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The discourse of delivering person-centred nursing care before, and during, the COVID-19 pandemic: Care as collateral damage

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Abstract

The global COVID-19 pandemic challenged the world—how it functions, how people move in the social worlds and how government/government services and people interact. Health services, operating under the principles of new public management, have undertaken rapid changes to service delivery and models of care. What has become apparent is the mechanisms within which contemporary health services operate and how services are not prioritising the person at the centre of care. Person-centred care (PCC) is the philosophical premise upon which models of health care are developed and implemented. Given the strain that COVID-19 has placed on the health services and the people who deliver the care, it is essential to explore the tensions that exist in this space. This article suggests that before the pandemic, PCC was largely rhetoric, and rendered invisible during the pandemic. The paper presents an investigation into the role of PCC in these challenging times, adopting a Foucauldian lens, specifically governmentality and biopolitics, to examine the policies, priorities and practical implications as health services pivoted and adapted to changing and acute demands. Specifically, this paper draws on the Australian experience, including shifting nursing workforce priorities and additional challenges resulting from public health directives such as lockdowns and limitations. The findings from this exploration open a space for discussion around the rhetoric of PCC, the status of nurses and that which has been lost to the pandemic.

KEYWORDS

biopolitics, chronic disease, compliance, nurses, person-centred care, practice

1 | INTRODUCTION

How might Foucault have described the medical institution during the global COVID-19 pandemic? What might he say about the models that have formed, the changing landscape of care within the neo-liberal epoch and how the global pandemic has remoulded the power relations across the social orders? In 1983, Foucault stated, 'In a given society, there is no general type of equilibrium between finalised activities, systems of communication and power relations. Rather, there are diverse forms, diverse places, diverse circumstances, or occasions, in which these interrelationships establish themselves according to a specific model' (Foucault, 1983, p. 217).

This paper argues that while person-centred models of care, particularly those led by nurses, have evolved over time, the pandemic has exposed the tenuous position that person-centredness has in contemporary health care.

Australian healthcare is hinged on the ideologies of new public management (NPM), whereby healthcare and services are run as a business, with each resource (material, human and financial) meticulously managed with the view of ensuring efficiency, productivity and efficacy (Australian Government, 2015). One priority area is the focus on care and management of people with chronic conditions, primarily due to service demand and associated costs for those who live with chronic conditions (Australian Institute of Health and Welfare, 2018). Unsurprisingly, the provision of care for those with chronic conditions is expensive. The costs associated with providing care to this group of health consumers are exacerbated by an uncoordinated and disjointed healthcare system and a disconnect between primary and acute care services, leading to duplication of care and disengagement. As a result, rather than achieving the desired improvements in health and well-being, this often results in poor health outcomes (Sambamoorthi et al., 2015). The rising cost of healthcare attributed to chronic conditions has precipitated new models of care, including nurse-led models, integrated care models that aim to address some of the gaps in current chronic care provision (coordination, continuity and advocacy). A common philosophy to such nursing care is that of person-centred care (PCC). A somewhat nebulous term, PCC is generally understood as a method of care delivery that considers the individual needs of the person and their family, respecting their rights and choices. While this is a commendable notion, the operationalisation of PCC is often positioned with nurses, who have little authority to action the system-wide changes needed to practice PCC. Indeed, recent research has suggested that PCC is more about maintaining the current, medically led system and changing the patient, more than it is about changing the system to meet the needs of individuals (Byrne, 2022).

The global COVID-19 pandemic triggered swift realignment of modern healthcare delivery around the world, across low-, middle- and high-income nations alike. Within the discourse of the pandemic, individuals were frequently reminded that COVID-19 is a disease of the chronically unwell, where older people, those with chronic conditions such as cardiovascular disease, diabetes, chronic respiratory disease and cancer, were described as more likely to become seriously unwell and die (World Health Organization [WHO], 2022). Around the world, health services altered the way that care was provided, within each nation's healthcare system. In Australia, there was wide-scale disruption of existing service models of care, where health professionals whose substantive roles were community-based or in nonacute settings were redirected to acute hospital-based work. This sought to achieve two aims: first, to locate the available workforce in the acute setting to address demand and second, to avoid transmission of the virus by scaling back or suspending the provision of home-based care and the associated coordination (Australian Institute of Health and Welfare, 2021a). Additionally, public health directives such as lockdowns imposed strict limitations on in-person home care and face-to-face appointments. The sudden and unpredicted changes to the way in which healthcare was provided inevitably impacted the provision of quality, PCC. Thus, tensions exist within the architype of modern healthcare delivery, how nurses are used to plug service gaps (through the promise of PCC) and the chaotic healthcare landscape created by the emergence of COVID-19. This paper explores the power relations that nurses are subjected to within the system demonstrating that nurses, as professionals, 'are always much more and much less than themselves' (Stronach et al., 2010, p. 110). We demonstrate that PCC in prepandemic times was a fallacy and that the pandemic has proven that the promise of PCC is at best fragile and, at worst, invisible.

1.1 | Methods

This article investigates the rising biopolitical tensions around how service provision and the role of delivering PCC by nurses have regressed during the COVID-19 pandemic. Fairclough's Critical Discourse Analysis (CDA) (2015) is used to analyse discourse from a range of freely available texts related to the topic areas. As demonstrated in Figure 1, the discourse is thus analysed for its dialectical/relational properties (dimensions of meaning), its features and structural effects (descriptive, interpretation and explanation) with reference to its political, social and cultural elements of power. CDA's ontological and epistemological focuses centre on the understanding that a person's experiences and outcomes are constructed by discourse (Fairclough, 2001). The subject can then be uncovered and understood in ways that have not been considered, to allow for alternative meanings to be explored and adopted (Evans-Agnew et al., 2016).

The data analysis is then located within the works of Foucault. Foucault's notions of Governmentality and Biopolitics (2008a, 2008b) are used as a philosophical foundation for the exploration of the discourse that prescribes the way in which care for vulnerable population groups (specifically those with chronic conditions) is provided by Australian nurses before and during the COVID-19 pandemic.

This paper uses document analysis, comparison and genealogy methods. A range of freely available text were included as per Table 1 below. These were organised into micro-, meso- and macro-level discourse and analysed under Fairclough's framework above. This allowed for the discourse to be understood in the wider societal context. It allows for the discourse to be explored within interconnecting relationships that lead to a certain positioning of people in society, in this case, people with chronic conditions.

This article presents an argument that the profession of nursing has undergone significant changes in response to the rising costs and care needs of people with chronic conditions, demonstrating that the dominant method of care is often described as person-centred. The tension here within is that this has changed in the context of COVID-19, bringing into question the commitment to and value of PCC. This also demonstrates that nurses, despite the emergence of nurse-led

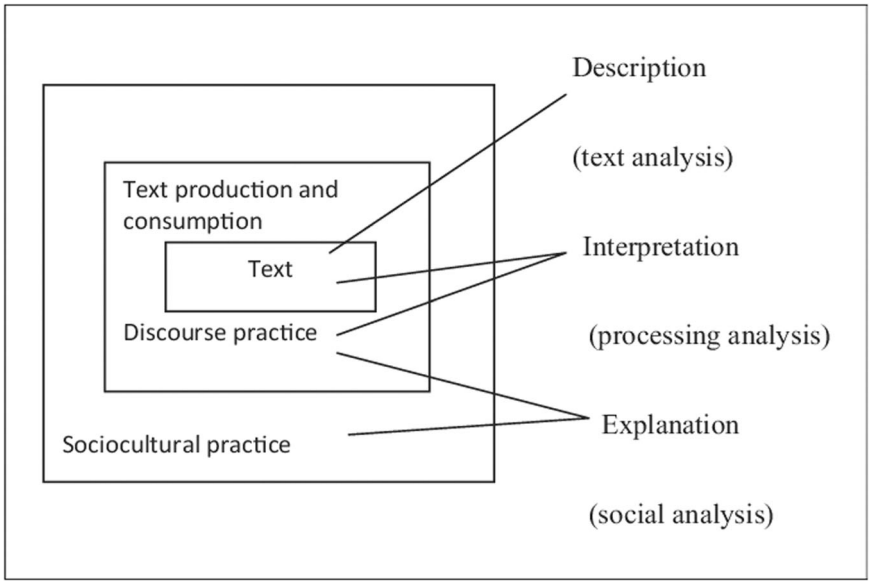

FIGURE 1 Overview of formal features and relationships of discourse to be analysed. Adapted from Fairclough (2013), Essex: Longman.

TABLE 1 Overview of social orders and orders of discourse to be examined.

Social orders	Orders of discourse	Sources of discourse/data
Micro	Nursing practice and person-centred care (PCC) in motion	• Media reports • Nursing organisations and clinical body reports and associated discourse. • Discourse targeted to individuals
Meso	Health organisation, leadership and strategy	• National frameworks and health directives • Clinical guidelines
Macro	Political directives in Australia International discourse and directives	• World Health Organization discourse • Other government (international and national) frameworks and discourse

models of care, are still at the mercy of the medically led model, which has a flow-on effect to how they care for patients.

In this article, PCC is viewed in the wider context of the health service, which includes the discourse, text and actions of the people enacting it. Therefore, analysis is inclusive of the micro, meso and macro levels of society that impact upon the way it is understood and operationalised.

Previous research in this area explored the existing tension between nurses' ability to deliver PCC in a system designed to maintain NPM efficiency, productivity and efficacy, and positioned PCC as a technology of compliance (Byrne, 2022), where individuals with chronic conditions are taught to care for themselves, omitting any genuine attempt to change system structures and models to meet their needs. The outcome of this previous research was a finding that PCC is often used as a way to ensure that people with chronic disease *comply* with societal norms, build self-care skills and avoid 'over' using the hospital system. That is, when PCC is used as a philosophy of chronic disease models of care, it positions the person as irresponsible and capable of managing their health better. A value judgement is often also associated with this, whereby an assumption is made that the persons living with chronic disease can, and want to, care for themselves and thus reduce their usage (and costs) of hospital services (Byrne, 2022). The investigation in this article expands on the previous research and examines the concept of PCC in the context of COVID-19. This article exposes how COVID-19 influenced, or not, the provision of PCC for people living with chronic conditions, a significant portion of which is made up of people in community and aged care sectors. Our aim is to spark discussion around the rhetoric of PCC, demonstrate the structures that inhibit the nursing practice of PCC and highlight that 'care' has become the collateral damage of the pandemic.

1.2 | Positioning Foucault's governmentality and biopolitics

Foucauldian philosophy states that access to power and knowledge shapes society; knowledge is created by those in power, the discourse from which becomes a norm in everyday practice, so that the rules of our societal systems both constitute and are constituted by our acceptance. Foucault expressed that there are, always, multiple truths in society, created by those in power but also

challenged by those existing within it. Dominant truth claims are perpetuated through discourse (as action and text) and constantly ordered and reordered through societal systems such as science, education, law, media and economic ideologies and ultimately perpetuated through an unconscious acceptance by the general population (Rabinow, 1987). In this way, the truth is shaped and reshaped through the discourse of everyday life (Fairclough, 2009). These truth claims can be accepted or challenged, and it is these tensions within society that create a space to examine what is and what needs to change (Hook, 2001). Thus, truth is not a single point of power, but rather it transcends politics and institutions to become a socially formed phenomenon (Foucault, 1991a). The concept of PCC centres on (at least discursively) the idea that the person is fundamental to decision-making (Slater, 2006) and capable of making such decisions (Morgan & Yoder, 2012). However, the practice of PCC is also informed by the nurse and the organisation (Byrne et al., 2020, p. 12). It can be argued, therefore, that PCC is both an object and a subject, influenced by interpretations handed down through levels of healthcare hierarchy (Byrne et al., 2020).

Governmentality, as expressed by Foucault, takes place in a period of neoliberalism. The era of neoliberalism is primarily focused on free markets, 'the freeing of markets from state intervention and regulation' (Fairclough, 2013, p. 11), which places priority on reducing state responsibility for providing social welfare. Governmentality is referred to as the conduct of conduct, describing a state of administration in which control by those in power is divested to the population through knowledge transference in the form of codes of conduct, modes of discipline and ways of being. An example is the policies that the government provides to direct health services on the practice of PCC.

Governmentality dictates how subjects (people in society) act and behave (Muller, 2017). The Governmental regime of power forms complex systems and institutions (orders) that target the population (people) to assume the role of actors within a societal order (Foucault, 1991b). These actors within society are all subject to the power of government. The government captures our attention and feelings of inclusion by giving us the freedom to take on a policy or act, thereby giving it meaning in our everyday world. Thus, actors perpetuate the government's bidding through our institutions such as schools, police, laws and health; although we have been given the freedom to implement it, we also conform to it. Flaskas and Humphreys (1993) identified power as unavoidable because it exists throughout all social relationships. In simple terms, Governmentality is the power over the household, by way of measures and institutions that form our understanding of any given social order, and hence our behaviour within it (Devisch & Vanheule, 2015). It assumes that a person/patient (as a social actor/subject) will choose to behave in a certain way because they have been conditioned to do so, even though they believe that it is their own choice (Fairclough, 1993; Foucault, 2007).

Within this understanding, Governmentality can easily spill into biopolitics, where people's health and bodies are economised. Foucault (2008b) refers to the production of the social body (or population) as Biopolitics, a driving force in the creation of conduct, order and policy. Foucault's position in this is described in the following quotation:

> The disciplining techniques of the liberal state articulate the population as a collection of productive bodies, risky bodies, consumptive bodies and so on and focuses on strategies to optimise [sic] these capacities … Biopolitics refers directly to the biological body and considers governance of the self, health and well-being, issues of longevity, birth and mortality …. (Muller, 2017, p. 8).

Biopolitics is not simply about ruling, but rather how ideas, ways of being and controls are embedded into social constructs in the context of bodies and health. It allows professionals, such as those in health care, to have the right to own the knowledge that the institution has created or developed and enact this on the government's behalf. This in turn enables the individual to self-regulate their actions based on the knowledge provided to them, and thus the common acceptance of a problem is achieved. This level of self-surveillance/agency ensures that subjects become responsibilised and self-policing, hence upholding the construct of government (Crossley, 2005). The subtlety of Governmentality and Biopower is such that the exercise of power is deeply ingrained through society and is seen as normal; thus, it transcends political power. Zuckert (1995) described it as follows:

> Taken as a whole, the modern state apparatus exercised much less evident coercion than medieval monarchs, but it has much greater power to shape and determine the lives of its individual citizens. (p. 187)

The investigation of historical factors, tools and strategies is what Foucault describes as an archaeology of knowledge, with the investigation of the mechanisms of power being a genealogy of knowledge; these allow researchers to look back in history to understand the situation today (Foucault, 1972). Thus, Foucault (1972) says that no decision can be made today without knowing how it became:

> The analysis of the discursive field is orientated in a quite different way; we must grasp the statement in the exact specificity of its occurrence; determine its conditions of existence, fix at least its limits, establish its correlations with other statements that may be connected with it, and show what other forms of statements it excludes. (p. 28)

Foucault describes several methods to achieve a historical analysis and genealogy of knowledge of a given topic. Foucault describes methods such as the analysis of power dynamics between a person and the intended audience, analysis of authority, identifying

points of incompatibility in discourse and exploration of the function, the rules and conditions that the discourse requires to be appropriate and legitimised (Foucault, 1972). Foucault described his work as a toolkit available to researchers and this is how we have used his work (Foucault, 1981).

Liberalism, as described by Foucault (2008a), is intrinsically linked with government regime, citizen rights, responsibilities, freedoms and conduct. Liberalism is thus a moulding of politics, economy and ideologies and is understood broadly as the limitations of government. Additionally, Foucault describes liberalism as a practice where the limitations of government are enacted by both citizens and authorities, together defining the limitations of government practices (Foucault, 2008b). Neoliberalism, on the other hand, is the practice and limitations of government and citizens in bringing about and embedding market reforms, such as privatisation, deregulation and trade (Povinelli, 2011). This is important as the effects of neoliberalism can be felt across all locations of society, but particularly so for those of diverse socio-cultural backgrounds. Indeed, poor health is secondary to social and political factors, including employment, economic opportunity and geographic location, among many other factors, which leave some members of society at a disproportionate disadvantage (Schofield et al., 2016). This article applied these theories as a lens to the analysis, bringing the argument back to the works of Foucault in describing the evolution and devolution of PCC.

1.3 | Evolving chronic disease models in Australia

While there are multiple factors impacting upon service delivery in Australia, government discourse has clearly positioned the 'problem' of chronic care as one of cost. It is difficult to quantify the costs of chronic disease alone, as most data are collected in terms of whole of hospital spending and are complicated by COVID-19 spending (Australian Institute of Health and Welfare, 2022b). Previous data suggested that the total yearly cost in Australia is between AUD$27 billion (Australian Institute of Health and Welfare, 2014) and AUD $34 billion (Australian Health Policy Collaboration, 2014), though these are likely conservative figures. Total health expenditure for the year 2015–2016 was greater than the growth of the Australian population, with per capita spending increased to 22% and the population increased by 17% (Australian Institute of Health and Welfare, 2018). The total health expenditure to Gross Domestic Product (GDP) in Australia is 9.6%, higher than the OECD average of 9% (Australian Institute of Health and Welfare, 2018). The cost of chronic disease extends beyond that of healthcare expenditure and includes lost Productive Life Years (PLY). This includes lost income and taxes and increased welfare payments, with Schofield et al. (2016) modelling further costs of AUD$20.5 billion lost by 2030 in Australia.

Individuals, families and communities living with chronic disease also shoulder significant financial costs. For example, people living with long-term respiratory conditions have 109% higher out-of-pocket healthcare costs than those with an acute condition, and because of this, people with a long-term respiratory condition are 6–16 times more likely to forgo health care (Callander et al., 2017). The results are similar across other chronic conditions. When compared with Canada, the United Kingdom, Germany, France, Norway, Sweden and Switzerland, Australians rated the highest in costs and disengagement from health care, suggesting that cost is a barrier for people accessing health services in Australia (Callander et al., 2017). This is a significant finding as the Australian healthcare system, unlike some of the comparison countries, is deemed to be universally free, ranking highly in global standards (Dixit & Sambasivan, 2018). In reality, this demonstrates that while a portion of healthcare costs in Australia are covered under Medicare (funded by mandated tax contributions), costs are complex and cannot always be predicted and assumed, with the costs of travel, medications and specialists often unaccounted for.

The social determinants of health (WHO, n.d) influence the susceptibility to and incidence of chronic conditions and multimorbidity. In the Australian context, chronic conditions and multimorbidities (two or more coexisting conditions) are more common in population groups such as those in rural/remote locations, the elderly and frail and Aboriginal and Torres Strait Islander people. The economic impacts as well as the lack of coordination, access and cultural appropriateness of services are particularly felt by these groups. Indeed, for many, the burden of disease is beyond financial, with chronic conditions impacting a person's health, well-being and quality of life.

The Australian healthcare model is fee for service, with singular disease groups of care. For example, individuals will see a general practitioner for their primary healthcare needs and a different specialist for renal, respiratory or endocrine issues. Given the comorbid relationship between chronic conditions, managing one's chronic condition can be complicated, contradictory, confusing and costly for services and individuals alike. Australian governments have hence explored new methods of chronic disease management. In conjunction with the WHO objectives of providing foundational health promotion (WHO, 1987), several policies, strategies and frameworks have emerged to try to meet the growing needs of people with chronic health conditions, whilst also better engaging people in their healthcare. The National Strategic Framework for Chronic Conditions (Australian Health Ministers Advisory Council, 2017) aims to improve the health and well-being of Australians by focusing on prevention, and therefore providing efficient, effective care through optimisation, and targeting priority populations, with First Nations people listed as the top priority. Some have suggested that discoursal positioning of those with chronic conditions (and other population groups) is problematic and paints a picture of people as sick and disorganised (O'Neil et al., 1998). Indeed, this can be further extended to those with chronic conditions, where they are labelled with terms such as 'failure to attend' (Byrne et al., 2021), noncompliant and nonadherent. This often frames people as recalcitrant and wilfully irresponsible, while ignoring well-known barriers to care access, continuity and coordination, responsibilising individuals rather than services.

1.4 | The rhetoric of PCC

To involve people as active participants in their healthcare, health services have (on the surface at least) embraced the concept of PCC. Many political, government and health service influences lead to the introduction of PCC. For example, in Queensland, Australia, a series of events highlighted the need for greater patient input into care and service design. The Forster report (2005) highlighted flaws in recruitment and administrative processes for medical professionals as well as the power imbalances that impeded both the nurse and the patient voice and found that existing government processes allowed for harm to go unaddressed. The subsequent political attention of such findings led to the creation of bodies like Health Consumers Queensland (HCQ). Originally formed under the government as a health advisory committee, HCQ was transitioned to a non-government organisation in 2015 (HCQ, 2016). It is now primarily focused on the education of consumers and staff members in working with people to codesign care and systems with the goal of:

> Consumers and community partnering with the health system for consumer-centred health care for all Queenslanders. We are committed to a health system which delivers quality and safe health services and values the voice of consumers in how health services are designed and delivered. (Health Consumers Queensland, 2016, para. 1)

This transition marked an important turning point for the consumer movement, where people seeking care were recognised as important to system design and to the quality of care services. Events such as these also led to the development of national standards around consumer engagement (Australian Commission on Safety and Quality in Healthcare, 2018). Within these standards, person-centred health services are described as services that have elements of person-centred governance, strategy, staff capability, technology and measurement that focus on consumer needs (Australian Commission on Safety and Quality in Healthcare, 2019).

While PCC is clearly articulated in government and health service documents, how PCC is operationalised is not as clear. Hence, the use of Fairclough's CDA provides an avenue to uncovered hidden ideologies within discourse, with reference to power relations (Fairclough, 2001). Sobolewska et al. (2020) identified several national and Queensland state frameworks, strategies and processes that articulate PCC in relation to chronic disease management. These are provided in Table 2 below.

The Australian healthcare system spans across federal, state and local government sectors, making the design and delivery of PCC complicated. In short, the review concluded:

> Although person-centred care as an approach is well articulated in health policies, there is still no definitive measure or approach to embedding it into operational services. Complex funding structures and competing priorities of the governments and the health organisations carry the risk that person-centred care as an approach gets lost in translation. Three themes emerged: the patient versus the government; health care delivery versus the political agenda; and health care organisational processes versus the patient. (p. 1)

TABLE 2 Identified chronic disease frameworks in Australia that utilise person-centred care.

Framework	Level
Australian Commission on Safety and Quality in Health Care—Patient centred care: Improving quality and safety through partnerships with patients and consumers	Commonwealth
National Strategic Framework for Chronic Conditions	Commonwealth
Bilateral agreement between the commonwealth and Queensland State	Commonwealth and State
Queensland Health Budget 2018–2019	State
My Health Queensland's future; Advancing health 2026	State
Specialist outpatient strategy	State
Health and Wellbeing strategic framework	State
Nurse navigator toolkit	State
Hospital and Health Service strategic plan	Local

Note: Adapted from Sobolewska et al. (2020).

While PCC was designed to mitigate some of the risks of the medical model and sought to balance the scales of power between provider and receiver, the lack of one consistent, accepted definition of PCC may inhibit its success (Byrne et al., 2020). Further, when applied to chronic care models, PCC is often measured by its ability to help individuals and families manage themselves, thereby avoiding hospital usage, and in this way, becomes a technology of compliance (Byrne, 2022). Indeed, behind the notion of PCC are ideologies of risk management, efficiency and hospital avoidance. Compounding this issue further is that nurses have been discursively positioned as the custodians of PCC, holding the responsibility of delivering care that meets consumers' needs without the authority to bring about wider system change that is required to enact it (Byrne, 2022). The duality for nurses is that they must practice PCC, while also maintaining their defined social role, embodying an oppressive position within the power relations (Fairclough, 2001).

1.5 | Nurses as (efficient, productive) professionals, responsible for PCC

Nurses have long been described as caring professionals, with 'care' being the fundamental premise of the role. The International Council

of Nurses states that 'nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings' (International Council of Nurses, 2002, para. 1). The care in nursing is subject to moral, ethical and social connotations, with nursing as a profession being synonymous with healing and compassion. The nursing code of ethics (International Council of Nurses, 2002, para. 2) states that the nurse 'demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness, and integrity', with their primary professional responsibility being to the people receiving care. Over time, this has become normalised in the discourse and evolved to be referred to as PCC.

In the same way that chronic disease models have been reframed within the NPM ethos, the profession of nursing has also been subjected to the influences of productive and efficient systems (Bergh et al., 2014). Despite care and caring being discursively positioned as fundamental to the profession of nursing, there has been a shift in the way that nursing time, resources and work have been defined and managed.

While health services moved to the NPM ethos, nursing as a vocation underwent significant changes. Nursing experienced a period of professionalisation, whereby it was restructured around individual accountability in terms of tasks, finances and quality of care. One major change was the education of nurses, which moved away from hospital-based training and into the university sector. This move was fuelled by several social, political and professional influences, including the predicted nursing workforce shortage, economic reform and the quality movement (Grealish, 2012). Additionally, the onus on lifelong learning was discursively positioned as an important resource within the health service. Nurses' professional learning is intrinsically linked to organisational position and risk aversion, which has led to nurses accepting (without question) the responsibility and accountability that this holds, regardless of environmental factors, which are largely out of their personal control (Rudge, 2013; Suhonen et al., 2018).

During the professionalisation period, the work of Benner articulated the education of nurses as a gradient from novice to expert and expressed a perpetual need for ongoing education and experience. This advocated for a competency-based approach to nursing (Benner, 1984).

> A competent nurse and a proficient nurse will not approach or solve a clinical situation in the same way. It is not that proficient nurses have internalised the rules and formulas learned during the earlier stages of skill acquisition; they are no longer using rules and formulas to guide their practice. They are now using past concrete experiences much like the researcher uses paradigms. (Benner 1984, p. 406)

Foucault describes the controls of subjects as technologies of the self (2008a); as such, competency standards are technologies that 'manage' nursing practice. As Fairclough (2001) argues, it is practices such as competencies that help to collectively define and organise a profession's performance while also shaping and reshaping policy and practice over time through curriculum development, and professional role development, to name a few. This practice of perpetuating and shaping a profession was demonstrated by Grealish (2012), who uncovered the social, political and professional implications of nursing competency standards, finding that they served a specific purpose within the professionalisation of nursing, ultimately becoming the method of classifying nursing performance in accordance with health system requirements. In doing so, competencies became the avenue by which the health institution changed the discourse of the nursing profession, embedding quality improvement into the competencies and other forms of economic control. While nurses adopted these changes as important to effective patient care as a profession, they unconsciously reinforced the financial order of care as defined by the system. Grealish (2012) noted that, after consideration, the nursing standards excluded caring, empathy, sensitivity and the consideration of the patient as a 'passive actor' (p. 27), moving nursing competence to that of critical thinking, safety, escalation and tactile skill and task. This created a shift of nursing practice from emotional labour such as caring to one of cost efficiency by using competencies to redescribe nursing practice (Davis & Adams, 2012). As Rudge (2013) notes, nurses' desire to provide good care still overrides the realisation that care cannot be fully delivered under a system that dictates what care is, based upon a financially defined diagnostic outcome, rather than a patient's response to treatment. This means that even prepandemic, the ability to practice PCC was stifled.

The subtle realignment that nurses are not realising is seen in the evolution of national competency standards for nurses. In 2016, the competency standards were rebranded as the Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia, 2016). Critique of the competency standards centred on how they were operationalised into practice and their misalignment to speciality fields and to more senior nurses (Terry et al., 2017). Rebranded as 'Standards for Practice', the new document provided a one-size-fits-all requirement of nursing practice regardless of practice area and level of experience, whereas competency standards seemed to align more with nurses looking to be registered for the first time (Cashin et al., 2017). The standards have been widely accepted by nurses as a legitimate indicator of safe practice, with nurses seeing the standards as a reflection of the professional role (Terry et al., 2017). Fairclough (1993) defines this as the social identity that is transformed into the new normal through discourse that has been strategically constructed through text, and then legitimised by the nurses themselves over time (Krzyżanowski, 2020).

Investigation of the standards is a key element of understanding the importance of nursing work and of what legitimises PCC; thus, below, we have completed a document comparison between the 2006 competency standards and the 2016 Standards for Practice. Table 3 demonstrates that the role of the patient transforms into one of equal ownership and responsibility and the role of the nurse moves away from resource allocation, management and system change;

TABLE 3 Comparison between the 2006 National competency standards for the registered nurse and the 2016 registered nurse standards of practice.

2006 National competency standards for the registered nurse	2016 Registered nurses' standards for practice
2.1d. Recognises and accepts the rights of others. 2.3a. Demonstrates respect for individual/group common and legal rights to healthcare. 2.3c. Considers individual/group preferences when providing care. 2.3e. Advocates for individuals/groups when rights are overlooked and/or compromised. 2.4c. Protects the rights of individuals and groups and facilitates informed decisions. 2.4a. Identifies when resources are insufficient to meet care needs of individuals/groups. 2.4f. Recommends changes to policies, procedures and guidelines when rights are compromised.[a] 7.1a. Uses resources effectively and efficiently in providing care. 7.8. Uses healthcare resources effectively and efficiently to promote optimal nursing and health care.	2.2. Communicates effectively, and is respectful of a persons' dignity, culture, values, beliefs and rights. 2.3. Recognises that people are the experts in the experience of their life. 2.5. Advocates on behalf of people in a manner that respects persons' autonomy and legal capacity. 3.2. Provides the information and education required to enhance people's control over health. 2.4. Provides support and directs people to resources to optimise health-related decisions. 4.4. Assesses the resources available to inform planning. 5.5. Coordinates resources effectively and efficiently for planned actions.[b]

Note: From Nursing and Midwifery Board of Australia (2006, 2016).

[a]This has been removed completely.

[b]The SFP amalgamated the subcategories of the older competency standards; therefore, the numbers in this table are somewhat misaligned.

both changes appear to empower the nurse and the patient and yet, we have argued, do not.

A subtle change to both nurse and patient is noted, particularly in points 2.4, 4.4. and 5.5, where nurses no longer 'identify' insufficient resources or 'recommend' changes to policies, but rather 'use' resources 'effectively and efficiently' (Nursing and Midwifery Board of Australia, 2006, pp. 3–6; Nursing and Midwifery Board of Australia, 2016, pp. 4–5). This shifts the role of the nurse to one that adapts their approach to care based on existing resources, rather than leading or initiating change. This shift in discourse is in keeping with NPM lean thinking approaches, where the responsibility of care delivery is divulged to the worker in ways that nurses subconsciously accept and then adapt to the change without questioning it (Fairclough, 2015; Urban, 2014).

Within the language of the Standards for Practice, the patient moves from a passive recipient to an active contributor within the healthcare team. This provides insight into how PCC is mobilised within the discourse of nursing whilst also shifting the accountability of care away from the organisation. Thus, within the healthcare structure, nursing is increasingly aligned with resource management rather than being agents for change, and with this, the refocusing of nurse manager work from nursing quality to financial efficiency (Newman & Lawler, 2009). An example in Table 3 is the shift from nurses '[identifying] when resources are insufficient' to 'assess [and coordinate] the resources available to inform planning' and the removal of standard 2.4f 'Recommends changes to policies, procedures and guidelines when rights are compromised' (Nursing and Midwifery Board of Australia, 2006, p. 3; Nursing and Midwifery Board of Australia, 2016, p. 5).

Supporting these findings is international literature identifying negative correlations between a reduced skill mix and poor quality of care in locations where lean management practices are upheld (Ball et al., 2014). This is representative of a deeper issue where nurses are directed to work under the standards within an ethical structure that prescribes the rights of individuals, autonomy, beneficence, justice and nonmaleficence (Nursing and Midwifery Board of Australia, 2008). Yet, ethics is not a consideration for health services when implementing lean processes and thinking (Rooddehghan et al., 2018). In fact, the NPM movement and lean thinking require 'minimalistic ethics', where fiscal management becomes central to care rather than those resources required for safe, effective care (Ljungblom, 2014, p. 193). Minimalist ethics describes a 'pacification of morality', which Callahan explained is the reprioritisation of moral conducts in times of hardship:

> If life is going poorly, someone obviously must be at fault, if not the government, then my neighbour, wife, or child. The warm, expansive self, indulgent of the foibles of others, gives way to the harsh, competitive self; enemies abound, foreign and domestic. It is not so much that the "least well-off" cease to count (though they do), but that all imagine they are now in that category. (1981, p. 261)

This paradox of nurses' responsibility can be traced back to the accountability of the profession with the standards prescribing multiple lines of accountability and responsibility. The standards state that nurses are accountable and answerable to 'the people in their care, the nursing regulatory authority, their employers, and the public. Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles' (Nursing and Midwifery Board of Australia, 2016, p. 2). This is summarised as professional, ethical, legal and employment accountability (National Health Service, 2014). This level of accountability is

translated into nursing practice through audit and 'tick box' documentation as well as accountabilities across the nursing hierarchy. In this way, nurses carry a disproportionate responsibility of care and patient outcomes that leads to a fear of potential blame (Hiscox, 2019, p. 2).

To summarise our argument thus far, chronic disease models have attracted considerable attention under the gaze of the well-run system. Using the umbrella of NPM, health services have normalised the discourse of efficiency, productivity and efficacy, thereby creating a truth that health services must be managed as a business. The traditional medically led model has been so well established that despite the well-known gaps and flaws, services have been introduced to plug these holes, without meaningful systemic change. This means that for many people, particularly those with multiple chronic conditions, care is fragmented, with overwhelming processes, rendering care ineffective. PCC has been introduced to bridge some of these gaps, and nurse-led services in the chronic disease space have emerged (see community models). Through discourse and models of care, nurses have been positioned as professionals who must maintain the NPM ethos, while also delivering PCC to individuals, families and communities. In this way, PCC is problematic; nurses and patients are leveraged to maintain the current system, and to mould within it. Enter COVID-19.

1.6 | Out with the new, in with the old

We now turn our attention to the COVID-19 pandemic, and how providing PCC to people with chronic disease has been further complicated by the rationalisation of resources and the redirection of clinical services. We have argued that before the pandemic, PCC was a concept of rhetoric, and for people with chronic conditions, was more about economic rationality and compliance, rather than one of genuine partnership. In the context of the pandemic, we argue that PCC has been rendered invisible, and that care is the collateral damage of the pandemic.

COVID-19 hit Australian shores in early 2020, with the first economic stimulus packages for healthcare, business and individuals being announced in March of 2020 (Parliament of Australia, 2020). An example of this is the New South Wales Government announcement of $700 Million in additional funding for the state's healthcare system, used for the doubling of intensive care unit capacity, COVID-19 testing clinics, the purchase of ventilators and establishing respiratory clinics (New South Wales Government, 2020). In the early stages of the pandemic, suggestions of economic rationality and system change were evident; for example, the government stimulus was allocated to 'bringing forward elective surgeries' (New South Wales Government, 2020). Later, elective surgeries would be ceased, and resources reallocated to acute services.

Indeed, as the pandemic progressed and lockdown measures were introduced, care services were drawn back to the hospital setting. In the first year of the pandemic, care in community sectors showed 'considerable reductions' across the care spectrum, with a reduction of general practice chronic care service utilisation and many chronic condition management services, such as cancer screening (Australian Institute of Health and Welfare, 2021b, p. vii). Some of the most disrupted services were reported to be care for chronic conditions, aged care, rehabilitation, palliative and end-of-life care and care for people living with disabilities (WHO, 2021a). Given that chronic disease management and coordination are areas of known deficit in the Australian healthcare system, this raises the question of how PCC is prioritised and rationalised in response to care redesign.

The introduction of terminology such as 'essential services' and 'essential workers' functioned to further peel back community healthcare services; essential services in New South Wales and Queensland (Australia) were listed as 'hospital or other medical or health service facilities' and 'emergency services' (Law Council of Australia, 2020, pp. 4–5). An example of this is the Queensland Health *COVID-19 Guidelines for Diabetes Services* (2022), which suggested that outpatient (clinic) services should only be provided for those with diabetes in pregnancy, children, those with newly diagnosed type 1 diabetes and those with high-risk feet. Notably missing from this is the person with chronic, type II diabetes. This discourse subtly reinforced the realignment of services with hospital-based, acute services, and deeper than this, suggests that those with acute care needs are more worthy of services.

Parallel to this, restrictions were placed on who could attend acute inpatient services and when. Indeed, the National COVID-19 management guidelines for older people living with frailty reference this fact as a 'practice point', whereby clinicians were directed to discuss visitor restrictions in relation to the care that would be planned for them (National COVID-19 Clinical Evidence Taskforce, 2022a). Not only does this position care within the hospital but it also places the responsibility of communicating such restrictions on practicing clinicians, predominantly nurses. This is an example of social actors disseminating the word of government, accepting it and perpetuating it as truth (Fairclough, 2001). There is no reference to PCC in the task force guidelines.

These types of discourse contributed to a lack of access, care coordination and consumer input. Indeed, Henrietta Fore, UNICEF executive director, commented that the COVID-19 pandemic continues to pose serious challenges to global health beyond the impact of the disease itself (WHO, 2021a) by way of access, continuity and service provision. The dominant way in which this rationalisation of care and redistribution of care occurred was through the discourse of 'safety'. Guidelines, frameworks, media reports and other forms of discourse focused on personal protective equipment (PPE), safety guidance and leadership (Ananda-Rajah et al., 2020). Indeed, the care of the individual revolved around the relative risk of the person, not for their own safety, but to prevent others being infected, that is, risk of transmission, risk to staff and risk of spreading the infection. This was particularly pertinent in residential aged care, where many residents were subjected to lock-downs in the name of safety (Australian Government, 2021). While strategic guidelines were created to combat the risk to aged

care residents, the monitoring of said risk often rested with aged care staff. For example, the New South Wales health advice for staff working between residential aged care facilities state that 'staff should assess and monitor risk by routinely screening and monitoring risk at each point in the episode of care, monitoring their own risk… identifying vulnerable patients and residents and consider COVID-19 risks in care' (New South Wales Health, 2021, para. 23). One solution to such risk, as presented by these guidelines, was to minimise the number of staff contacts as much as possible, 'while maintaining the health and wellbeing of patients and residents' (2021, para. 23). How one simultaneously reduces patient contact and supports health and well-being is not defined. There is no reference to PCC in these guidelines.

Other solutions came in the form of telehealth appointments, prescriptions and other forms of consultation. Limiting the physical proximity to certain people (again, aged care, people with disability, people with chronic conditions) was discursively framed as a way of managing their personal vulnerability and recognising their increased risk of infection. Healthcare workers were directed to increase telehealth (Department of Health and Aged Care, 2022) and to increase the use of family and carers- 'these people are likely to have knowledge of the symptoms that indicate illness or that the person is deteriorating' (Department of Health, 2020a). Indeed, telehealth services significantly increased during the pandemic, with aged care assessment team (ACAT) and regional assessment service (RAS) assessments defaulting to telehealth only (Department of Health, 2020b). This represents a reduction in service provision and care coordination, though it was described in the discourse as 'providing care remotely' (Department of Health and Aged Care, 2022, para. 1).

In keeping with this care redistribution, the services, staff and care available in the community were reduced, allowing staff to be used in the hospital setting. To reconcile this, community services were described as 'lower priority' and thus services were 'redirected' as described in the quote below from Price Waterhouse Cooper (Burns et al., 2020, para. 8)

> Some lower priority services and activities will be put on hold whilst attention is devoted to the management and treatment of coronavirus disease. Clinical staff will need to work to the top of their license, and innovative solutions found. These impacts will be felt not only inside health services, but in different parts of the community as planned treatment is delayed.

While this redistribution of service and redeployment of nurses occurred, individuals were told to stay home and care for themselves and their families. In fact, one pathway stated that people with chronic, comorbid conditions and other risk factors such as age, BMI and personal safety should be managed at home with COVID, with hospitalisation only being considered in high-risk and very high-risk circumstances. Even then, 'the decision to transfer to hospital should be made after consideration of goals of care' (National COVID-19 Clinical Evidence Taskforce, 2022b, p. 1), a point that alludes to the ideology that not everyone (in this case those with significant risk factors) can be saved, and perhaps worse than this, should not be saved. Given the economic rationality of care that occurred through these times, discourse such as this falls dangerously close to the governing of life and death (Foucault, 2008a).

In this way, resources, along with models and care services, retreated to the traditional, in-hospital style of care. While telehealth models were increased, this was done to replace the community-based, coordination services that largely cared for those with chronic conditions by nurses. Those services, which had previously been described as person-centred, dissolved, and the traditional hospital-based models of care were left standing.

1.7 | The hospital-based nurse

We now steer the argument to how this impacted upon nursing practice. As part of the workforce strategies to manage COVID-19, community nurses were recalled to hospital settings, as were nurse-led services (Australian Institute of Health and Welfare, 2021a). In fact, some services were indefinitely ceased, as resources were syphoned into testing clinics and COVID-19 wards. This resulted in many people who would normally receive at-home care and coordination being left with little or no support. Within the discourse, proof of rationalisation of care and reducing service provision in the chronic care sector is evident.

Australia employed several workforce strategies for the redistribution of nurses. These included rapidly upskilling nursing with critical care (ICU-based) skill and bringing retired nurses back under special pandemic licence, where nurses were provided provisional registration to support the ailing workforce. Courses such as the *Surge* project aimed to rapidly upskill nurses in critical care skills, with the intention of redeploying acute-based nurses to hospital-based COVID wards. What is interesting is that projects such as these excluded nurses in aged care, community health, Aboriginal health, primary care, specialist centres and retrieval services (Department of Health, 2020c). As discussed above, many of these nursing services were pulled back and redeployed, and yet, their exclusion from critical care upskilling suggests a hierarchy of nursing skills and experience. This suggests that those in the current linear hospital system are better valued for their clinical skill, task and process orientation.

In line with this rationing of nursing skill, a subregister of retired nurses was opened. The expression of interests for this nursing register states (Department of Health and Aged Care, 2022, para. 1):

> The Australian Government is calling on retired, part-time and under-employed health care workers to put their names forward through an Expression of Interest to support the health workforce and the Australian community. Areas of work are across prioritised health care sectors and communities that need help most. This includes aged care and Indigenous health.

Hospital-based nurses were used in critical care areas, community-based nurses were used to backfill the hospital nurses and retired nurses were asked to put in an EOI to backfill community sectors. This is further evidence of the powers at play with regard to nursing hierarchy; community sectors, aged care and Aboriginal and Torres Strait Islander services were deemed as appropriate to work with reduced services and technical capability, and higher-skilled nurses were relegated to the hospital. Given that the hospital was used for the acute care of those unwell with COVID, this suggests that chronic disease management, care of the aged and Aboriginal and Torres Strait Islander care are deemed a lower priority.

Indeed, nursing during the pandemic was described as one of the most difficult and exhausting situations for many nurses. Not only did nurses leave, or voice an intention to leave, but there also were many reports of nurses being traumatised and experiencing moral injury as a result of an inability to deliver the care that nurses would normally strive to provide (including that which is person-centred).

News outlets reported that nurses were being asked to 'do more with less—cover more hospital beds, handle more patients and work longer hours' (Andrew, 2021). Because of the redistribution of services and the priority placed on hospital-based care, nurses in the community were left feeling particularly isolated. The powerlessness felt by community nurses was described by Holroyd et al. (2022, para. 12) as feelings of needing to be 'heroes', yet having no equipment, time or space to deliver PCC.

Adding insult to injury (and in the case of the pandemic, injury to nurses was real; WHO estimates that between 80,000 and 180,000 health workers died of COVID between January 2020 and May 2021 [WHO, 2021b]), nurses in Australia were then subjected to a pay freeze. Estimated to save $3 billion to fund public projects, nurses, teachers, police officers and paramedics (public servants) had a pay freeze imposed upon them for 12 months. The normal 2.5% pay rise was waived, leaving nurses feeling 'undervalued, ripped off and disgusted' (Kinder, 2020; The Guardian, 2020).

One year into the pandemic, nurse-led services and models of care were not being seriously considered in relation to pandemic care. Castro-Sánchez et al. (2021) found that pandemic-related research focused on the emotional toil of nurses during the pandemic, finding that workforce gaps, limited integration in research structures and clinical redeployment may have hampered nurse-led research. Indeed, advanced nursing models of care and service delivery (such as nurse-led models and nurse practitioner models) have not been adequately utilised during the pandemic, with suggestions of these advancing models still at the 'white paper' stage (American Nurses Association, 2022). In Australia, the Australian Medical Association used the pandemic to strengthen their stance on nurse practitioner models, indicating that nurse-led models risk patient safety (Australian Medical Association, 2021). This ignores strong evidence around nurse-led care (see, e.g., Carey & Courtenay, 2007; Chan et al., 2018; Wijtvliet et al., 2020), and only works to maintain the current medical-led model, flaws and all.

In summary, nurses were deeply impacted by the pandemic, professionally and personally. The actions of governments and health services were geared towards the economic rationalisation of resources, placing priority on hospital-based, medically led systems, designed around the traditional fee-for-service models of old. Improvements that had been made in the community sector were dissolved, as were the small gains in nurse-led care, ergo-rendering the opportunities for PCC invisible.

1.8 | Biopower, biopolitics and PCC

This brings us back to the questions posed at the beginning of this paper: What is there to say about the models that have formed, the changing landscape of care within the neo-liberal epoch and how the global pandemic has remoulded the power relations across the social orders? Foucault (2008b) refers to the production of the social body (or population) as Biopolitics, a driving force in the creation of conduct, order and policy. Within this are modes of discipline, or the way in which people are forced into certain roles, moulded into preferred citizenship. The ordering of this, particularly in the context of this article, can move into modes of discipline and methods of punishment (Foucault, 1991a). In these unprecedented times, we must reflect on how care is being delivered, how it is prioritised and consider who is being left behind. We argue that COVID-19 has rendered PCC invisible; thus, *care* in health provision is the collateral damage of the pandemic. What we have demonstrated above is that forms of governmentality, biopower and biopolitics have worked to responsibilise high-risk individuals, and deeper than this, exclude them from care and enact discipline techniques as methods of compliance. That is, individuals seen as risky were told to stay home, and care was redirected back to the acute sector. This form of self-regulation was designed around economic rationality and resource allocation, where health services categorised their citizens to 'regulate their economic activity, their production [and] price' (Foucault, 2008b, p. 7). Biopolitics is not simply about ruling, but rather how ideas, ways of being and controls are embedded into social constructs in the context of bodies and health. As an already costly or 'risky' group of people, services leveraged the existing modes of discipline (e.g., what Foucault refers to as the normalisation of judgement, Foucault, 1991a), allowing for the reduction and abandonment of care.

Thus, this rationing of care, hierarchy or care provision and nursing care was largely accepted by the Australian community. Australians appear to have accepted this level of self-surveillance/agency, becoming self-policing, hence upholding the construct of Government (Crossley, 2005). For this to have happened, the underlying ideology of people as rational citizens was pushed to the surface. Rational citizens are those who can and will make 'good' choices for themselves through autonomous self-regulation. Being a rational person is upholding citizenship. The citizen is afforded certain rights such as healthcare in return for upholding social responsibilities (Olson, 2008). Citizenship is often expressed as a liberal–democratic view of its people including its political and legal structures. However, according to Foucault, citizens are a construction of the social orders,

institutions and spaces that they belong to Foucault (2008a, 2008b). Therefore, citizens are constantly moulded and formed to fit the changing landscape of a political environment. Citizens are moulded through choice architecture that dictates and constrains the potential choices available, nudging individuals towards a specific predictable behaviour that simultaneously forbids other options. The citizen is free to make whatever choice is available but is covertly persuaded in one direction (Forberger et al., 2019). In this way, the government can control the level of risk associated with any given choice through the creation of obedient citizens (Foucault, 1979).

When discourse and policy are designed about this rational citizen approach, those who can self-care and manage do well and live long, with the system working within their needs. On the other hand, those who cannot are destined for failure and when that failure occurs, they have 'no one to blame … but themselves' (Zuckert, 1995, p. 187). This is precisely the minimalistic ethics that services apply, whether knowingly or absently, when care is rationed away from those who need it most. The economic and rationality discourse framed the pandemic response and healthcare redesign as essential for safety and risk. What is really being said is that the risky individual holds ownership of their health status; their choices dictate their outcomes; and health service must be managed financially. Therefore, to save those with COVID, services must be removed. The naturalisation of the market brings about the naturalisation of the subject of Government (Selmeczi, 2009). When we treat health as a commodity or market, we treat those within it as commodity and place higher value on those who succeed within the market. Ethics are minimal; economies are king. The outcome of such positioning of citizens is that those who can adhere to the notion of positive choice compliance and self-care do well and live long, with the system working within their needs. This is an extension of discipline and punishment in the neoliberal climate (Foucault, 1979; Wacquant, 2015); institutional relocation of resources and the deeply embedded truths of rational citizens collectively created the conditions of conduct, therefore the conditions for discipline.

In keeping with the notion of risk taking, a person's life as a whole, not just their labour power, are factors in their human capital (Foucault, 2008a; Gordon, 1991). In this way, citizens are a resource to be managed and their human capital will be harvested by the government. All citizens are viewed as potential economic beings and thus all institutional elements focus on how best to obtain this from the people, and this is what Foucault calls biopower (Foucault, 2008b). Thus, governmentality is always pressed upon society invoking the population's biopower, occurring in and outside of pandemic times.

There is no more costly or risky human being than those with multiple chronic conditions, and this has been clearly described throughout this article. We have demonstrated the costs of caring for those with chronic disease, including productivity loss and reduced workforce participation, extending to the family unit as members take on carer responsibilities (Business Council of Australia, 2011). The Business Council of Australia (2011) estimates that eliminating chronic disease would increase the national full-time workforce and productivity by 10%. Therefore, the problem of chronic disease is not simply one of care costs, but one of societal engagement and citizenship. Chronic diseases impeded the production of biopotential and biopower, leaving the business, in this care health services, open to risks. Thus, Foucault's observations stand true as 'governing the poor' is more aligned with maintaining markets than with the well-being of people (Procacci, 1991, p. 157).

Of course, this framing of people as rational consumers and economic management of health services is fundamentally flawed. People, families and communities are complex and subjected to structural inequalities as well as social determinants of health, all of which dictate how a person can live their lives and what choices are available to them. Expecting a person with multiple comorbid conditions, frailty, disability or other socio-cultural needs to manage themselves and their families is reckless and harmful. Indeed, those with chronic conditions and multiple health needs are no longer a minority, but rather make up the majority of people entering the health service, with 47% of people in Australia living with one or more chronic conditions (Australian Institute of Health and Welfare, 2022a). The very philosophy of PCC is in the maintenance of the person as an individual, meeting their social needs and coordinating services to support health and well-being.

The current, single-disease group structure of the health service in Australia does not meet the needs of these people, nor does it allow for continuity of care. While some services started to address coordinator issues (such as community nurses), these are not without their challenges, with most services needing to juggle care needs in a complex and fragmented system designed around fee for service. Despite this, nurses in these roles persisted, only to be the first to be ceased during the pandemic. By reducing these services, access and continuity of care during the pandemic, large portions of the Australia community were stripped of care. We question this. Why are those in most need to care still unable to access continuous, cohesive care that supports their socio-cultural health needs? Is the value of care only related to the costs associated with delivering it? In abandoning PCC during the pandemic, have health services abandoned those most in need of care?

Nurses are players within this institution informed by the power relations, structures and politics. These dictate the way they may (or may not) practice, how they are to position themselves in relation to other professionals and the people they care for based on the traditional biomedical model led by the medical specialist (Glasdam et al., 2015). There is now a tsunami of nurses leaving the profession (McKinsey Company, 2022). The pandemic has merely exacerbated an existing problem.

Nurses consistently reported significant levels of burnout, exhaustion and moral/ethical distress during the pandemic. In line with the evolving standards of practice and professionalisation of the nursing role, nurses were applied to the pandemic as tools and used as resources. Opportunities to deliver holistic care in a person-centred framework within their current form were removed, and how nurses may contribute to the pandemic to their full scope of practice was not explored. Nurses view caring as viewing the person behind

the patient, that is, PCC. This is a sophisticated marriage of care and science, existing within the health sphere of which some elements they can control and others they cannot (Andersson et al., 2015). Nurses must prioritise care between patient groups, often making moral and ethical decisions based on the person's situation, age and the perceived good that care can achieve. Failure to do so can lead to moral distress and missed care, impacting care delivery and professional practice (Suhonen et al., 2018). Stronach et al. describe this as professionals juggling economies of performance and ecologies of practice (2010, p. 121), where nurses are discursively positioned as simultaneously accountable for practice and performance, while also responsible for PCC.

Ethics, in the context of nursing practice, can be viewed as 'inside in', not rich enough to provide omnipotent guidance to all clinical situations, and 'outside in', where virtue is following prior principles consistent with 'merely a process of following the correct rule' (Stronach et al., 2010, p. 113). How nurses deliver PCC to individuals inside a system focused on lean productivity is unclear, suggesting a tension between the care of nursing and the daily demands of the job. How they then deliver it in the context of a pandemic is even less clear. In fact, the power relations that exist sees nurses assessing available resources to 'effectively and efficiently' plan care (Nursing and Midwifery Board of Australia, 2016, p. 5) rather than ethically or holistically. This places nurses in a no-win situation where, as a professional, they are tasked with providing optimum care based on expert assessment of patient needs, and as an employee, they must uphold the agreed organisational targets (Harvey et al., 2017).

This highlights the reality that while nursing practice is grounded in the principles of social justice, their existence within a system designed within NPM principles makes it very difficult for nurses to make change. Nursing as a profession has been moulded within this productivity movement and discursively framed as both the deliverers of care and a resource within the health system. This important point has been articulated by Mold (2017) and Bourgois et al. (2017), who found that health care needs to be refocused, with a greater emphasis being placed on meaningful activities and personal growth and development through value-based care that addresses structural vulnerabilities, that is, system structures that exclude and marginalise population groups.

2 | CONCLUSION

We have argued that PCC was rhetoric before the pandemic, but during the pandemic, has been rendered invisible. The investigation of care, using Fairclough's CDA, in the context of Foucault's Governmentality and Biopolitics, found that those charged with delivering care do so under the guise of minimalistic ethic and the assumption of rational citizenship. The nursing workforce has been left exhausted and paralysed by the pandemic. While discourse has suggested that as a profession, they are primed to deliver PCC, the reality remains that they are often powerless to invoke any system-wide changes required to support such practices. Indeed, the professionalisation of nursing before the pandemic saw the role change to one of resource allocation and task. During the pandemic, this is precisely what happened to the role; there was no room for providing PCC, or indeed care in general, as the role has been reduced to that of traditional, hospital-based tasks. In this way, nurses 'are always much more and much less than themselves' (Stronach et al., 2010, p. 110), whereby they are asked to be 'heroes' in giving more of themselves but are provided no power or freedoms to enact change and deliver care. In this way, it is the care that is missed from nursing practice, becoming the collateral damage of the pandemic.

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The authors declare no conflict of interest.

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Data from this project are freely available from internet sites.

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