"This Is What You Signed Up for":
Oral Histories of New York State Nurses During the COVID-19 Pandemic

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Abstract

One of the first healthcare providers in New York City to die from COVID-19 was a nurse. When the city was already seeing hundreds of cases a day at area hospitals, particularly in neighborhoods already marginalized by health and economic disparities, nurses at one hospital in the Bronx staged a demonstration to protest the lack of essential personal protective equipment. The astounding response by hospital administrators was to threaten nurses that they would be fired if they continued to speak out regarding their concerns. Like many activists, healthcare providers took to social media to warn the public about the realities of both the COVID-19 crisis and the threats to the health and safety of their own families. However, in at least one Facebook thread, the response to nurses was, "This is what you signed up for." As scholars of women's history, we have to wonder about the irony of nurses being lauded as heroes in one breath and criticized as hand-wringing turncoats in another. Did such a callous response have anything to do with the fact that nursing is still considered to be a "feminized" profession? As it turns out, nurses—who are always at the forefront of patient care—were right to raise the alarm. By mid-June, more than 140 nurses in the United States were estimated to have died from COVID-19. Countless others continue to put their lives on the line to do the jobs they have committed to do every day. This article does what some hospital administrators and health officials did not. We listen to nurses. Through oral history interviews, we highlight what nurses in the New York metropolitan area, one of the epicenters of the pandemic, experienced during this staggering healthcare crisis.

1 On January 19, 2020 the United States' Centers for Disease Control and Prevention (CDC) confirmed the first case of COVID-19 in the United States, in a man in Washington state who had visited Wuhan, China. It would be a few more days before cases were identified in Europe. At this point, COVID-19 was a distant concern for many Americans, with top health officials in late January calling their risk of contracting the virus "low" (Miller and Hauck). At an early February campaign rally in New Hampshire, President Donald Trump talked about the virus "miraculously" going away by April ("Clip of President Trump Rally In Manchester, New Hampshire"; Stevens and Tan). As the number of cases in Washington state and elsewhere grew throughout February, the devastation to the healthcare system in northern Italy started to become apparent. On March 1, the first case of coronavirus in New York State was diagnosed in a 30-year-old woman living in New York City. Throughout early March, nurses and other health care providers were increasingly looking for guidance and protocols as they anticipated the arrival of the virus.

2 By the time the virus surged in late March, it became clear that the CDC was changing the protocols on an almost daily basis. Infectious disease protocols requiring that healthcare providers change their PPE (Personal Protective Equipment) after seeing an infected patient changed, leading hospital administrators to tell nurses and doctors to reuse their N95 masks, surgical masks, gowns, face shields, and goggles. As the pandemic progressed, nurses at Jacobi Medical Center and Montefiore Medical Center, both in the Bronx, began to complain about the lack of PPE. One callous response circulated on social media was, "This is what you signed up for." In addition, some hospitals threatened that nurses would be fired if they continued to speak out about the lack of PPE in their workplace.

3 This article does what the social media trolls and some hospital administrators did not. We listen to nurses. For almost 20 years, nursing—a profession dominated by women—has been regarded as "the most trusted profession" in the United States (Reinhart). Knowing that nurses are always at the forefront of patient care and have a wealth of professional knowledge, we suspected they would be some of the best sources for understanding the early days of the pandemic. In order to learn from these most trusted sources, we conducted oral history interviews with six nurses who worked in hospitals at the epicenter of the pandemic, in New York City and two of its northern suburbs. Of the six nurses, two worked at public hospitals, four at private hospitals.[1] They ranged in age and experience from 24 to 62 years old. Collectively, even in this small sample, they had 74 years of nursing experience. Because of the ongoing nature of the pandemic, the trauma experienced by healthcare providers, and the sensitivity of hospital administrations, three of the nurses we interviewed requested that we change their names in order to maintain their anonymity.[2]

4 In the early days of the pandemic, New York Governor Andrew Cuomo echoed the state's Health Commissioner, Howard Zucker, downplaying the risk of death by reassuring the public that most of the people who had died from COVID-19 globally were "debilitated, senior citizens, many of whom have an underlying illness" ("Video, Audio, Photos"). As the health crisis escalated,

1 New York City's 11 acute care public hospitals are funded by the city, state, and federal government and comprise the largest public health system in the country. Run by the Health + Hospitals Corporation, New York City's public hospitals are ultimately under the purview of the mayor. Six of the 11 hospitals are trauma centers, and all patients receive care, regardless of their ability to pay or immigration status. The system is the state's largest provider of care to Medicaid recipients and the uninsured. Medicaid provides coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Private sector hospitals, by contrast, may be for-profit or nonprofit and typically serve fewer uninsured patients.

2 The interviews have been lightly edited to remove audible pauses: "um", "so", "like", which are common in interpersonal conversations, but in a transcript can distract from the power of a speaker's words.

politicians and health officials increasingly spoke about "flattening the curve". At the same time, many nurses encountered the sickest patients they had ever seen. They were confronted with a virus about which very little was known and for which there is no vaccine or treatment. Unfortunately, for more than 120,000 Americans (as of May 2020), supportive care to relieve symptoms could not prevent death. Many nurses found they could do very little for the sickest patients. The nurses we interviewed responded with professionalism and competence. However, their interviews also speak to the stress, fear, mixed messages from hospital administrators and health officials, and multiple challenges of responding to a global pandemic, while the infrastructure to inform them became increasingly politicized. At the same time, the interviews demonstrate that COVID-19 is an extremely potent virus that taxed the resources of even the most seasoned professionals.

'It Hit Us by Surprise'

5 A defining characteristic of nurses' experiences during the COVID-19 crisis in New York was the extent to which recommendations kept changing—about who could be tested, how to safely care for patients suspected of or known to have COVID-19, and which PPE was available and would protect them. Some of the nurses we interviewed described receiving detailed information about the virus and preparedness plans from their facilities, whereas others noted a lack of guidance and response to their concerns as the crisis unfolded and protocols lagged behind the reality of what nurses were seeing daily.

6 Three of the nurses, working in private hospitals in Manhattan and Westchester County, described their facilities as being adequately prepared and were pleased with this response. One recalled how her hospital began holding town hall-style COVID-19 informational meetings by late February, whereas the others said they were attending regular emergency meetings, in which strategies and protocols were discussed and the establishment of facility command centers were announced by early March. They all said they received regular updates about COVID-19 from administrators thereafter. "I felt very aware that this is being taken seriously and that there are resources in place and that they'll be updating us," said Blima,[3] a nurse practitioner specializing in

3 We decided to refer to the nurses by their first names for readability and to help maintain the anonymity of the nurses who didn't want to be identified. We recognize that the academic convention is to use last names and that our choice to use first names may be misconstrued as a gendered practice, by writing in an overly familiar way about women professionals. This is not our intention. We hope our work demonstrates our deep respect for each of the women we've interviewed.

oncology. “And we got updates by email really frequently. . .I felt like there was a lot of information being shared.” Jessica,[4] a labor and delivery nurse in Westchester County, was similarly impressed with her hospital’s preparedness. “I was actually amazed at how on top of it they were and how organized leadership was and transparent,” she said.

7 Other nurses described starkly different preparedness levels, inadequate communication from administrators, and insufficient—or dangerously nonexistent—protocols. “There wasn't a whole lot of preparation per se, because I feel like it hit us by surprise,” said Lily,[5] an advanced practice nurse who works at a public hospital in the Bronx. **“**At first, I think, many people uttered the words, ‘Oh, it's just like the flu. Wash your hands, wear a mask, do your regular PPE stuff.’” She did not fault her facility, though. She regarded the virus as being so new, with so many unknown factors, that the situation was difficult to prepare for.

8 Protocols restricting who could be tested—and a lack of tests due to faulty manufacturing processes at two of the CDC’s facilities (Kaplan)—led to delays in testing throughout the United States. In the New York City–area, as elsewhere, these delays masked vital information about how long and extensively the virus had been circulating. It was a turning point in New York’s COVID-19 crisis when, on March 2, a man in New Rochelle, a city in Westchester County that borders the Bronx, became the second person in the state to be diagnosed with the virus. Before his diagnosis, he had spent four days in a local hospital with what was suspected to be symptoms of pneumonia (Goldstein and Salcedo). A week later, finding evidence that the virus had been spreading widely in the man’s community in New Rochelle, the governor established a one-mile “containment area” in his neighborhood, closing all schools and religious facilities, banning large gatherings, and bringing in National Guard troops to help disinfect public facilities and provide food to people who were quarantined due to illness or contact with the man (“Governor Cuomo Accepts Recommendation”; “N.Y. Creates ‘Containment Zone’”).

9 Just a few miles away, nurses at public hospitals in the Bronx were still being told by administrators, per local and state health department guidance based on CDC protocols, that evaluation and testing criteria would be based on a person’s travel history to China or Italy and a narrow set of symptoms. Kelley, an emergency department nurse at a public hospital in the Bronx that includes a trauma center, and her coworkers were frustrated by their hospital administrators’

4 ‘Jessica’ is a pseudonym.
5 ‘Lily’ is a pseudonym.

lack of action. “We had already been saying, ‘Hey, guys, New Rochelle, they're on lockdown. You know, they have the military there. . . . It’s 15 minutes from here. What are we going to do?’ And we still weren't really getting . . . any real answers. It was always like, ‘Well, the Department of Health says . . . ”. She described how one day, while using her hospital’s computer system, she watched as the triage questions were updated right in front of her. A question about whether a patient had been in New Rochelle, in addition to China and Italy, was added. For Kelley, it was shocking to see the protocol change so randomly. “It was 3 p.m. and it literally flipped.” Describing her hospital’s preparation for the virus as “pretty bad,” she said, “if anybody is to look back at that point in time and say that we did a good job, they would be lying.”

10 Tara,[6] an ICU nurse at a private, Rockland County hospital, said her facility seemed to be completely unprepared for the crisis and disregarded nurses’ concerns about PPE, beginning with the first patient she cared for:

> . . . it surprised me how much we weren't prepared for it . . . We'd already heard about cases in Westchester and in the city. It was just like, ‘When is this going to happen?’ And then it just suddenly did . . . the very first day I assumed care of that patient, I got a text right before I went into my shift from my manager, forwarded from administration, saying that we were not to wear masks in any room that was not suspected . . . and, at that point, they were not officially suspecting anybody. We were all upset, because we were saying, ‘Well, *we* all suspect it,’ but it wasn't an official suspected case until a doctor ordered the tests . .
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> They locked up the masks on us . . . We’re all scared, because we haven't even seen it [the virus] yet. . . . They did not swab the patient until the day he died . . . about five days into the admission. . . . all those staff members that had taken care of him . . . we all knew that we were in there, we had all wanted to wear masks, but we weren't allowed to. We were all begging the doctors to test this poor patient, and . . . it just ended up in massive exposure to the very first patient we had. . . .
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> I think they were trying to save what [PPE] we had, but, at the same time, they didn't have a protocol in place to establish who could be a case. . . . They should have immediately started screening patients in the E.R., as soon as we heard about this, even in February. ‘If they meet these criteria, just isolate them and wear a mask,’ and that’s it. Maybe we would have run out [of masks] sooner, but we ran out anyway.

Tara’s comment that administrators “were trying to save” the existing supply of PPE hints at a lack of preparedness beyond the control of her department and facility; namely, a federal response to a growing global crisis that failed to anticipate the need for increased testing capabilities and PPE. The World Health Organization (WHO) declared a global health emergency on January 30 (“Committee regarding the outbreak”), and the United States followed the next day with a declaration of

6‘Tara’ is a pseudonym.

a public health emergency ("Statement on the second meeting"). It was another two months, however, before President Trump, amid much pressure, invoked the Defense Production Act, a decades-old law that allows presidents to order manufacturers to produce vital supplies during an emergency. Even then, the act was initially used to increase the production of ventilators only—not PPE, despite its growing unavailability nationwide.

'Making Sure That We are Doing the Right Thing'

11 That nurses are the most trusted professionals stands in stark contrast to the difficulty they often have in ensuring their voices are heard. This was powerfully exemplified in the experiences of several of the nurses we interviewed, who described their resiliency and willingness to confront hospital administrators and restrictive policies. Such advocacy for the safety of their patients, themselves, and their colleagues took many forms, from demanding greater availability of PPE and testing to promoting changes in policies separating patients and family members. Many described the institutional responses they received as deeply frustrating and counterproductive to their safety and work. Yet, unlike some of their colleagues in other New York hospitals, the nurses we spoke with did not report experiencing professional repercussions for their activism.

12 Kelley, who became her union's top official at her hospital in February, described how she and the nurses at her facility held a protest in late March to demand improved access to protective equipment (Schwirtz), which was locked in administrators' offices, requiring the emergency department staff to locate a manager and request PPE when it was needed. It had become apparent as the crisis unfolded that what they thought was a problem limited to their hospital was a much more widespread issue. Kelley recalled contacting her network of nurse friends and colleagues and learning that their facilities had also restricted access to PPE:

> We're like, 'Oh, my God, they're really going to not give us protection.' Like, everywhere. And that's when we had a protest. . . . We highlighted the issues with the Trump administration. Why was the Defense Production Act not enacted forever ago? . . . Why were we not making this stuff? . . .You're making us wear masks for five days at a time, knowing full well that a week before then, if we had been caught doing any of that, we would have gotten in trouble. . . . These things are one-time use. You're supposed to wear them once. . . . The biggest, frustrating thing was how fast the standards changed.

The protest, and the nurses' willingness to use local news outlets to amplify their voices, resulted in a groundswell of community support and provisions, including the donation of much-needed masks and face shields, "which was great," said Kelley, "but it just kind of highlighted the bigger

issues, that we were getting by on the help of everyday people when our government was just kind of letting it all happen."

13 At her institution, she noted, the protocols nurses received "were not at all for the possibility of getting a multitude of these patients. . . .We had one room set aside. 'If you have somebody that you think has it [COVID-19], this is the room that you're going to use.' One room. And that room in particular didn't even have a bathroom in it." Kelley described how the nurses questioned administrators about what they should do if another person with the virus arrived in the emergency department. "We can't pretend that we're only going to get one at a time. . . . Obviously, nobody was ever going to prepare us for what we actually saw and experienced." Ultimately, administrators set aside five rooms with bathrooms. The amount of patients who soon began arriving in the hospital's emergency department far outweighed this capacity.

14 The confusion and challenges due to shifting recommendations from administrators, city and state health officials, and the CDC were mentioned by several of the nurses. As the crisis ramped up, the CDC released guidelines detailing changes to long-standing infection control policies when caring for patients with confirmed or suspected COVID-19 ("Interim Infection Prevention"). Notably, these revised guidelines recommended the use of surgical rather than N95 masks, unless a provider is involved in an aerosol-generating procedure.[7] The document acknowledges the breakdown in the supply chain of masks and says that when it is restored, facilities "should return to use of respirators [N95s] for patients with known or suspected COVID-19."

15 Nurses described how this sudden shift in PPE guidance prompted daily attempts, both at home and while at work, to remain aware of new and revised recommendations as the crisis evolved. Lily said her facility held "daily meetings of what the rules are today. What's the CDC guidelines today? What did Cuomo say today? So, we had a 12 o'clock meeting every single day." Christine, a nurse on a critical care step-down unit at a hospital on the northern tip of Manhattan, said, "The policies were constantly changing: What was the proper PPE to wear? What was proper protocol for certain things?" Her hospital sent institution-wide emails to keep staff updated about new recommendations. Kelley's experience, by contrast, was distinguished by a lack of communication:

> It just seemed like we were yelling into the abyss, because nobody seemed to have any answers. And, meanwhile, we were expected to just go in there and work. And there was

7 Aerosol-generating procedures include airway suctioning and intubation, such as when putting a patient on a ventilator.

> the whole issue with the masks. The CDC changed their criteria for the masks. It was, 'You wear an N95 at all times,' and then it turned into 'No, only for aerosolizing procedures.' 'Actually, you can wear the mask for multiple days in a row.' 'Actually, you could just wear a bandana.' It just kept changing and changing.

Some nurses said shifting recommendations were to be expected. "They were giving us information as they knew it, but they didn't know much," said Blima. "As you learn things, you change your recommendations. And to me, that seems logical. . . . The New York City surge was so disastrous that my impression of the CDC is that they gave us the information as they learned it."

16 Tara said the constantly changing protocols caused her to doubt the CDC's authority: "We felt really abandoned by even the CDC guidelines. . . . It's almost like they just bowed to whatever shortages they were anticipating in the hospitals, and that is really disappointing, too, because that ignores people's safety." She recalled an interaction she had one night with her nurse managers, when she was working as the charge nurse in the ICU:

> . . . they handed out our brown bags with our names on them, because that's how they were distributing the masks at this point, per week. . . . They handed it to me [and] said, 'Can you hand these out'? I looked in the bag, and there was no N95. There was just a surgical mask. And I [asked], 'Well, where's the N95s?' And they said, 'Oh, we ran out.' . . . Just like, you know, 'not only are we not going to protect you, but you have to be the one to break the news to your coworkers, too'. . . . There was a point where we really did completely run out. But most of the nurses had saved their N95s, because we all had kind of felt like that might happen, that they'd just not give it to us anymore. So, at the worst point of it, we were using the same one for about a week.

As a nurse practitioner, Blima volunteered to be on her facility's first COVID-19 team and found the PPE to be "not great" during the first week. Her institution updated its policies regularly to reflect the CDC's recommendations, but she cited an example of how challenging it could be in practice to obtain the recommended PPE:

> I had a patient on airborne precautions who had coronavirus and was on a nonrebreather mask. . . . I wanted an N95, and it took about 10 minutes of negotiating with the RNs on the floor. They went to their manager to see if they could give me an N95. . . . And I remember getting that [N95 mask] and wearing it around my wrist all day, so I don't lose it. And I remember videotaping it and saying, 'More precious than diamonds. Here's my new bracelet'. . . . I think they were trying to conserve the PPE and not let it all run to waste, but, I mean, I was literally on the first COVID team. . . . It was a little frustrating that I had to go through hoops to get it.

She points out that the other COVID team members she was making rounds with had to wait while she tried to obtain the N95. "We were limiting people going into the room, and I was the nurse practitioner, so I wanted to go in. . . . There's [also] the emotional implications of thinking that

I'm not important enough for an N95. . . . I stood my ground on that. You know, you've got N95s, and I need one." The implication of such a struggle to obtain appropriate PPE includes delayed care and wasted time, as well as the risk of nurses being excluded from essential discussions and care.

17 Other nurses described how their observations and work at the bedside with patients and families informed their efforts regarding restrictive visitation and contact policies during the crisis. Lily advocated for evidence-based best practices when caring for women who tested positive for COVID-19 and their babies, making sure the new mothers had contact with the infants and the opportunity to breastfeed:

> . . . the thought was that they had to separate them. But really, it doesn't make sense. . . . Keeping her from her baby on Tuesday, when she's going home with the baby on Thursday [and will still be COVID positive], doesn't really give you any kind of benefit. Instead, while she's in the hospital, you can teach her how to take care of her baby and still keep the baby safe. So, she wears a mask, she wears gloves. . . . It's really vital and important that she learns how to take care of her baby and breastfeed and recover and have her baby with her. That was probably the strongest role for advocacy, of just making sure that we're doing the right thing.

She added that her hospital always allowed women to have a support person accompany them during labor. Some private hospitals had stopped allowing this as the crisis accelerated in late March, before the governor signed an order reversing such policies (Van Syckle and Caron). "I'm really proud of the hospital," said Lily. "They were really staunch in 'Absolutely, every woman gets a support person.'"

18 The pain of seeing families separated due to COVID-19 was a theme many of the nurses mentioned. It clearly informed the care they provided and their activism. As Jessica recalled:

> A man had died in the ICU, and his wife was in there at the bedside, and she wasn't allowed to go hug him or touch him. . . . The family members were in the lobby, and they wanted to come up and see their father. And they were just absolutely hysterical. . . . And the rules were that nobody was allowed to go see the deceased . . . except for one, and the wife was there. . . . I was helping console them in the lobby, and then it was just like, 'We have to make an arrangement for these people to come and see their father.' Not that they can go close or touch him, but to just go and console the mother. . . . It was really distressing to watch a family lose their father, and they couldn't console each other. . . . And that was just one family out of thousands.

Sometimes, the activism of nurses inspired other nurses as they struggled to manage and voice their own concerns. Christine illustrated this point:

> I saw a lot of people online saying, 'Oh, this is what you signed up for, this is what you should expect going into this job.' And I actually read an article [in which a nurse who

> cared for a patient with Ebola] wrote a statement to nurses taking care of COVID patients, [saying] 'This is NOT what you signed up for. You didn't sign up for going into the hospital unaware of what you're walking into and not being properly protected'. . . . It's nice [to hear] because I know you don't sign up to take care of a disease that you've never seen and not have the proper equipment to deal with it. We sign up to take care of patients, but we are supposed to be equipped with the materials we need.

We heard from those we interviewed that when there was lack of guidance and PPE, nurses and patients suffered. Yet, the nurses we interviewed also indicated their willingness to show up for each shift, even amid so many unknowns and while their safety and that of their families was at risk. Tara, who was critical of her hospital's response during every phase of the crisis, for instance, said she felt unsafe showing up to work, but she still did so—caring for up to eight intubated patients at a time, when the norm in the ICU is one to two patients per shift.

'It was just like no concern for our lives or anything'

19 The challenge of providing nursing care during a pandemic was compounded by the fact that healthcare providers and other hospital staff (including police officers, security guards and custodians) also got sick. Each of the nurses discussed their worries about bringing the disease home to their families, or the extent to which their families worried about them. Tara took care of the first COVID-19 patient who arrived at her hospital. Her nursing coworkers had to fight some of the doctors and the hospital administration in order for him to be tested. After the patient died, Tara stayed away from family and friends for almost two months in order to keep them safe. Christine lived with her parents. In mid-March, she took care of the first COVID-19 patient in her hospital. "It definitely was scary." She said, "I didn't want to bring it home to my parents, because this patient that I did take care of was the same age as my parents." She later learned that her parents had become infected, likely at a Saint Patrick's Day party.

> I even told my manager that I lived with my parents, and they're showing symptoms. I just took them to get tested. They're positive. . . . I was exposed to them. And this was kind of the beginning of the height, like where we were starting to get more of a rush by the time they got their positive results. And he told me that I still had to come to work. I just had to wear a mask at all times. And if I started to feel any symptoms, to let him know. And then I would get tested and then I'd probably be out for two weeks if I had tested positive.

Despite her best efforts to protect her husband and two children, both Blima and her husband were sickened by the coronavirus.

> It's a private house. So it was a safe area. My husband would pass me a garbage bag. I'd put everything in there and he passed me a towel and I'd walk straight to the shower, so I

> wouldn't let my kids come near me. My four-year-old would run at me to hug me, and I would just shrink back. And my husband had to take him away from me, you know, like those kinds of practices. But I didn't sleep in his bed. I did sleep in a separate bed. I just didn't think it would be smart. I didn't let him kiss me. I said, "Just not smart." You know? So we took some precautions that felt reasonable to us. And I still caught coronavirus.

In contrast, Lily pointed out that she felt safer at work than going to Walmart, "because, I think, people didn't really take it seriously in other places, but at work we did." Jessica credited her experiences with other epidemics with helping her feel safe going to work.

> I did feel safe, because . . . the good thing about working for 40 years is that every 10 years or so, we've had some crisis to deal with. And in the beginning of the COVID pandemic, I don't think anybody knew, really, the extent of how bad it was going to be. . . . years ago, I remember the AIDS crisis, when it started . . . you use the techniques that we've learned to protect ourselves, right from, you know, Nursing 101. How to wash your hands and use gloves and protect yourself in that way. So, every 10 years. We've had Ebola. We've had SARS. We've had Zika virus not too long ago, where people just really freaked out, until they knew a little bit more and the research was done and they learned how to protect themselves.

'Like nothing you could ever imagine'

20 By far, the period when nurses witnessed exactly how deadly COVID-19 could be occurred in late March and stretched into April. Hospitals in New York City and the surrounding counties experienced what the nurses referred to as "the surge." The fact that large numbers of staff were out due to illness meant that some hospitals were short staffed during this time. Nurses were shifted around the hospital in order to care for COVID-19 patients. Students, military, and travel nurses (from other parts of the country) also helped tremendously. The nurses learned not to take anything for granted. Patients who presented with mild symptoms could decline quickly. Even nurses, like Jessica, who had years of experience recounted how overwhelming it was.

> We were not prepared for the amount of people that came in at the same time, I think. . . . That's what was pretty incredible and the big difference between what happened with AIDS and what happened with the COVID virus. We just had so many people all at once, rapidly deteriorate. Just the numbers that died so fast, it was pretty incredible to see. And how many codes, which is a rapid response to attending somebody that is deteriorating in the hospital. They announced overhead, you know, a code, and the code team comes and helps out and helps do resuscitation. And it was just rapid fire, one after another. You'd hear it overhead, and you're like, 'Oh, my goodness, another code, another code.' It was just multiple ones in a shift. And we had where the supervisors were becoming ill. Half the staff was out ill. The doctors were out ill. Everybody got sick as the numbers increased in patients coming in.

She recalled one particular evening when "I had 12 codes in the 12-hour shift. And it was just going from one floor to the next, helping out the staff, stabilizing the patient, or they died, and then just moved on to the next one and another hour. And it was just . . . it was surreal. I can't even explain how it was." Tara also recounted how stunning the death toll was in her hospital,

> It was just . . . it was like, you could, you just had to kind of accept that, no matter what you did for these patients, they were probably going to die anyway. At least as an ICU nurse, it's not the same on other floors. But as an ICU nurse, you get the patients that are on ventilators, because those patients end up in the ICU, they don't end up on the other floors. So, those are the most unstable patients, and they were just so unbelievably sick that you . . . even in their 30s and 40s, you could do nothing for them. You would do everything that you could, but . . . you could see it from a mile away, when the patient would be dead within three days.

The rapid decline in patients was surreal and heart-wrenching for many. Knowing that patients were dying alone, without family to comfort them, was difficult to watch. Through these interviews, even as people openly spoke with us, it became clear that many had witnessed and experienced trauma. Almost everyone used metaphors of war ("It was like a war zone") to describe what they saw and experienced. But as Jessica said, "We take an oath when we become a health professional to treat everybody as best as we can."

Conclusion—Pandemic and Protest

21 We conducted these interviews in the midst and immediate aftermath of another important national and international moment. On May 26, the murder of George Floyd, a Black man arrested by four police officers was recorded by distraught bystanders in Minneapolis, Minnesota. A crowd witnessing Officer Derek Chauvin kneel on Floyd's neck for eight minutes and forty-six seconds begged for Floyd's life. Within two days, the viral video had been viewed over three million times. The United States erupted in protests against police brutality, and these protests quickly spread internationally. "Black Lives Matter" and "End Police Brutality" placards were held by marchers in New York, São Paulo, London, Cape Town, and Tokyo.

22 Floyd's death and the rage expressed by protesters highlighted other racial inequities, including the large numbers of impoverished Black, Latinx and Indigenous people whose deaths from COVID-19 were exacerbated by health conditions related to racial disparities. Many of the nurses we interviewed were well aware of these disparities, through observing who entered their hospitals and who died. What the protesters were likely less aware of was that a disproportionate

number of nurses of color died of COVID-19 in New York ("In Memoriam: Fallen NYSNA Nurses").

23 For some of the nurses we interviewed, both the #BlackLivesMatter protests and protests to open the U.S. economy after almost three months of COVID-19 lockdowns raised concerns that another wave of infection could result from large crowds participating in demonstrations. If this happens, or if, as anticipated, virus surges occur in other states, how well prepared will the CDC, federal government, state and local health officials, and hospitals be? As Kelley aptly put it, "If there is a second wave, it would be unforgivable to make the same mistakes."

24 Meredeth Turshen argued almost 40 years ago, "bacteria and viruses may occur spontaneously in nature, but there is nothing natural or spontaneous about epidemics" (Turshen, 15). Turshen's argument is that the response to epidemics, the political will that is in place to address them, the efficient mobilization of resources, the willingness to address health inequities, and clear communication about the progress of disease, all play a role in determining whether the outbreak of a viral illness will be controlled—or disastrous. What more does this mean in a pandemic, especially for nurses?

25 What do nurses really sign up for as they fulfill their oath to take care of every patient who enters the doors of their hospital? The nurses interviewed here consistently demonstrated their skill, knowledge, commitment to patient care, advocacy, and compassion. But did the CDC, federal and state officials, and hospital administrations consistently do the same? We cannot help wondering if part of the dismissal of nurses' concerns is related to the fact that nursing is a mostly female profession, employing significant numbers of women of color. The nurses we interviewed did not sign up for: having their safety or that of their families disregarded, having to follow inconsistent and nonsensical rules, the chaos that reigned at times, and guidelines suggesting that a bandana was acceptable PPE for a virus as potent as COVID-19. A global pandemic coupled with inconsistent leadership from government officials is more than any dedicated group of professionals can or should have to address. A historical watershed means that nothing is ever the same after that particular moment. There is no "return to normal." If the United States has reached a watershed moment as a result of the COVID-19 pandemic, we hope that the voices of the nurses featured here will be heard, respected, understood, and deeply appreciated.

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