Towards a Notion of Relational Sacrifices: A Case Study of Nursing during the COVID-19 Pandemic in Wuhan

Introduction

In this article we critically examine the depiction of nurses as sacrificial, heroes and angels fighting on the frontline of the war against COVID-19 against the lived experience of Shanghai-based nurses who volunteered to be seconded to treat COVID-19 patients in a hospital in Wuhan, China. In the article, we argue that the military discourses of soldering and war and the discourses of heroic sacrificial nurses become conflated during the COVID-19 pandemic. In this article, we challenge the discourse of 'necessary sacrifice' with that of an empirically grounded discourse of 'relational sacrifice' based on the lived experiences of these nurses who treated COVID-19 patients on the wards of hospitals in Wuhan, and the lived experiences of their families, back in Shanghai. In the article, we examine three major themes that emerged from our empirical fieldwork and related data, namely: relational sacrifice, the lived reality of nursing COVID-19 patients and the camaraderie experienced between nurses and patients during the pandemic.

Theoretically, following the philosophy of Moshe Halbertal, especially his book *On Sacrifice*, we tease out the similarities and differences between the sacrifices of nurses and soldiers and we also explore, through Halbertal's reading of Kantian moral philosophy, the conflict between self-love and self-transcendence through the lens of what we call 'relational sacrifice'. As such, the primary focus of the article is on the lived experiences of our participants and their families in the context of their nursing service in Wuhan during the early period of the pandemic. We further develop the notion of 'relational sacrifice' through

examining the lived reality of nursing COVID-19 patents and the unusually high levels of camaraderie experienced between nurses and patients during the pandemic.

Wuhan in late 2019 and early 2020 became the epicentre of the COVID-19 virus. At this time, the Chinese government faced considerable challenges internationally in terms of accusations about the origin of COVID-19 in Wuhan and also challenges concerning governing legitimacy internally due to accusations that it had mishandled the pandemic at the beginning of the outbreak primarily related to what were seen as oppressive lockdown measures, overwhelmed local hospitals including a shortage of healthcare workers and hospital beds in Wuhan. In response to these internal challenges, the Chinese government confronted the Pandemic through measures that attempted to control the spread of the virus, but they also went out of their way to win back the trust of the Chinese People in what has been described as China's 'Chernobyl moment'. At this critical time, tens of thousands of healthcare workers from around China, who are mostly female, were sent to Wuhan, and proved to be the pivotal force in bringing China out of this crisis. As Zhang et al. Find:

> among the more than 42,000 medical staff sent to Wuhan from all over the country, female doctors accounted for about half, and women accounted for more than 90% of the nurses. That is, 28,600 nurses rushed to help Hubei, among which 25,300 were female nurses, most of whom worked in quarantine areas while facing serious social panic and a substantial shortage of medical resources. (Zhang et al. 2020)

These nurses were described as an 'army of angels' who not only saved patients' lives but, we argue here, they also played a part in saving the government from a political disaster.

Sacrifices Implied in Militarizing and Mothering of Nursing

Many scholars have used a military metaphor of healthcare workers as "waging war on the front line" against COVID-19 (for example, Billing et al. 2020, p.3; Gagnon & Perron 2020). The use of military metaphors of disease prevention and treatment as a battle to be fought have been around since Florence Nightingale came to prominence during the Crimean War 1853-1856. Nurses were described as soldiers fighting the "invisible enemy", disease, with no "magic bullet" to control it (Gagnon & Perron 2020, p.111). As a result, "frontline" nurses and other health professionals were frequently described as heroes, soldiers and even as "superhumans" who were willing to put themselves in danger and ultimately sacrifice their lives for the sake of others if necessary (Hall et al. 2003, p.214).

It is not unusual for major public health care crises to be presented in public discourse through war metaphors. It is also not unusual for healthcare workers such as nurses to be represented as "war heroes," (Gagnon & Perron 2020, p.112). For Hallett, historically, female nurses have been stereotyped as victim-heroine, whose courage enables her to 'stick at' her duties, whose kindness and humanity makes her the patients' favourite 'nurse' (2014, p.4). Of course, in recent decades we have seen much more gender diversity in both the military and in nursing as more and more women enter military service, and more and more men are becoming nurses (Chambliss, 1996, p.83). There can be little doubt that the military metaphor supported a number of nursing behaviours. A minor example is the uniform (Winslow 1984, p.33). For nurses, their uniforms were a significant aspect of the performance of their gendered nursing identities Halford and Leonard (2003).

For Halbertal, soldering in the theatre of war is a complex mixture of sacrifice and brutality, that which is noble and that which is debased (Ibid). Gagon and Perron's research suggests that nurses themselves often drew on this imagery to describe their experiences and convey how they felt, the hardships they faced, the way they were treated and impacted, the

physical and emotional cost of these stressful experience (Ibid.). Furthermore, 'the nurse as hero' discourse that emerged during the COVID-19 pandemic revealed a discursive pattern, similar to that of the sacrificial expectations of soldiers in the times of war. This includes religious notions of martyrdom to describe nurses' selflessness in uncertain and, at times, dangerous conditions (Mohammed et al. 2021, p.4).

Moreover, nursing is often represented in congruence with metaphors for mothering. As substitute mother, the nurse cares for sick children (patients) and follows the orders of the traditional father (the physician) (Winslow 1984, p.32). In this relationship, nurses reproduce the historical link between nursing as a profession and embodiments of compassion, consequently maintaining the association between reproductive labor, mothering, and normative forms of femininity (Selberg, 2013, p.20), as such, nursing is an example of normative femininity organized around the moral authority is often linked to motherhood and the moral tasks of raising upstanding, moral citizens (Selberg, 2013, p.12). For Mohammed et al, the valorisation of nurses' sacrifices to work during the early outbreak of COVID-19 pandemic without proper equipment (e.g., PPE) was additionally conveyed through symbols of war and nationalism (2021, p.4). This discourse positions nurses on the frontline of responding to the COVID-19 pandemic, like frontline soldiers who put their lives at risk for a greater cause. Through this discourse nurses during the pandemic were positioned as 'necessary sacrifices' (Mohammed et al. 20201, p.7) and that this resonates with religious metaphors and practices associated with martyrdom.

We argue that these religious metaphors that emphasise nurse's selflessness, during the pandemic, are reinforced by the historical construction of nurses as innately virtuous and self-sacrificing (Gordon and Nelson, 2005). As such, the depiction of the sacrifices made by nurses during the pandemic were gendered through the positive construction of feminine religious sacrifice and the embodiment of selfless heroic womanhood (Bashford 1998, p.52).

Like female ‘Christs’ (Bashford 1998, p.52), nurses can, in certain situations, be characterized as outstanding moral subjects, who often placed their commitment to patients, public safety, and professional duty over their fears by their personal safety and anxieties over constrained clinical resources. We argue that this was the case during the Pandemic, especially in the case of the nurses who volunteered to go to Wuhan in the early period of the pandemic.

However, we also argue that the depiction of nurses as either heroes, or as angels can detract from the gender diversity and also their professionalism. The hero and angel constructs undermine the professionalism of the nursing workforce, and reinforces the perception that nursing is an innately feminine, nurturing role (Stokes-Parish et al. 2020, p.462). As an ‘angel’, the nurse is viewed as a caring, comforting female servant of God (Stokes-Parish et al. 2020, p.463), or as sisterly or maternal examplar (Hallett 2014, p.8). Yet, we argue that these depictions of the idealized subjectivities of nurses fail to acknowledge the emotional complexities and sense of conflict (Mohammed et al. 2021, p.7) experienced by front-line nurses who volunteered to travel from Shanghai to Wuhan to nurse COVID-19 infected patients in Wuhan. Other than a sense of ‘compassion fatigue’ as a cost of caring (Austin et al. 2009, 195), we identify a relational sacrifice as a result of caring during the early outbreak of COVID-19 pandemic.

Methodology

Empirical data for this study is based on 5 months fieldwork in Shanghai from March to August 2021. We interviewed 9 nurses and 3 doctors who were sent to Wuhan in early 2020. Participants are between 25 to 50 years old who were recommend by the general office of their respective hospitals. Other than 1 male doctor, the other 11 interviewees are all female. Interview period range from 40 minutes to 1 and half hour. They work respectively in ICU, psychological, and pespiratory departments in 5 hospitals in Shanghai and all of them had

volunteered to treat COVID-19 infected patients in hospitals in Wuhan. We We also interviewed 3 officials working in Shanghai Women's Federations for their perspectives on their role of female healthcare workers in the fight against COVID-19 pandemic. Because the sensitivity of conducting this research, all of interviewees are anonymized..

We employed a thematic analysis of the data as advocated by Boyatzis (1998). In taking this approach, in our analysis, we produced an overview thematic grid that generally summed up the data and allowed us to determine and collate the opinions of our participants on the subjects being explored. We adopted an iterative process of moving between the data and the literature to identify material relevant to the research question, consistent with thematic analysis. We then assigned appropriate thematic codes to relevant sections of the transcripts of the focus groups and interviews, and refined subcategories emerged.

The thematic grid that we then created, allowed us to determine and gather together individual interview on the topics under exploration. In this process, certain low-level codes (such as commitment to families, familial relations as a mechanism for achieving particular ends, the worries that the mothers have for their daughters, not easy for them to change their minds and return home, nurses had to spend more time with patients who needed to express their feelings and thoughts, nurses were also expected to give emotional support to the patients etc.) were combined into a higher level of code as more abstract themes that inform the current writing (such as the notion of relational sacrifices, the lived experience of nursing COVID-19 patients, and COVID-19: A Catalyst for enhanced caring). In the end, we would then be able to discuss our findings and draw our conclusions.

Relational Sacrifices

In the context of industrial transition and mass-scale urbanization and the widespread sense of uncertainty and insecurity for individuals and families, the Communist Party in China has made a vigorous effort to support the family as the fundamental unit of society and for securing the prosperity of the nation (Zhang, Li and Foley 2014, 15). It is also because of this commitment to families among Chinese people that authorities in China often emphasize familial relations as a mechanism for achieving particular ends, this can take the form of what Deng and O'Brien (2013) call "relational repression." For example:

> Chinese local officials frequently employ relational repression to demobilize protesters. When popular action occurs, they investigate activists' social ties, locate individuals who might be willing to help stop the protest, assemble a work team, and dispatch it to conduct thought work. Work team members are then expected to use their personal influence to persuade relatives, friends and fellow townspeople to stand down. Those who fail are subject to punishment, including suspension of salary, removal from office, and prosecution (2013, p.533).

Yet, as we show in this section of this article, the social ties of nurses, particularly their immediate family of parents, partners and their own children, have come under pressure through their decision to volunteer to work in Wuhan. In this section, we explore the impact of the intersecting discourses of family and nation on nurses working in Wuhan during the pandemic.

During the Pandemic, many frontline healthcare workers felt a sense of collective support and personal worth, which they never experienced before. As a nurse told us,

> I am not fighting here on my own. The government, every level of our village, counties, districts, my work unit, and my school, all the support systems are

> standing behind me. I was very touched. It's just that I have never felt my personal worth to our country, but at the time, I could feel that I was not alone and that I felt something bigger than myself. (Nurse6)

In this regard, we can observe an exponential relationship between the individual's self worth with the sense of collective support. This not only provided many of the nurses with the enhanced motivation to continue to nurse their patients during the pandemic, but also, as we reveal below, this uplift in national support for the nursing profession also provided a significant political opportunity for the Chinese Government to prove its leadership to the country. We argue that nurses have been employed as social and moral models who formed an archetype for how the public should think and behave in the context of COVID-19, thereby forming a tool to enact disciplinary power over the general population (Mohammed et al. 2021, p.8). This framing of the national response to the pandemic as collective responsibilisation became a significant aspect of individual nurses' personal sense of sacrifice, responsibility and protection on the 'COVID-19' wards in Wuhan, for example, one of the nurses told us:

> Am I afraid? Yes, but there is my responsibility. we have a strong motherland and the national strength. Although I was a bit scared, but our government has got our back. There is a shield behind us. And the government has made sure to ensure our safety. (Nurse12)

From the above, we can see that for frontline health workers during the pandemic, their individual professional devotion to their patients is being reinforced by the national collective fight against the virus. As such, the heroic aspect of this nurse's professional self is in an exponential relationship with the collective national response to COVID-19 in Wuhan. The

result, being that the health care system, and individual within it, became connected through a chain of supportive nodes developed by the Chinese Government. One of our participants recalled how her sense of obligation to her patients had been correspondingly enhanced through her perceptions of the care and support both she and her family received from Chinese Government, Shanghai City officials:

> Later on, after we had been in Wuhan for a while, government support had gradually arrived, and I also received comfort given by my family and the school of my son. They even informed me of my son's performance and told me that they would try their best to help him out if needed. The city government also sent some milk and food over to my home. They not only took care of me, but also my family. I thought to myself, I must do something for the patient like them, so I made up my mind. I must not act like a coward. (Nurse2)

It was perceptions such as the above, from a range of participants that we observed the phenomena of 'relational' rather than 'individual' sacrifice amongst participants. That is, although our participants were at the frontline in terms of their care and treatments of patients infected with the COVID-19 virus, they were not alone in their potential sacrifices, their families were also working to support them from home. Furthermore, the extent of this relational sacrifice was being explicitly recognized and targeted by Chinese Government and City-level officials as an essential aspect of the nurses' support structure for continuing to volunteer to work on the COVID-19 wards and intensive care units in Wuhan. The examples of relationship sacrifice were not just confined to the immediate families of nurses, it inspired acts of care and kindness across families, where, for example, nurses' husbands and mother-in laws mobilized their support too. For example,

> My mother-in-law was a frontline health worker in the fight against SARS. For her experiences of this epidemic, my mother-in-law knew that I had a great

> responsibility and took the initiative to take over the role of taking care of her grandchild. After hearing the news of the unfortunate infection of the nurse in our department, my husband took the initiative to stew ribs soup at home, and bought milk, fruits, and other nutritional products to the sick nurse's home (Nurse4).

As well as family members being inspired to perform caring acts, the relational sacrificial impacts of the nurses nursing COVID-19 infected patients in Wuhan extracted a considerable cost on the mothers of nurses. For example, during our interviews, many of the younger nurses raised the issue how their own mothers worried about them and how their worrying had impacted their health. As a nurse told us,

> When I left for Wuhan, my mum lost weight and her skin got darker, but it is hard to tell from the video calls, so I didn't know she has changed that much. But when I came back home later on, my relative told me that my mother had poor appetite, and she lost a lot of weight and looked a lot older all at once. (Nurse10).

The worries that the mothers have for their daughters are directly reflected in their loss of weight of bodies, the darken of their skin and poor appetite. Another nurse's mother stayed up until the early hours of the morning to ensure that her daughters was still well, and not infected with COVID-19 following her shift at the hospital in Wuhan. For example:

> It was already early morning when I finished work. I checked my mobile phone and there were unread messages from my mother. I replied to her: "I just finished my job". I thought she would see it when she woke up in the morning, but my phone rang immediately, she replied to me instantly. I was surprised, so I asked her why she was still awake. After all, my mother always goes to bed at 9 o'clock in the evening. She said: "It's okay, no matter how late it is, I will be waiting for you." Every day, my mother waited for me to return to the hotel to let her know

> that I was safe, so she could sleep tight. I don't know how many sleepless nights she has endured. (Nurse9)

This is another example of relational sacrifices and maternal love, where the nurse's mothers saw their role as being 'there' for their daughters, with some even adjusting their sleeping patterns to coincide with her daughter's work patterns, so that the mother could support her daughter and relieve her understandable worries about her daughter's own state of health. As mother themselves, some of our participants had to leave their own child behind at home to nurse Covid-19 infected patients in Wuhan. This proved to be particularly challenging for single mums. As a nurse told us,

> I think that with my knowledge and working experience, I can make a small contribution to Wuhan and our country. However, I am a single mother. At that time, a thought flashed: 'if I went to Wuhan, what should I do with my son? What if I am away for a long time? If school opens, who will take care of him?' I immediately called my family and told them what I thought. The family members held back their sadness and hesitation and said to me: "We will support you! Leave the child to us, rest assured!" My tears flowed down at that time. (Nurse12)

Another participant told of us about her colleague who was a breast-feeding mother at the time who decided to travel to Wuhan to nurse. This nurse had to make the decision to stop breastfeeding her child (and hence not considered being a 'good mother' to her child) for the sake of volunteering to travel to Wuhan to care for patients infected by COVID-19.

In recognition of their personal and relational sacrifices, nurses and doctors alike who served in the frontline of the COVID-19 pandemic, were awarded with an invitation to become members of the Chinese Communist Party. As a nurse told us her thoughts of helping others in distress, helped her to overcome her concerns for herself,

> I just found them (the nurses who had volunteered to serve in Wuhan) very brave, and I wanted to be like them. This was the second transition of my mind after crying for the disastrous scene. I thought to myself, I must do something for the patient like them, so I made up my mind. I must not act like a coward (Nurse9).

Recognition, such as the above, at the level of the government and the wider social recognition of the personal and relational sacrifices made by the nurse and their immediate families was a significant source of motivation to volunteer and to continue in their work as nurses in Wuhan during the pandemic, for example,

> With the dedication and hard work of my family, I have no worries, and ignited my passion for fighting and confidence in winning. They are the greatest motivation for our front-line staff. We are determined and confident that we will be able to overcome this epidemic! (Nurse1)

Therefore, personal fears and concerns for their own safety, and their concerns for the sacrifices their families were also having to make in support of them, were somewhat countered by the emergence of a courageous spirit amongst the nurses. Crying 'like a coward' is replaced with being brave and courageous.

The lived experience of nursing COVID-19 patients

As well as all the bravery, courage and personal and familial sacrifices that the nurses and their loved ones made to nurse COVID-19 infected patients in Wuhan – there was another side. For example, the Shanghai-based nurses who volunteered to work in Wuhan, they found that it was not easy for them to change their minds and return home. In a sense, there are parallels here with 'army deserters.' One nurse told us,

> Our team superior told me "don't ever think about going back to Shanghai". You are someone who had been to an epidemic area, so there was no way Shanghai

would welcome you back. And then my head was like “boom”, with his words circling in my brain. This was the first time that I experienced such strong feelings, and my tears just ran down my cheeks. It is sort of becoming a normal routine. You know, just shedding tears. (Nurse3)

The restrictive and oppressive side of their volunteering experience also extended to how they spent their time off work and where and what they ate during shifts. One doctor told us, male doctors are also like food supervisors, administrators, and supervisors of medical teams, even to the extent of controlling and regulating what they ate in the name of restricting infections and related health issues amongst the staff:

Yes, just tell them that you must eat in the hospital, and you can’t eat anything casually, so we stipulate that you can’t order takeaways, but can only order canned food. As for the takeaway outside, it’s strictly forbidden. What if something happens here and you get diarrhea inside? …. Yes, I don’t want to see any incidents. (Doctor3)

Despite these restrictions on what and where the nurses could eat whilst on duty, the pandemic was a social catalyst in terms of care, a cross-class and cultural conduit into the lives and social spaces of groups otherwise beyond the reach of agents of social authority (Rafferty et al. 2005, p.3). Some nurses reported that during the pandemic they went beyond the call of duty in the case of their patients. In this agential role, another nurse told us how she brought her skills as a mother to support a child on her ward, who was recovering from COVID-19 to catch up with his schoolwork. In this case, the nurses acted as a schoolteacher in order to support her patient with his studies. Just like in other female dominated professions, nurses, like secretaries, can combine their “dual roles” as mothers and as employees (McDowell, 1999, p.138), for example:

> Among the patients I was taking care of, there is a 10-year-old child, Xiaosong, who is the same age as my brother. It turned out that he was in a hurry to transfer to the hospital, they didn't bring textbooks or extracurricular books, and they couldn't take online lessons. From that day on, I had another "part-time job", which is helping Xiaosong with his studies. Last night, after taking over, the patients were asleep, I sat down at the nurse's station and write up test questions for Xiaosong, including ancient poems, English words and phrases. He was good at math, and my knowledge of math can barely guide elementary school courses. The little guy slept until 7 o'clock today. I went to measure the blood oxygen saturation at 6 o'clock. I couldn't bear to wake him up. When I took his finger out, it probably interrupted his sleep, and he withdrew his hand fiercely. (Nurse11)

Indeed, much of the nurses' work is determined by others. In the context of nursing COVID-19, routine duties for caring for critically ill patients on ventilator was described to us by a nurse,

> During the treatment process, the nurse should provide life care for the patient. Severely ill patients basically cannot get out of bed, and most of the patients have been treated with invasive ventilator, and the amount of daily care is very large. Skin protection and nutritional support are routine care tasks. Nurses should also closely observe the vital signs of patients, observe whether their condition has changed at any time, and take active and effective forward-looking preventive measures to prevent complications. For some particularly critical patients and patients on ventilators, nurses need to provide professional care, such as airway management, ECMO (artificial membrane lung) care, prone position ventilation, bedside hemofiltration, these are all professional nursing job. (Nurse10)

However, we argue that COVID-19, also saw a modification of the traditional 'competences' and responsibilities between doctors and nurses. According to Gamrnikow, the difference between doctors and nurses is mapped out in spheres of competence which made nursing practice dependent on medical intervention (Gamarnikow, 1978, p.105). As Gamarnikow further argues, the difference in competence was not a neutral division, based on equal contribution to, and participation in, the healing process. Rather, it created stratified health care and interprofessional inequality. The dominance of medicine in health care and its control over initiating and directing the healing process relegated nursing practice, in both its aspects, to a subordinate position (Gamarnikow, 1978, p.107). However, in practice, doctors have access to distancing mechanisms that would create a buffer between them and the patients (Selberg, 2013, p.20-21). This is reflected in the process of caring for COVID-19 patients. On the COVID-19 wards, the necessity of wearing PPE also resulted in changes in the responsibilities of doctors and nurses – with nurses taking on more and more of the duties traditionally though of those of doctors, as one nurse told us, "doctors cannot enter the ward on time in case of emergency, because it takes them half an hour to wear PPEs before they are able to do a check". As such, nurses often had to take on these duties themselves. As a nurse told us:

> At this time, it was not like in our general ward. But this was an epidemic area. For the doctor, if he/she wanted to visit the patient, it took half an hour to put on the protection suit, and then just checked the patient for five minutes before leaving. So, in a situation like this, we mainly rely on nurses to do the pre-check. The nurses were required to have some professional judgment. That's the way we handled this. (Nurse9).

As such the nurses, took on extra responsibilities, simply because they had to. According to Chambliss, this is all part of the expectations of caring profession, such as nursing: 'to care is

to do the leftover work, to take that responsibility, whether ordered or not' (Chambliss, 1996, p.66-67). The Nurses caring responsibilities also extended to their colleagues, as a Nurse told us:

> The team members are scattered in various departments, I am worried every day. Because everyone could not meet each other, I asked them to report their physical condition in the WeChat group every day. As soon as I heard the team members showing symptoms of cough or sore throat, my nerves tightened. The daily report was sent to a group chat daily. I have learned that the coordinator of our team actually gathered the reported data and turned it into a briefing for our dean. Such report was also sent to the health committee. (Nurse9)

In other words, nurses' health, in the context of the pandemic, was no longer an individual problem, but something to be collectively monitored, just like in familial relationships, where a family members symptom of being unwell do not go unnoticed and are responded to. As well as expected routine tasks, especially for unconscious patients, nurses devoted themselves to providing even more 'psychological' care to conscious patients, as a nurse told us

> In fact, in our daily nursing work, when nothing happens, we are doing repetitive tasks, that is, giving patients injections or disinfection. But in fact, the most important thing is psychological care. Women are the most suitable for this job. This kind of disease requires psychological care, which is actually more important than daily care. (Nurse6)

As such, the physical presence of nurses as "being there" for the patient (McKivergin & Daubenmire, 1994, p.69) therefore also means promoting psychological well-being among patients in the ward. Yet, "being there" for the patients also means physical absences of

nurses as not “being here” for their own children. As one of the nurses, who is also a mother, told us,

> My son asked me on the video call: “Mom, when will you come back? Did you defeat the monster? I miss you.” This made me shed tears. I said, “Dear, I will come back after beating the monster. Today, I have won. I will continue to fight the monster tomorrow. I don't know when I can come back.” At this time, my son turned his back on me in the video chat. My heart was broken. I told him that as long as I beat all the monsters here, I would go back to accompany him as soon as possible. (Nurse6)

We found that COVID-19, was often referred to as ‘the monster’ or ‘the enemy’ by the nurses, which once again, reflects parallels in military discourses, as discussed in the introduction. However, a key difference in the ‘nursing’ and ‘military’ discourses – is that in the case of the Shanghai-based nurses serving in Wuhan, the invisible enemy as a ‘monster’ would not be defeated, by violent forces, but, rather by caring patience, we will elaborate on this in the next section.

COVID-19: A catalyst for enhanced caring

According to James, nurses perceive ‘good care’ as being associated with spending time listening and engaging with patients like they would with unwell family members (1992, p.502). The nurses who participated in our research project depicted COVID-19 as being a catalyst for enhanced care-giving, cordiality and a sense of camaraderie between nurses and patients, as they fought a common ‘enemy’ together. For example, one nurse told us,

> At that time, patients received more care from us than usual. Nurses were really good to them, and the relationship between nurses and patients was very good. It's

> not like in ordinary time, nurses now treated patients like they were family. (Nurse2)

In many cases, the nurses were all that the patients had, as visiting from friends and family (as in many other parts of the world) was forbidden during the early period of pandemic. As such, the absence of 'family support' at the patient's bedsides, required nurses to be more attentive to patients' psychosocial needs (Jørgensen et al., 2021, p.3). Nurses had to spend more time with patients who needed to express their feelings and thoughts, especially when their relatives were not allowed to visit them at the hospital. This required the nurses to be even more present and willing to listen to the patients' concerns (Jørgensen et al., 2021, p.4). As a result, many patients reciprocated the nurses' enhanced caring through showing more patience, tolerance, and cooperation in return. As a nurse told us,

> When we entered the ward on the first day, they thought we were here to help them as we were from Shanghai. Their cooperation was really good. The degree of cooperation is really better than ever. It is the time when the nurse-patient relationship is most harmonious. … Yes, when the nurse-patient relationship is the most harmonious, they really think about us, and we also think about them. That's how it is. At that time, everyone was pulling in one direction, hoping that they would get better soon, and we also hoped that they would get better, so we could go back home, and we told them the same. This feeling is as if everyone's in the same boat. (Nurse5)

There was a sense amongst our participants that their care giving as nurses, of 'going beyond the call of duty' and their sacrifice in coming to Wuhan to care for patients infected by COVID-19 all had the cumulative impact of increasing the value of nursing as a profession in the eyes of patents and their family members. It was also a catalyst for transcending personal fears and to enact their own moral values (Mohammed et al. 2021, p.4)

through benevolence, enhanced caring and 'just getting on with it'. For Habertal, following Kant, self-transcendence is at the core of the human capacity for a moral life (2012, p.63). That is,

> The conception of the moral life as founded by self-transcendence, coupled with the background condition of a strong self-privileging tendency, undergirds Kant's description of the conflict as the struggle between self-love and the categorial imperative (Habertal 2012, p.64).

In this circumstance, perseverance of nurses becomes a moral imperative, a way of managing disaster as if it were routine (Chambliss, 1996, p.49). They were not only expected to perform bodily care as in the normal ward, but also were expected to give emotional support to the patients who were conscious and who themselves were suffering from worry, anxiety and depression in the context of pandemic. As a nurse says,

> Whether it is the health of the patient or ordinary people, it both relates to the physical and the mental. In addition to physical illness, patients need psychological counseling and psychological cues. They are very scared in the pandemic environment, not only the patients, but also us. At that time, someone needs to be driven positive. If nurses are driven from a positive aspect, the patient will also develop in a good direction. Therefore, the physical discomfort caused by the virus also needs to be considered, but it requires more mental support to combat the mental pressure. (Nurse4)

The nurses who participated in our research reported having to draw on their professionalism, expertise, and courage to both overcome their understandable fear of becoming infected during clinical and other duties, but also in terms of trying to treat patients when 'wrapped up' in PPE, wearing masks, face shields and double gloves. In addition, many

nurses have been redeployed into new roles, teams or newly purposed wards so have been working in unfamiliar settings and without established support from colleagues (Billing et al. 2020, p.2). The relocation of nurses from Shanghai to Wuhan contributed to higher workloads, the reason being that incoming nurses from Shanghai were often deployed in units where they were not sufficiently experienced especially in intensive-care nursing during a pandemic (Jørgensen et al., 2021, p.3). As a nurse from Shanghai demonstrates,

> At the beginning, I was not sure what to do with these patients, and what to do about myself. After half a month, I had developed better understanding of the disease. The cause of the disease, the condition of the disease, or its *modus operanti* were clearer. (Nurse5)

Trauma teams specialize in the psychological strength required to continue working when the world seems to be falling apart. As a nurse says, "Nurses must not only help patients overcome the disease, but also help them overcome the 'devil' in heart." In order to deal with these traumatic moments, nurses and physicians have developed a number of strategies. As a nurse says, chatting and doing craft activities (e.g., paper folding) was common coping strategies amongst nurses, and their care giving to patients,

> With one patient, we fold paper cranes, and those who are conscious and can talk, we chat with them or talk about their happy times. For example, when an older person talks about his grandchildren, he wants to talk about things that make them happy. (Nurse6)

Similarly, eating food is another way of releasing pressure and sharing food was used to build relationships between nurses and patients. As a nurse says,

> Because I hope everyone can support each other, I show the positive part of myself. For example, today someone said that I look beautiful, and someone gave

me something delicious to eat. Under this pressure, I can gain relief from food. (Nurse9)

With laughter, things seem less consequential, less of a burden (Chambliss, 1996, p.46). Food in combination with humors, miscommunications due to dialect, were also a source of rapport on the COVID-19 wards. For example, a nurse told us.

> Another time, during a meal distribution, ‘an auntie’ [an older female patient] said that she could not eat eggs, but I mistook it for "I would like to have seven eggs", ...So I said, “7 eggs are too many, it’s not good for your health. Okay, take this first, and there will be more in a while, and I'll get one for you." The ‘Auntie’ looked at me and laughed. Then a nurse from Tianmen came to help me out with translation. After laughing, I thought to myself, it seems that learning dialect is also the basic skill of a good nurse. (Nurse6)

However, we also noted a darker side to this image of the heroic, sacrificial nurse where nurses also suffered multiple pressures (e.g., home sickness, fear of COVID) and as a consequence, stopped self-caring and receiving help and support during a very stressful period.

Conclusion

In this paper, we have explored the lived experiences of nurses from Shanghai who volunteered to travel to Wuhan to care for patients infected with COVID-19. We examined the prevalence of heroic, militaristic discourse surrounding the nurses volunteering and also the personal and relational sacrifices that they and their families made in response to the pandemic. The relational sacrifices of the family members left-behind at home is a contribution to the literature on COVID-19 nursing. In addition to heroism and sacrifice, the paper focused on the lived reality of these volunteer nurses in terms of their often inadequate

experience of intensive care in pandemic contexts, their negotiation of unfamiliar work and working contexts, and the control and regulation they experienced – and also, their experiences of enhanced responsibilities and perceptions of their profession being more valued in the eyes of patients, as a consequence of their enhanced care-giving, sacrifices in the care of others.

We observed considerable emotional labor amongst our participants; however, we feel that this terminology does not quite capture their experiences in the context of the pandemic. The nurses in our study were not just 'performing' emotional labor in a superficial way, their enhanced care giving during the pandemic was a source of redemption and a shield against fear, despair, was a source of redemption and a shield against fear, despair and homesickness. Thus, becoming a better, more caring nurses, beyond the call of duty in the care of their patients, was not only appreciated by their patients, but also provided the nurses with the opportunity to reach deep to find the courage to become more and give more. . It was this collective dynamic that mobilized them and their patients to fight 'the monster' together.

As such the nurses' embodiment of sacrifice and their determination to not to be beaten by their self-concerns through developing enhanced care-giving practices for COVID-19 infected patients – became not only a source of redemption, but also a source of resilience in face of overwhelming pressure. As such, we argue that the 'war' or 'conflict' that these nurses were engaged in fighting was not only 'the monster' virus', COVID-19, it was also the conflict between self-love or self-preservation and self-transcendence (Halbertal 2012, p.4). It was through self-transcendence that they truly found their 'calling' and their ability to 'rise above' the 'self-privileging' tendencies of their 'ordinary' lives and its expectations.

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