TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

FACING UP COVID-19: WHAT CANNOT BE RELATIVIZED IN NURSING HIGHER EDUCATION

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ABSTRACT

Objective: to present reflective arguments on the measures to accelerate the training of nurses and their early insertion in the health system during the COVID-19 pandemic.
Method: an analytical and theoretical-reflective text, based on the central construct of "Nursing knowledge", whose theoretical framework of reference was formed by two of the fundamental patterns of knowing, from Chinn & Kramer's perspective: the ethical and the empirical.
Results: newly graduated nurses, in the process of accelerated training, will have few resources available from the empirical knowledge pattern, both due to the reduced framework of knowledge evidence and to the difficulty in dealing with mechanisms that are often unknown. As they do not have levels of clinical knowledge, such as that developed in the applications of practical experience, recent graduates may have to confront situations that will impact on the ethical knowledge pattern.
Conclusion: the acceleration in the training of Nursing students and their insertion in the health system in the current pandemic situation must be viewed with caution, as the risks are high, both from the point of view of clinical decision-making and from the perspective of facing dilemmas and ethical problems.

DESCRIPTORS: Coronavirus infections. Pandemics. Nursing education. Nursing students. Knowledge.

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ENFRENTAMENTO DA COVID-19: O QUE NÃO PODE SER RELATIVIZADO NA EDUCAÇÃO SUPERIOR EM ENFERMAGEM

RESUMO

Objetivo: apresentar argumentos reflexivos sobre as medidas de aceleração da formação de enfermeiros e inserção precoce no sistema de saúde durante a pandemia da COVID-19.
Método: texto analítico, teórico-reflexivo, baseado no construto central - conhecimento de enfermagem - cuja estrutura teórica de referência se formou por dois dos padrões fundamentais de conhecimento, na perspectiva de Chinn & Kramer: o ético e o empírico.
Resultados: enfermeiros recém-egressos, em processo de formação acelerada, terão poucos recursos disponíveis do padrão empírico de conhecimento, tanto pelo reduzido arcabouço de evidências de conhecimentos, quanto pela dificuldade para lidar com mecanismos que são, muitas vezes, desconhecidos. Por não disporem de níveis de conhecimento clínico, como o desenvolvido nas aplicações da experiência prática, os recém-graduados poderão se confrontar com situações que impactarão no padrão de conhecimento ético.
Conclusão: a aceleração da formação de estudantes de enfermagem e sua inserção no sistema de saúde na atual situação de pandemia deve ser vista com cautela, pois os riscos são elevados, tanto do ponto de vista da tomada de decisão clínica, quanto do ponto de vista do enfrentamento de dilemas e problemas éticos.

DESCRITORES: Infecções por coronavírus. Pandemias. Educação em enfermagem. Estudantes de enfermagem. Conhecimento.

CÓMO HACER FRENTE AL COVID-19: LO QUE NO PUEDE RELATIVIZARSE EN LA EDUCACIÓN SUPERIOR EN EL ÁREA DE ENFERMERÍA

RESUMEN

Objetivo: presentar argumentos reflexivos sobre las medidas de aceleración en la formación de enfermeros y su inserción temprana en el sistema de salud durante la pandemia del COVID-19.
Método: texto analítico, teórico-reflexivo, basado en el constructo central de “Conocimientos de Enfermería”, cuya estructura teórica de referencia consistió en dos de los patrones de conocimiento, según la perspectiva de Chinn & Kramer: el estándar ético y el estándar empírico.
Resultados: los enfermeros recién graduados, en proceso de formación acelerada, tendrán pocos recursos disponibles del estándar empírico del conocimiento, debido tanto a la reducida estructura de evidencias de conocimientos como a la dificultad para lidiar con mecanismos que a menudo se desconocen. Por no disponer de niveles de conocimiento clínico, como el que se desarrolla en las aplicaciones de la experiencia práctica, los recién graduados podrían tener que hacer frente a situaciones que afectarán el estándar de conocimiento ético.
Conclusión: la aceleración en la formación de estudiantes de Enfermería y su inserción en el sistema de salud en la situación actual de pandemia debe ser vista con cautela, pues los riesgos son elevados, tanto desde el punto de vista de los procesos de toma de decisiones clínicas como desde la perspectiva de hacer frente a dilemas y problemas éticos.

DESCRIPTORES: Infecciones por coronavirus. Pandemias. Educación en Enfermería. Estudiantes de Enfermería. Conocimiento.

INTRODUCTION

New cases of SARS-CoV-2 infection continue to emerge in many countries around the world or, in others, remain at high levels. This number has grown more intensely since the World Health Organization (WHO) named the disease caused by the new COVID-19 (acronym of the term *Corona Virus Disease* 2019) coronavirus. Different nations have adopted strategies to deal with the high speed of dissemination, illness, and serious and lethal cases in the population.

However, the problem affects different segments of the health sector, generating unplanned and excessive demands for supplies and new knowledge, particularly on drugs, health equipment, and new care guidelines. In addition, it requires the establishment or reactivation of a hospital infrastructure, largely of the intensive care type, which, to a certain extent, contrasts with the historical trend of health dehospitalization.

The *basic reproduction number* (R_0) of the SARS-CoV-2 virus tends to vary by geographic location. However, estimates point to 1.4 to 3.9 contaminated individuals per person, with a mean of 3.28. That is, for each infected person, approximately another three may be affected by the disease.[1–2] This high rate puts the general population and health professionals themselves at risk.

Likewise, the growth in the total number of cases, the requirement of rapid training for precautionary measures, and the problems with the imbalance between demand and supply of personal protective equipment seem to create a multi-causality for the contamination of health professionals. In China, the first dissemination focus of the disease, in March 2020, a total of 3,000 contaminated health professionals was estimated, with 22 deaths.[3] In May 2020, count records of the Brazilian Federal Nursing Council (*Conselho Federal de Enfermagem*, COFEN) pointed to 73 deaths of Nursing professionals in the country, when there were already more than 120,000 contaminated and 8,536 dead individuals. Using the data reported on the same subject matter, it is possible to extract a rate of 8.55 Nursing professionals among those killed by the disease in Brazil, against 1.20 in Italy.[4]

When they get sick, the professionals are removed from their duties, both for them to recover their health and to prevent the dissemination of the virus. The consequence of this distancing is the reduction in the numbers of human resources in the health services, thus causing profound losses in the care environment.

Given this reality, the Brazilian federal government, in late March and early April 2020 and estimating future pressures on the health system, implemented regulatory measures in relation to the training of health professionals through ordinances of the Ministry of Health (MoH) and of the Ministry of Education.

Ordinance No. 356 of the Ministry of Education, of March 20th, 2020,[5] providing for the performance of students of the health area courses in combating the COVID-19 (new coronavirus) pandemic, subsidized Ordinance No. 492 of the Ministry of Health, of March 23th, 2020,[6] which instituted the "*O Brasil conta comigo*" ("Brazil counts on me") program. This program deals with the exceptional and temporary supplementation with students from the federal education system enrolled in undergraduate courses in Nursing, Pharmacy, Physiotherapy, and Medicine interning in health services under the Unified Health System (*Sistema Único de Saúde*, SUS).

The program suggests that student participation takes place in two ways: through computing the workload of the Mandatory Curricular Internship or through volunteering, with three possible compensations: the additional 10% in the public selection process for Residency Programs in Health promoted by the MoH; obtaining a discount on the monthly fee, to be defined and granted by the Higher Education Institutions; or receiving a scholarship to work in the SUS.[6]

Ordinance N. 383 of the Ministry of Education, of April 9th, 2020, defined rules for anticipating the graduation of students in the health area (Nursing, Physiotherapy, and Medicine) in the last period of graduation, establishing as a criterion that the student has completed 75% of the supervised internship hours and defining that the course completion certificates and diplomas, issued as a result of this Ordinance, would have the same value as those issued following the ordinary procedure.[7]

These measures occurred precisely during the quarantine decree period in the main capitals of Brazil, interrupting the activities considered non-essential, among them classroom teaching. Several questions were raised about the operationalization of the aforementioned measures due to the lack of debate with the Higher Education and health services institutions involved in the implementation process.

The insertion of novice nurses in assistance and their reflexes in care are the object of research studies and debates in the area, particularly when it comes to helping people who require intensive care, either in the appropriate clinical spaces, or in non-critical units.[8]

The restriction of vacancies in Intensive Care Units (ICUs) was already a problem before the country experienced the COVID-19 pandemic, in view of the increase in the number of people in need of this type of therapy, among other contributing factors.[9] The pandemic only worsened the scarcity of beds, of material and human resources, and of personnel technically prepared for critical care.

It is understood that the borderline situation of life and death at the global level of a pandemic always puts humanity in dilemmas of multiple dimensions. However, COVID-19 is certainly the first global disease to occur in a context in which the countries have health and health professional training systems with national and international regulations, guidelines or standards and in the circumstances of the existence of a robust scientific and technological apparatus to combat it. If, on the one hand, this can bring benefits to facing the disease, on the other hand it makes reflections on conditions that disturb the planned logic of health care teaching more complex.

In addition to the operational aspects, other issues raised concerns about the background that led to these measures and about the possible consequences of their implementation, especially without a broader debate, even if brief, having taken place. Therefore, the relevance is understood of a reflection on the theme.

Therefore, the objective of this article is to present reflective arguments about the measures to accelerate the training of nurses and their early insertion in the health system during the COVID-19 pandemic.

METHOD

This is an analytical and theoretical-reflective text in which, so as to deal with the multiple possibilities of argument production, a central construct for reflection and a theoretical framework of reference were applied to conduct it.

As a central construct of reflection, Nursing knowledge based on its five fundamental patterns of knowing was selected, from Chinn & Kramer's perspective: empirical, ethical, personal, aesthetic, and emancipatory.[10] However, it was decided to conduct the reflection referenced in the fundamental patterns of the Nursing ethical and empirical knowledge, depending on the nature and extent of the theme.

REFLECTION

Reflections referenced to the empirical pattern of Nursing knowledge

The empirical pattern represents a quadrant of the development of Nursing knowledge regarding scientific competence. To achieve an adequate performance in this segment of knowledge, Nursing professionals need to deal with two central questions: "What is that?" and "How does it work?"[10]

Empirical knowledge is particularly developed by means of research. The questions about the "what", referring to concepts and definitions, and about the "how", concerning mechanisms, processes or methods, are central. The research findings are usually the starting point for decision-making, with evidence-based practice being crucial for Nursing education.[11] However, an enormous portion of the questions remain unanswered during the current pandemic.

When questions not yet answered by science are placed alongside the increase in the users' demand in the health services and the worsening of the clinical conditions favored by the characteristic of the disease, the pressure for rapid responses in care is evident. Such situation can require promptness and agility in the assessment of the situations and in the provision of care, in addition to the mastery of skills for handling artifacts and adequate personal equipment in the face of a highly infectious disease. Furthermore, without anchoring evidence from research or from structured models learned in formal education, decision-making can be attracted to the application of skills obtained from the clinical experience or from the familiarity with similar situations, factors that are possibly inaccessible to newly graduated nurses.

A research study conducted on this topic evidenced that recent graduates lacked technical skills in primary and advanced and specialized procedures.[12] A study on the social representations of recently graduated nurses on intensive care provided in non-critical units reveals that inexperience and weaknesses in training are limiting factors for the care actions, which predisposes these nurses to errors that compromise patient safety.[8]

There are two seminal theories related to the transition to the practice of newly graduated nurses: Benner's Novice to Expert Theory and Duchscher's Stages of Transition Theory.[13] Both point out the procedural character of sequential levels of proficiency or evolutionary and transformation stages of the professional. Other theories and studies that applied their assumptions allow inferring the enormous challenge that new graduates will be subjected to when they are called to act in a crisis situation with still unpredictable consequences.

In the context of a health crisis, such as the one faced in this pandemic, the hired professionals are being summoned for immediate insertion in the active work fronts, both in care and in management, with little or even no time available for adequate preparation and training. The "newbies" are strongly dependent on the empirical knowledge pattern manifested in the theoretical content learned, so their performance is guided by little flexible rules.[14]

In this sense, the government's call to the recently graduated professionals can be considered an extreme measure due to the character of health emergency that the country is going through, but it must be viewed with caution, due to the responsibility and commitment that the health professionals must direct towards the population. Regarding professional decision-making, factors such as examining risks, possibilities, and uncertainties require comparative skills and choices that can be rendered even more difficult when the information is limited to findings from observational studies or clinical tests that do not apply to patients in particular situations.[15] Without having this theoretical framework, which is continually being updated, recent graduates may find it very difficult to act in a context of high individualization of care and decision-making under uncertainties.

As for the universities that are being encouraged to carry out the mandatory internships of students in scenarios of care for the population in the midst of the pandemic, it is observed that immersion in the clinical practice can be considered crucial for the acquisition of knowledge in the learning process.[16] Interns are beneficial as an addition to the professional team and, therefore, excellent collaborators with regard to the ethical and technical-scientific qualification of the services in which they participate, provided that they are supervised. When considering the complexity of the technical activity in learning, this aspect is accompanied by another more valuable one: the person who will receive the care to be provided.

Despite being a relevant moment for health care actions, and in particular those of Nursing, due to its characteristics, the COVID-19 scenario does not present itself as conducive to the mass insertion of students who are still in the process of skills development, whose reflective exercises on clinical situations in the practice are core activities for their professional training.[17]

People with a suspected or confirmed diagnosis of COVID-19 have dominated the entry doors of the health services. Unfortunately, life-death limit situations and the absence of specific equipment for respiratory emergencies have characterized the service environments for these users. When it comes to the development of intensive therapies, the students, even in the last curricular year, would not have the skill and experience needed for the professional practice and, only in an extraordinary way, these would be met in the need for leveling emergency care teams. It is observed that, when they are beginners in the profession, their little experience leads the professionals to direct attention to the objective of the practice and to the necessary gestures to perform the task (care technique) in a slow manner and still without the skill resulting from active performance time.[18]

Considering the challenges presented, recent graduates in the process of accelerated training would have few resources available from the empirical knowledge pattern to sustain their care actions. This is so much due to the reduced framework of knowledge evidence capable of answering the question “What is this?” from the training, as well as to the difficulty in dealing with mechanisms that are often unknown, making it difficult to answer the question “How does this work?”

Unfortunately, as they do not have levels of clinical knowledge such as that developed in the applications of practical experience, recent graduates may confront situations that will impact on the ethical knowledge pattern.

Reflections on the ethical pattern of Nursing knowledge

Ethical knowledge tends to be guided by two central questions: “What is right?” and “Is this a responsible action”?[10] The Nursing Professionals Code of Ethics incorporates principles in the duties that guide the practice: justice, commitment, equity, resoluteness, dignity, competence, responsibility, honesty, and loyalty. These, in turn, advise that the relationships with the individuals being cared for must be based on law, prudence, respect, solidarity, and diversity of opinion and ideological position.[19] However, in disaster situations, the natural order of the course of action is interrupted due to the rapid decrease in the available resources, so that the goal becomes doing more good for more people and with a more efficient use of resources.[20]

The calamity situation, including that caused by the current pandemic, opposes both the code of Nursing ethics and the broad bioethical principles of autonomy, beneficence, non-maleficence, and justice, as well as it weakens the usual patterns which are taught for screening and classifying patients. In view of the reality of managing limited resources, the application of utilitarian thinking becomes inevitable, causing nurses to consider that they are hurting principles of their Ethics Code.[20]

It becomes extremely difficult for everyone to answer the question “What is the right thing to do?” The possibility for the health professionals to advocate for the benefit of the people under their care is put to the test in view of the utilitarian demand to do the greatest good to a greater number of patients.[20]

At the center of the debate on assistance to patients severely affected by COVID-19 is the decision to choose which of them will receive mechanical ventilation, given the scarcity of ventilators. Can the utilitarian decision be based on the social value of an occupation or profession? Or should the choice be made from the maxim of “whoever arrives first is served first”? Or will the decision be based on the life cycle, with young people taking precedence over older adults? Perhaps it is more appropriate to use a score based on sequential organ failure as a model for predicting mortality?[20] Certainly, under such conditions, whatever the premise adopted by the professionals, it will invariably hurt some of the ethical principles of their profession, making the decision by utilitarian thinking an extremely stressful task for those involved.

Added to the natural stress of the utilitarian decision is the fact that the transition to the practice in professional roles is already a period of great stress for newly graduated nurses.[21] A study that investigated the transition of newly graduated nurses in long-term care identified four characteristics of these professionals: lack of life experience, lack of experience in the particular context, fear of losing skills, and willingness to take the initiative.[22]

Most of the recent graduates are in their twenties and will have few life experiences to deal with situations in which the right or responsible thing to do can be a decision called into question. At the global level, we have verified conflicting positions from the other countries, with acts against social isolation measures *versus* health recommendations, polarization of the debate on economic impacts *versus* impacts on health, and a series of dilemmas that require life experience in testing personal and collective theories about what is appropriate, right, and useful.

Another important example to be cited is that recent graduates will continuously deal with death, including that of colleagues, but the topic is still a taboo in health care training and practice, demanding reflections, research studies, and teaching-learning strategies to minimize the problem situations that arise during professional training and in the clinical fields, with important influences on the quality of the care provided.[23] A number of research studies carried out with Nursing students on the care of terminally ill people evidenced unpleasant emotions and sensations, feelings of impotence, sadness, anguish, and insecurity.[24–25]

The lack of experience in dealing with calamities of this nature, and for which they were not trained, becomes a risky element that challenges the competence of the recent graduates to respond appropriately to the question “Is this a responsible action?” How can they judge their own actions, considering the fluidity of the patterns in which they may be anchored and the inexperience in the face of the new? How to deal with patterns of practice that prescribe human comfort, even at death, when they are surrounded by reports from colleagues who were unable to maintain their own comfort behind protective equipment that obliges them to suppress their needs for hydration, eating, and eliminations for hours?

Experiences such as Hurricane Katrina, which hit New Orleans in the United States of America in 2005, indicate that few guidelines can be followed in times of disaster and that, usually, options are not offered to the patients, deeply injuring the principle of autonomy.[20] The disaster already caused by the SARS-CoV-2 virus far exceeds the one observed at that time.

In order for the extreme situations faced by recent graduates to have a minimized impact, training programs and the elaboration of strategies to reduce stress could be structured, enabling job/work satisfaction and retention.[12] Under the MoH ordinance, Nursing students in the last cycle of

their training are encouraged to develop the mandatory internship in health units that are not in their natural configuration. They will learn in a context of exceptionality, gaining experiences that conform outside the usual models of clinical and ethical decision-making. Therefore, depending on the time they spend in this experience, they may have their usual skills, which were built in years of clinical teaching, molded to a new reality. If this is the current need and possibility, at least it needs to be discussed and considered in the process of training and managing the human resources.

Even with the monitoring of the supervisor during the internship, it is difficult to guarantee that, in view of the scarcity of human resources in health, the students will be able to have the attention of this professional to facilitate their learning so that they attain a desirable qualification in facing such acute life-death issues.

In normal situations, newly graduated nurses tend to engage, taking the initiative to accelerate their professional development, and can be classified as resilient by their supervisors.[22] In scenarios of such apprehension and expectation as in the service to individuals with COVID-19, how would the safety conditions of the students who perceive willingness to take the initiative be guaranteed even in the face of excessive risks?

Already in its name, the "*O Brasil conta comigo*" program instills the dimension of a mission for the insertion of the student. In addition, it creates engagement bonus mechanisms by computing the workload of the Mandatory Curricular Internship or volunteering, even in the face of the suspension of higher education activities by the quarantine measures implemented by the state and municipal authorities, or rewarding those engaged with an additional 10% in the score in public selection processes for Health Residency Programs promoted by the Brazilian Ministry of Health.[6]

In the competitive health market, engagement would add the presumed willingness to take the initiative with the advantages of being ahead of the competition. Thus, it is valid to direct to the governmental spheres and to society as a whole one of the central questions of the ethical pattern: Is this conduct responsible?

The educational system and society need to reflect on the risks and benefits of exposing students to the right-wrong attempt in the face of ethical situations distanced from the purpose of the profession of caring and comforting as the highest values of life. Inserting students still in their process of professional training in such an adverse care scenario is, beforehand, assuming risk situations beyond those expected in the learning scenarios, in addition to compromising the safety culture inherent to good care management.[26]

On April 20th, 2020, the Brazilian National Health Council recommended actions that can be seen as a first step to mitigate the risks of the aforementioned normative measures and to incorporate more agents in the planning of their execution. Its recommendations are synthesized as follows: agreement between Higher Education Institutions and the health units with observance of the internship covenants and compliance with National Curriculum Guidelines and pedagogical projects of the courses; use of undergraduate health students at the frontline of care as a last resort, after all calls for professionals through different mechanisms; definition of the hierarchy of the intervention scenarios, according to the potential risk for the students' health, preserving them from "cognitive, psychic, occupational, and work-related stress"; guarantee of all the appropriate Personal Protective Equipment (PPE); combination of appropriate remote, face-to-face, and hybrid learning strategies/methodologies and signed in partnership with the Brazilian SUS management; supervision of the students in service-teaching partnership.[27]

The care scenarios for patients with suspected or confirmed COVID-19 have been of constant stress for the health professionals, in particular those from Nursing, due to the specificities of care, which require greater contact and exposure. In China, some symptoms of stress and others of

impairment of the mental health of the population and health professionals led the country to implement interventions to alleviate such problems.[28]

We are facing a morbidity with a reduced evolution time, as well as with transmissibility and pathogenicity not yet completely known. Updates to service and individual and collective protection protocols are routine, requiring technical updates,[29] which makes the teams even more apprehensive. This also requires updating and training students and teachers to keep up with this scenario of intense change.

Until July 20th, 2020, the Nursing Observatory website, created by the COFEN's Crisis Management Committee, recorded more than 26,000 Nursing professionals who were or had been quarantined in Brazil.[30] This absenteeism encompasses professionals with COVID-19 suspicion or confirmation, as well as those distanced for belonging to risk groups, which has contributed to a considerable deficit in the assistance scales that certainly led to government decisions to include undergraduate students in the scenarios of combating the pandemic and anticipating graduation.

CONCLUSION

The fundamental knowledge patterns were adequate as a reference for the analysis, interpretation, and production of arguments in view of the problems arising from the acceleration in the training of Nursing students and their insertion in the health system in the current pandemic situation.

Limitations of the governmental measures are observed, especially due to their nature of vertical production, from top to bottom. Their conception did not incorporate the collective of educational Nursing institutions, nor did it include the subjects most directly involved in Nursing education, nor the users of the health system, despite the existence of an institutional framework, structures, and mechanisms of representation in Brazil that would allow for agreement, including the speed required by the pandemic. The National Health Council itself, a representative body that would come forward with recommendations almost a month after the ministerial ordinances, could be an appropriate channel for the collective construction in a more horizontal initiative.

It is inferred that the governmental option can generate greater potential for issues of uncertain impact on the development of empirical and ethical knowledge patterns, especially by suppressing partners who could anticipate problems or propose recommendations that would only come to reality, at least partially, in April 2020, via the National Health Council.

Including undergraduate students in the active work in priority areas at this time of confronting the epidemic would certainly bring benefits to the teams with regard to the renewal of the workforce, in addition to including younger professionals who, for the most part, would not be in the group with higher risk for disease worsening. From a utilitarian perspective of human resources, it could be a measure that can be defended. However, the issues reflected in this article pointed out that the risks are high both from the point of view of clinical decision-making, as well as when facing dilemmas and ethical problems.

The contributions of this article are in the sense of arousing caution in the training institutions and in the students themselves with regard to adherence to the acceleration of training since, until July 2020, questions about the feasibility and benefits of the measures presented in the ministerial ordinances, as well previous experiences in other countries and world scenarios, seem to be of little help in this regard.

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NOTES

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