operational decision-making roles.[39] Currently, nurse funding in most countries is aggregated (and invisible) within the daily cost of an occupied hospital bed. When medical requirements justify adjustment to bed costs, nursing is rarely mentioned.

The pandemic has disrupted traditional medical approaches to treatment. Doctors have adopted digital health technology options and influenced funding policies delivering fee parity with face-to-face services.[40] Nurses could use similar contemporary approaches to provide care, treatment and support, and work towards policy changes allowing equal access by nurses to government funding and business models that insurance companies and the general public would accept. Nurse primary care clinics could be set up in shopping centres or with pharmacies and provide face-to-face and online support services to an ageing population, new mothers or other vulnerable groups, with referral to physicians if a medical issue arises. Furthermore, physicians could refer their patients to nurses for nursing issues. Nurses could enter the gig economy and use technology to provide a user pays service for particular nursing interventions and support for early discharge, post-partum care, or help with rehabilitation health issues. For example, nurses could contract services to aged care facilities or medical clinics using this model. I know a group of nurses who provide concierge and advocacy services to people confused by complex medical care and services. Physician businesses could contract specialist nursing services rather than

denying patients nursing care, or having to go to hospitals where they may or may not receive specialist nursing care. Clinical nurse educators could contract to any health and medical services to provide staff training, technology coaching and implementation sessions, and more.

In a number of countries, including Australia, universities now prefer to hire academics on revolving short contracts rather than tenure. Therefore, nurse academics could exit university-exclusive contracts and only accept offers for the teaching or research work that they prefer, and copyright their intellectual property. Universities prefer remote learning so independent academics could set up support teaching sessions for students needing more than the internet. They could also practise clinical nursing as a contractor to hospitals or in their private practice in the community, as do allied health services and doctors.

Opportunities abound for nurses to practice independently in a professional environment where they can thrive. So, what has stopped many of us? Nurses and nursing have traditionally been systematically constrained in their education and funding frameworks to guarantee a supply of inexpensive workers for public health systems and a limited number of small services overseen by physicians. If independent nurse practice is to evolve, we must identify conflicts of interest among those making decisions in healthcare environments (including among nursing leaders) and expose vested interests. Current healthcare business models depend on a submissive, accommodating nursing workforce to be sustainable, a truth nurses must acknowledge and account for when designing and marketing their independent business offerings.

Who could possibly object?

We need to be fully aware of the challenges ahead. Long-established medical business models control access by other health professions to government and insurance funding. Through practice scope regulation for all registered health professions, doctors set limits on independent practice, professional autonomy, scope and responsibility. The primary restriction nurses face in pursuing innovative, independent practice is the influence medicine exerts over nursing professional direction and scope. Any proposal for nursing advancement will be resisted by those controlling the status quo, but in a time of global change and power redistribution anything is possible. It is unlikely that those in power will relinquish it freely – nurses will have to take it. Opportunities, previously quelled, are now feasible, and the normalised covert strategies, used in the past to constrain nursing employment options, are under public scrutiny and evaluation.

Through many years of policy engagement at all levels of government and organisations, I have, in policy forums and advisory committees, observed and debated many lines of arguments used by medical representatives against other health disciplines, hoping to set up an independent practice. Some instinctive medical responses include bogus claims about risks to public safety; bombast about two-tiered health systems; medical monopolies being so underpaid it would be unfair to introduce business competition; or threatening to close their practices if forced to compete with nurses (or others). The 'floodgates' argument is another popular choice to scare government officials away from allowing non-doctors to access universal health insurance funding, despite the widespread rorts of that same funding by medical business operators.[41]

In terms of public image, physicians continually suppress competition for funding by portraying their expertise as superior to that of other practitioners. In some instances, they encroach on other disciplinary practice fields with impunity, thereby extending their scope of practice to gain access to health funding that would more appropriately be allocated to nursing and allied health services. Doctors lacking skills in the encroached professional areas hire nurses and allied health professionals to do that work for low wages, while the balance of the funding is retained by the medical business that has government authorisation

to run subsidised programs which they designed to influence funding policies.

Critics who question medical wealth-building strategies often have their credibility targeted in medical reprisals. The most common approach is to label criticisms and questions as 'doctor bashing', which allows physicians to play the victim. Usually, a non-medical friend will make the first accusation of 'doctor bashing', then a doctor will make a supporting statement, and other doctors will quickly support that statement, expressing regret that 'it has all come to this' to gain public sympathy. The tactic resembles the 'phone tree' concept, where organised support for a person or cause creates the impression of a groundswell. Whenever resistance to medical domination occurs, or alternative options for meeting a communities' health and welfare needs are offered, elite medical media voices create scary myths about threats to public safety if doctors are bypassed or not placed in charge. As a result, physicians get appointed to funding gateway positions and, in many countries with limited regulatory scrutiny, government funding for medicalised, non-medical issues are easily rorted for profit.

Systematically, medical practitioners and their industry representatives have infiltrated all levels of government and exerted unprecedented influence over government officials and political figures. Physicians have established themselves as elite media voices on any topic related to medical/health practice treatment and services.[42] Even military officers, convinced of medical superiority, accept the strategic risks of obtaining their health information from a single, compromised source. The medical putsch globally controls national research funding and research priority setting favouring medical specialities above all other health disciplines, in similar ways to that of national and international cartels.

Medical strategists set up policy environments that assume the need for medical sign-off on the work of nursing and allied health professionals by suppressing the nomenclature for health professionals and subsuming all other disciplines under 'medicine' or 'medical workers' or 'multidisciplinary teams'. Rarely will the words' nurse' or 'nurse practitioner' be uttered or written in medical texts or communications, even for primary health care, which nurses and allied health practitioners mainly deliver. Another cartel-like strategy is the push to regulate more drugs needing a medical prescription, such as Panadol which is available from pharmacists. If politicians and others are convinced that common medication requires a prescription and, therefore, a medical assessment, income is increased. When over-servicing by doctors is unrestrained, broader public access to safe medicines is effectively limited. Similar tactics are underway to medicalise normal ageing to increase demand for medical treatment of functional problems that would be prevented or reversed by other health practitioners.

Policy strategies include convincing governments to endorse mandatory physician referral as essential for every stage of medical treatment so that funding can be claimed for every signature. Referrals between generalists, specialists and among specialists are even more lucrative. The gap payment between what Medicare (the Australian universal health insurance scheme) estimated as 84% of the cost of the intervention is increased by medical businesses to 'whatever the market will bear'. Medical industry pressure is applied to governments by charging patients this 'gap' payment which, in Australia, can be greater than the subsidy for particular procedures. Medical commentators now criticise the government for making medical care unaffordable for many by not increasing the funding limit. Ironically, the many medical businesses that respect and comply with universal healthcare funding rules are in dire need of a review of subsidies to keep pace with inflation. Unfortunately, the risk of widespread cheating from other medical businesses taints the entire medical argument for government funding increases.

Medical business models benefit financially from universal health insurance systems by 'up-selling' to increase the number of government-subsidised

medical and prescription items they can claim.[43] Income is tripled if doctors up-sell three to four subsidised items at every patient encounter or treatments spaced out so that patients return several times for follow-up. Some medical colleagues have refused to rort the system this way and have declined to work in such businesses. With no public scrutiny or cost-benefit analysis of medical costs and no justification for medical companies to continually increase their charges against all Medicare items, the medical wealth-building campaign currently underway in Australia is alarming.

Doctors' salaries are much higher than the national wages in most countries.[44] A physician's usual response is that they should be paid well for their years of dedicated study and hard work. No other group of health professionals pursues this entitled argument as much as physicians who collude widely with other medical businesses to fix pricing for the 'cartel' and support inflated medical costs that taxpayers must cover.

Caution is advised when considering announcements of 'doctor shortages'.[45] From my experience in hospitals, medical faculties and university forums, medical student intakes at undergraduate and postgraduate levels are a function of strategic planning by medical faculties in consultation with medical colleges and peak medical industry organisations. Student application numbers to medical programs are manipulated to create scarcity, generate higher earning potential, and boost social status for graduates. Local resistance to some immigrant doctors has been a long-term feature of medical industry planning for similar reasons. When forced to accept more students or immigrant doctors, medical fraternity strategies I have observed opt to accept them but ensure they remain under the control of established medical hierarchies that determine specialisation sizes, suitability of applicants and locations.

A tale of policy arena 'combat'

During the early 1990s, I was actively involved in building support in Australia for introducing nurse practitioners. Later, in 1996 I collaborated with unions, government officials and hospital administrators in shaping regulations and industrial relativities for nurse practitioner registration, scope and remuneration. When Australian nurse practitioners first appeared around the turn of the century, general practice physicians saw them as competitors for patients and medical health funding. But nurse practitioners were not proposed as a replacement for doctors. Instead, it was a way to bring expert nursing services to the general public, adding a new cohort of skilled professionals to expand the primary health environment where no nursing services at this level were available; and to provide clinical leadership to the nursing profession. Medical lobbyists responded by successfully convincing the national government to fund nurses working under medical direction and then argued that that was a far better and safer model of primary care nursing than autonomous nurses. Medical commentators and advisors in policy forums back then constructed the 'practice nurse' role to confuse government officials and the general public about nurse practitioners whose value and safety without medical oversight, they loudly questioned. Persistent lobbying by medical representatives and the acquiescence of nursing representatives eventually forced Australian nurse practitioners to relinquish most of their clinical independence and partner with doctors.

Practice nurses today have established themselves within primary care medical practices as a valuable augmentation to medicine and developed specialty practice despite constraints on clinical autonomy and business partnership options. Nurse practitioners remain the appropriate health care providers in communities and deliver holistic health management, assisting recovery and preventing complications from illness and medical procedures. Nursing has the numbers, skill and knowledge to provide community health care and health advice. We need access to appropriate health funding and commitment from those in positions of control over nurses, to lead nursing forward.

Nurses embarking on this daring career pathway should prepare for intense competition for voice, visibility, power and status. Still, the promise of a successful,

innovative career on your terms must tempt many. Despite spirited opposition from physicians concerned about business competition from nurses, the medical model of self-employment, contracting out of their services, and gaining funding through policy engagement is impressive, and well worth emulating and refining for your nursing career outside the public hospital system.

Conclusion

Nurses need not accept oppressive working conditions or work designed to stunt their careers, skills and personal options. Powerful medical and nursing vested interests have limited nursing's evolutionary development for too long. The current exploitation and repression of nurses across world health systems beg for a nursing response and a reckoning. Nurse education that limits graduates to hospital workplaces needs in-depth review to help graduates prepare for independent practice options. These options exist but will require a groundswell of support from nurses to remove policies that bind them to medical control and break the medical monopoly on universal health insurance funding to permit access by nurses to enough specified items to earn a wage as independent practitioners. Nurses in leadership positions need to either support the long overdue evolution of nurses as independent, autonomous self-employed practitioners in the business of offering nursing and health services and support to our societies - or stand aside.

Implications for practice

Demonstrating respect for human lives and rights is an obligation for those managing public resources and setting policies that affect us all. Yet, many nations are considering legislation to compel nurses to work in precarious situations. The systematic ill-treatment and mismanagement of nurses during this period justify moral and legal scrutiny in order to regulate future health hierarchies and administrative roles.

Nurse safety must be central to policy deliberations that affect workplace risk reduction and patient safety spending. Policies that put nurses at increased risk encourage those with a choice, to abandon unsafe health system employment. Personal accountability by administrators for their decisions on staff and patient safety has been largely ignored in health system policies, but this protection must end now.

References

1. McDonald T. Getting the COVID-19 pandemic into perspective: a nursing imperative. Int Nurs Rev. 2020a;67: 305-317. doi: https://doi.org/10.1111/inr.12608
2. Brissenden N. - Poor time to slash COVID funding: nurses. PerthNow 16 November 2022. https://apple.news/AYnqCyZSTSVmDaCiGOmNVAw [Accessed 23 November 2022].
3. Zollino A. - Are robots the answer to a nursing shortage? Reuters Now post 19 January 2023. https://www.news.com.au/national/are-robots-the-answer-to-a-nursing-shortage/video/e65bd426f8c99785f94665797c32bcc1 [Accessed 20 January 2023].
4. Graham-Harrison E. - Economists hail end to zero Covid in China but huge human toll is feared. The Guardian Australia. 11 December 2022. https://apple.news/A6svByGqoT_6JAtQ9deAhxA]Accessed 1 January 2023].
5. Pulrang A. - Things high risk people need now to fight Covid. Exploring disability practices, policy, politics, and culture. Forbes https://apple.news/AZaUDfR2ERouPLLzqrGjSEg [Accessed 10 January 2023].
6. McDonald T. Speak truth to power and consolidate the nursing visibility gained during COVID-19 Int Nurs Rev. 2022;69:255-260. http://doi.org/10.1111/inr.1276
7. Esterman A. - Thousands more Australians died in 2022 than expected. COVID was behind the majority of them. The Conversation 12 December 2022. https://apple.news/AWPw7HXLkRymy2w10jCseQA [Accessed 11 January 2023].
8. Young E. - The Pandemic's legacy is already Clear. The Atlantic 30 September 2022. https://apple.news/AONPVCW1hS8-xJb4-JoEy6A [Accessed 23 November 2022].

9. McDonald T. Are we there yet? A guide to achieving endemic status for COVID-19 and variants. Int Nurs Rev. 2023;00: 1-6. https://doi.org/10.1111/inr.12823
10. Finnis, A. - When will I test negative for Covid? How long Omicron infection can last and when are you the most contagious? Apple News 24 April 2022. https://apple.news/ASBDF_NcCTTWbVDT9c68cwQ [Accessed 10 January 2023].
11. Kavanagh A, Dickinson H. & Baxter N. - Doing away with COVID isolation rules means increased isolation and risks for people with disability. The Conversation 14 October 2022. https://apple.news/A0cue24yATdKbxpUMjHDQrg [Accessed 11 January 2023].
12. Giannini D. & Mitchell A. - Ministers chastised for health advice snub. PerthNow https://apple.news/APTZolcDUTT6KF26d6haLGw [Accessed 6 January 2023].
13. Butler M. - Minister for Health and Aged Care Australia. Radio interview 3 January 2023 with Graeme Goodings, FIVEAA https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media [Accessed 10 January 2023].
14. Tilo D. - NSW to repeal automatic compensation claim for COVIC-hit workers. HRD Newsletter international 16 November 2021. https://www.hcamag.com/au/specialisation/employment-law/nsw-to-repeal-automatic-compensation-claim-for-covid-hit-workers/ 316598 [Accessed 10 January 2023].
15. Lu D. - "They can't ignore us any more": five women on long COVID and medical misogyny. The Guardian 18 October 2022. https://apple.news/AlyvMqmcXQ1yYAkdsPt62ZA [Accessed 23 November 2022].
16. Ruya, Y. - Packed ICUs and crowded crematoriums: COVID-19 roils Chinese towns. Washington Examiner 24 December 2022. https://apple.news/AHYLa_eCoSlSZcMzifAfZJQ [Accessed 11 January 2023].
17. Anderson T. - Myths of the pandemic deniers. TheAltWorld https://thealtworld.com/tim_anderson/myths-of-the-pandemic-deniers [Accessed 12 January 2023].
18. Shah R. - The Covid emergency is ending. Politico 2 November 2022. https://www.politico.com/news/magazine/2022/02/11/covid-emergency-ending-lull-what-next-000 08156 [Accessed 10 January 2023].
19. O'Brien B. - More than 7,000 nurses go on strike in New York City. Reuters 10 January 2023. More than 7,000 nurses go on strike in New York City | Reuters [Accessed 11 January 2023].
20. Maclellan K. - UK Strikes to continue after govt's talks with unions fail. Reuters 9 January 2023. UK strikes to continue after govt's talks with unions fail | Reuters [Accessed 12 January 2023].
21. ICN - International Council of Nurses. Finnish nurses call for improved salaries and working conditions to address nursing shortage and patient safety ICN News 4 April 2022 Finnish nurses call for improved salaries and working conditions to address nursing shortage and patient safety | ICN - International Council of Nurses Accessed 19 January 2023. [Accessed 12 January 2023].
22. Yan Z, Li JA, & McDonald T. Nursing education development in China (1887-1949): influences on contemporary nursing. Int Nurs Rev. 2014;61(3): 380-388. doi: https://doi.org/10.1111/inr.12113
23. Harris H. - German doctor is jailed for nearly three years and fined £25,000 for illegally issuing mask exemptions... Daily Mail Australia. https://apple.news/ATeUVBrA3RiqCkFLZcniVIQ [Accessed 6 January 2023].
24. Butler M. - Minister for Health and Aged Care Australia. Radio interview 3 January 2023 with Graeme Goodings FIVEAA https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media [Accessed 10 January 2023].
25. Payne S. - COVID-19 responsible for 14.83 million deaths, World Health Organization. ABC News 15 December 2022. https://apple.news/ASw98i6KNQ3G4raLE4L 7yuQ 1/1/2023 [Accessed 12 January 2023].
26. Wang H, Paulson KR, Pease SA, Watson S, Comfort H, Sheng PO, Aravkin AY, Bisignano C, Barber R M, Alam T, Fuller JE, Nay EA, Phan D, Jones D, Frish ME, Abbafati C, et al. (COVID-19 Excess Mortality Collaborators). Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020-21. Lancet, Published online/ March 10, 2022 https://doi.org/10.1016/S0140-6736(21)02796-3
27. Wong J. & Claypool E. Narratives, masks and COVID-19: A qualitative reflection. Qual Soc Work. 2021;20(1-2): 206-213. https://doi.org/10.1177/14733250209733330

28. Tanzida Akther SDBMKKRDSIRMRP. How Inadequacies in the Nursing Field Deteriorate the Quality of Health Care in a Developing Nation. Ann Rom Soc Cell Biol [Internet]. 2021May23 [cited 2023Jan.27];25(6):3467-75. Available from: https://annalsofrscb.ro/index.php/journal/article/view/6106 [Accessed 18 January 2023]
29. McNamara A. – Nurses across the country protest lack of protective equipment. CBSNews 28 March 2020. https://www.cbsnews.com/news/health-care-workers-protest-lack-of-protective-equipment-2020-03-28/ [Accessed 11 January 2023].
30. Koy V, Yunibhand J. & Turale S. "It is really so exhausting": Exploring intensive care nurses' perceptions of 24-hour long shifts. J Clin Nurs, 2020;29(17-18):3506-3515. https://doi.org/10.1111/jocn.15389
31. Bae SH, Pen M, Sinn C, Kol S, An B, Yang SJ, Rhee HY, Ha J & Bae S. Work hours and overtime of nurses working in Cambodian hospitals. Int Nurs Rev. 2022;69(2): 150-158. https://doi.org/10.1111/inr.12720
32. Koy V, Yunibhand J. & Turale S. Comparison of 12 and 24-hours shift impacts on ICU nursing care, efficiency, safety, and work-life quality. Int Nurs Rev. 2022;69(1): 38-46. https://doi.org/10.1111/inr.12715
33. Fontaine D. & Behring S. – Understanding the American nursing shortage. Healthline 11 August 2021. What's Causing the American Nursing Shortage? (healthline.com) [Accessed 18 January 2023].
34. Ellis D. – Doctors and nurses highlight what is needed to fill gaps and future-proof the healthcare system. Doctors and nurses highlight what is needed to fill gaps and future-proof the healthcare system (news-medical.net) [Accessed 18 January 2023].
35. Daniel D. & Thompson A. – Nurse job vacancies doubled during pandemic Sydney Morning Herald 16 July 2022. https://apple.news/AAqAL6zz7Tm27UwLLf9Vx5w [Accessed 10 January 2023].
36. Busby M. – Protesters march for fair pay for nurses and other NHS staff. The Guardian 8 August 2020. https://www.theguardian.com/society/2020/aug/08/hundreds-march-fair-pay-nhs-nurses-coronavirus [Accessed 18 January 2023].
37. Allegretti A. & Stacey K. – NHS workers could be banned from striking, No. 10 suggests. The Guardian 8 December 2022. https://www.theguardian.com/society/2022/dec/07/nhs-workers-could-be-banned-from-striking-no-10-suggests [Accessed 16 January 2023]
38. United Nations – Articles 4 & 12. (1948) Universal Declaration of Human Rights https://www.un.org/en/about-us/universal-declaration-of-human-rights [Accessed 16 January 2023].
39. Shapiro S. Solving the shortage: Give nurses a voice and provide opportunities for growth. Johns Hopkins Nursing. 2008;6(2) https://web.jhu.edu/jhnmagazine/summer2008/features/solving.html [Accessed 30 January 2023].
40. Peek N, Sujan M, & Scott P. Digital health and care in pandemic times: impact of COVID-19. BMJ Health & Care Informatics. 2020;27(1):e100166. doi: 10.1136/bmjhci-2020-100166 PMID: 32565418; PMCID: PMC7307522.
41. Ferguson A. & Gllett C. – Sleeping patients billed by doctors in latest case of Medicare rorts. Posted online 22 October 2022. https://www.smh.com.au/national/sleeping-patients-billed-by-doctors-in-latest-case-of-medicare-rorts-20221021-p5brt4.html [Accessed 16 January 2023].
42. McDonald T. Quo Vadis: A question of historical awareness. Int Nurs Rev. 2020b; 67(2): 1-6 June Issue. https://doi.org/10.1111/inr.12575
43. Practice Builders – Increase your medical practice revenue by up-selling and cross-selling. Website Practice Builders posted 19 January 2018. https://www.practicebuilders.com/blog/increase-your-medical-practice-revenue-by-up-selling-and-cross-selling/ [Accessed 16 January 2023].
44. Yanatma S. – Doctors' salaries: Which countries pay the most and least in Europe? Euronews 3 January 2023. https://apple.news/Ad6SR3xg9RmuRr7uJJPp7EQ [Accessed 6/1/2023]
45. Breadon P, Romanes D, & Fox L. – How do you fix general practice? More GPs won't be enough. The Conversation 7 December 2022. https://apple.news/AIWW27Lt0To2V68gkuV21wA [Accessed 7 December 2022].

อนาคตที่มืดมนของพยาบาลในระบบการจ้างงานแบบดั้งเดิมที่แพร่หลายทั่วโลก: ความเข้าใจเชิงลึกเกี่ยวกับการปฏิบัติและทางเลือกในอาชีพ

Tracey McDonald

บทคัดย่อ: การระบาดใหญ่ของโควิด-19 ได้ทดสอบความสามารถของผู้นำโลกในการจัดการปัญหา และพบว่าผู้นำที่มีความสามารถเป็นที่ต้องการอย่างยิ่งในระบบ การบริการสุขภาพของสถาบันที่มีแนวคิดแบบดั้งเดิมจะไม่สามารถยั่งยืนได้ในไม่ช้านี้เนื่องจากภาวะผู้นำและความสามารถในการจัดการที่ไม่น่าเชื่อถือในการระบุและบรรเทาความเสี่ยงต่อพยาบาลและเจ้าหน้าที่อื่น ๆ ที่ทำงานด่านหน้าในสถานการณ์ที่มีการระบาดใหญ่ของโควิด-19 วัตถุประสงค์ของบทความนี้ คือ การแบ่งปันความเข้าใจเชิงลึกเกี่ยวกับอาชีพการพยาบาลและทางเลือกในการให้บริการพยาบาลแก่ชุมชน และวิเคราะห์วิจารณ์ การต่อต้านที่อาจจะเกิดขึ้นต่อพยาบาลที่เลือกรูปแบบการปฏิบัติอิสระในแนวทางธุรกิจที่พึ่งตนเองในการให้บริการด้านสุขภาพ

จากการวิเคราะห์ พบว่า การเลือกปฏิบัติที่ไม่เหมาะสมและการจัดการที่ผิดพลาดต่อการทำงานของพยาบาลในช่วงการระบาดของโควิด-19 เป็นเรื่องที่น่าตกใจอย่างยิ่ง พยาบาลลาออกจากการทำงานในโรงพยาบาลและจากระบบสุขภาพทั่วทั้งโลก บางคนลาออกจากการทำงานเป็นพยาบาลเอง แต่ไม่ว่าจะด้วยเหตุใดก็ตาม สถานการณ์นี้ถือเป็นความหายนะครั้งใหญ่และเป็นการสูญเปล่าของบุคลากรที่มีทักษะและอุทิศตนในการทำงาน เมื่อระบบโรงพยาบาลและระบบสุขภาพกลับกลายเป็นพิษเกินกว่าพยาบาลและการบริการพยาบาลจะทำงานได้เต็มที่และมีความเจริญก้าวหน้าและเมื่อเจ้าหน้าที่ของรัฐและนักการเมืองไม่ได้ให้ความสำคัญเคารพหรือให้คุณค่าของการพยาบาลอย่างที่ควรจะเป็น จึงถึงเวลาแล้วที่พยาบาลจะต้องพิจารณาตัวเลือกรูปแบบการจ้างงานและการปฏิบัติอื่นๆ โดยสรุป แรงสนับสนุนจากคนส่วนใหญ่จึงเป็นสิ่งจำเป็นสำหรับพยาบาลในการลบล้างนโยบายที่ถือปฏิบัติมาจนกลายเป็นปกติที่ผูกมัดพยาบาลกับการควบคุมทางการแพทย์และในการทลายการผูกขาดทางการแพทย์ในระบบกองทุนประกันสุขภาพถ้วนหน้าเพื่อให้พยาบาลได้รับการอนุญาตให้เข้าถึงการให้บริการบางรายการที่มีการระบุอย่างเพียงพอในการรับค่าจ้างในฐานะผู้ประกอบวิชาชีพอิสระ

การนำข้อมูลจากบทความนี้ไปใช้สำหรับการพยาบาลและผู้กำหนดนโยบายทางการพยาบาล คือ ความปลอดภัยของพยาบาลและความมั่นคงในการปฏิบัติงาน ถือเป็นหัวใจสำคัญในการพิจารณานโยบายที่ส่งผลต่อการใช้จ่ายในการบริหารจัดการและลดความเสี่ยง ส่วนนโยบายที่ทำให้พยาบาลและผู้ป่วยมีความเสี่ยงเพิ่มขึ้นนั้น จะกระตุ้นให้ผู้ที่มีทางเลือกละทิ้งการจ้างงานในระบบสุขภาพที่ไม่ปลอดภัยได้ ความรับผิดชอบในการบริหารสำหรับเจ้าหน้าที่และความปลอดภัยของผู้ป่วยที่ได้รับผลกระทบจากการตัดสินใจของผู้บริหารได้ถูกละเลยมานานในระบบสุขภาพทั่วโลก ฉะนั้น ขณะนี้จึงถึงเวลาที่ต้องคิดพิจารณาใหม่แล้ว

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คำสำคัญ: การเสริมสร้างศักยภาพ โควิด-19 นโยบายการจ้างงาน, การจัดการบริการสุขภาพ สิทธิมนุษยชน, ภาวะผู้นำทางการพยาบาล รูปแบบการปฏิบัติ ภาวะผู้นำทางการเมือง การเมือง ปัญหาแรงงาน

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