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Who Cares?

AN ETHNOGRAPHIC EXPLORATION OF THE
VALUE OF CARE WORK IN THE LIGHT OF THE
COVID-19 PANDEMIC

by L.S. Pijnacker

Who Cares?

“How do Dutch nurses experience and give meaning to the societal valuation and framing of their work, in the light of the Covid-19 pandemic?”

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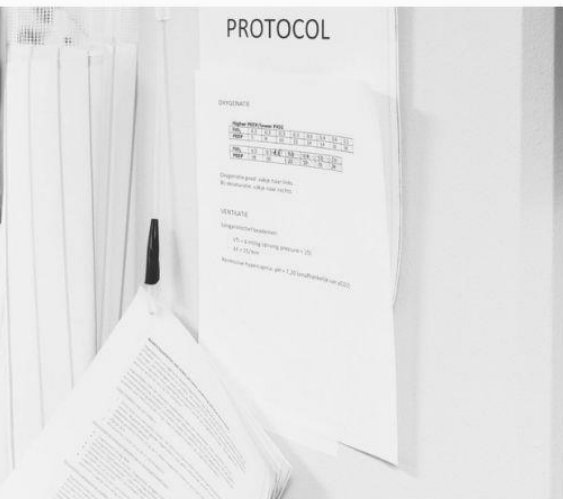
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“A student once asked anthropologist Margaret Mead, “What is the earliest sign of civilization?” The student expected her to say a clay pot, a grinding stone, or maybe a weapon. Margaret Mead thought for a moment, then she said, “A healed femur.” A femur is the longest bone in the body, linking hip to knee. In societies without the benefits of modern medicine, it takes about six weeks of rest for a fractured femur to heal. A healed femur shows that someone cared for the injured person, did their hunting and gathering, stayed with them, and offered physical protection and human companionship until the injury could mend. Mead explained that where the law of the jungle—the survival of the fittest—rules, no healed femurs are found. The first sign of civilization is compassion, seen in a healed femur.”

- Margaret Mead in Ira Byock, *The Best Care Possible: A Physician’s Quest to Transform Care Through the End of Life* (Avery, 2012)

Photo on titlepage is from the photo collection of Dutch newspaper Volkskrant on health care workers during the first wave of the COVID-19 pandemic named “Als de maskers afgaan, spreken de gezichten”. Used on 30-01-21. <https://www.volkskrant.nl/kijkverder/v/2020/als-de-maskers-afgaan-spreken-de-gezichten~v382125>

The images on page 3 display the IC unit, shared by a participant of this research (under a pseudonym), nurse and photographer Kim Marquardt. Using these pictures, Kim created a book for all her colleagues, and a selection is used in the online exhibition named Corona in de Stad: Amsterdam Zorgt.

The images that display banners such as “Van Hero naar Zero” and “No Nurses no Future” have been shared by multiple participants through WhatsApp conversations after initial interviews. Also, see attachment 1: Photo elicitation for reference.

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The experiences I share in this master thesis result from the years of academic training in both my bachelors and master's program. I want to express my gratitude to everyone who contributed to the personal and academic development I have enjoyed at the department of Cultural Anthropology at Utrecht University.

A thesis might have only one author displayed on the cover. However, it is a product that is created through the contributions and support of many. This research became very special to me due to the incredible stories that nurses shared with me. The inspiring stories gave me further insights into the entanglements and nuance of everyday lived realities. I especially want to thank Kim Henkels de Lange, Hugo Schalkwijk and my supervisor Teun Westenenk. Kim has repeatedly shared insights on her profession, provided updates and efforts to contribute to this research. Hugo was one of the first people to show genuine interest in this research's societal and academic relevance and provided many valuable contacts. Teun for his feedback, time, guidance and feedback to explore these topics. His insights helped me to stay focussed and fine-tune the academic relevance of this thesis.

Furthermore, I want to give a special acknowledgement to my parents for their support and patience in my decision to explore a for them unfamiliar field. Finally, I want to thank my partner Bob. His ongoing support, enthusiasm and faith in me and this research were invaluable in the past months of preparing, Conducting fieldwork, analysing data and writing this thesis.

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Prologue

I have been in hospitals before, unfortunately even on the IC unit, so I know the surroundings, the smells and the sounds. Yet, this time is different. Today I do not enter the hospital through the large entrance on the front of the building. I meet Inge at the back of the building, where we enter through a relatively small door. Around us, many other hospital employees are parking their bikes and finishing final phone conversations before starting the morning shift. The clock in the hall tells us that it is currently 7 am. As I yawn, Inge pauses before putting on her face mask. With a cheeky smile, she says: "I don't think I will ever get used to these early hours either".

As we enter the building and walk through the windowless halls, Inge guides me towards the dressing rooms, where large piles of green scrubs wait for the nurses to arrive. This is a side of the hospital I have not seen before. Nurses around me are chatting in routine-like conversations while taking off their everyday clothes and changing into the characteristic uniforms we have seen on our televisions and newspapers during the first month of the Covid-19 pandemic. I remember the images of nurses in full protective suits, with marks from their face masks and overwhelmed looks on their faces. These memories seem to contrast the relaxed Monday morning atmosphere I find in the dressing room today.

We move towards the IC unit, where we both will work today. Now that the number of Covid-19 patients has decreased, the hospital has finally allowed me to assist on their IC/Covid unit. Inge stops and points towards an empty hall: "this used to be filled with patients", she explains with a distanced look on her face. We walk to a window a few meters further, where two men are in a deep sleep. The two men are the only patients left after a year of endless streams of patients filling these rooms. Suddenly, Inge points to a door that, for me, resembles the other entries we passed on our way in. "This is the door I told you about in our interview", Inge explains. "The first day I came to work, this door was covered with yellow tape. That's when I knew it had officially started. I remember thinking it resembles a scene of the Walking Dead, a bit of adrenaline and the feeling that this was a very important moment".

Introduction.

“I decided to have a meaningful job, one that pays a lot less compared to others. The fact that I had to make that choice is already ridiculous, but especially in these historical times of the Covid-19 pandemic, it feels good to have meaningful work. I do not just have any other job. This profession matters. I am no hero, but it does feel good. What we do matters” - Suzanne¹

The year 2020 was named the ‘year of the nurse’ by the World Health Organisation (WHO) in honour of the 200th anniversary of Florence Nightingale’s birth. Florence Nightingale is seen as the founder of modern nursing. She is known for her work as a manager, statistician and trainer of nurses during the Crimean War in the nineteenth century. Her lasting legacy for the collective memory invokes the personified epitome of compassion and patient care. The outbreak of the Covid-19 pandemic gave this year of the nurse and Nightingale’s homage an entirely new dimension. When Dutch comedian Youp van ‘t Hek addressed the nation on New Year’s Eve 2020, as a Dutch tradition named the *oudejaarsconferentie* (translated the ‘new Year’s Eve Conference’) as he has done for the last ten years, he took time to praise a particular group within Dutch society: nurses. While almost 2,7 million people watched (Segers 2020), he addressed the invaluable care he himself received while hospitalised due to the Covid-19 virus.

In early March 2020, suddenly, all eyes were on nurses and other health care workers in the so-called ‘frontline’ (Van Mersbergen & Hanneke Van Houwelingen 2020). This societal attention sparked a new debate on how society values those with ‘essential jobs’ (*cruciale beroepen*) in Dutch society (Rijksoverheid 2020; CBS 2020). In the years before the pandemic, nurses protested to raise attention for their workload, understaffed hospitals and low wages (Algemeen Dagblad 2019). These protests on the valuation of health care workers and others with essential jobs before the pandemic received little attention from the masses (González-Padilla and Tortolero-Blanco, 2020). However, during the imposed self-isolation practices throughout the pandemic, the debate was forced to move into the online spheres (ibid). Due to the sudden outbreak and the vital role of health care workers, citizens in large Dutch cities used the online spheres to organise several occasions of mass-applause in person, where some even symbolically dressed in white, to demonstrate their support for health care workers (Boere

¹ Suzanne – IC nurse, interview with Author. Interview on 29-04-2021. Utrecht, The Netherlands.

2020). After the renewed attention for Dutch health care started in March 2020, the government promised individual financial compensation for the efforts of all Dutch health care workers. According to government sources, the compensation - or *zorgbonus* - is a sign of appreciation to those who showed exceptional effort during the first wave of the pandemic (Rijksoverheid, 2020a). In 2020, the number of this compensation was a contested amount, where negotiations circled 300-1000 euro' (ibid.), but regardless of concern among health care workers, there has been no permanent raise in wages. In the end, after much debate, all healthcare workers received around 500 euros as a one-time compensation. The tediousness of debating compensations for 'essential jobs' signifies a recurring trend of decreasing attention to vital sectors in neoliberal societies.

Evelien Tonkens (2016) argues that, in Dutch public sectors, neoliberal ideologies have severely affected how political structures prioritise spending. 'Essential work' (Graeber 2018, 26) – i.e. firefighters, police officers, garbage men *and* healthcare workers – has therefore suffered many changes, yet little of those changes were for the better. The marketisation of the public sector has resulted in a severe decrease in public attention and interest (ibid.). This is now called the frontline workers' hazard pay in international debates, followed by the continuity in devaluating essential jobs (Estelle-Brown and Pearson, 2020, 2). Therefore, this thesis focuses on the social construction of 'essential work' concentrated within the realm of care. Specifically, it will examine the phenomenon in which nurses are ascribed war-time narratives with all its facets, including 'frontlines' and 'our heroes'. The central question of this thesis is therefore:

“How do Dutch nurses experience and give meaning to the societal valuation and framing of their work, in the light of the Covid-19 pandemic?”

In this thesis, I explore the lived experiences of Dutch nurses to understand how they give meaning to their profession and how they experience valuation in various ways amid decades-long neoliberal reforms in the public sector. I will explore how stereotyping and particular frames are ascribed to – and negotiated by – nurses through the lens of Foucault's understanding of power and discourse (Hall 1997). It aims to understand the social mechanics of societal perceptions towards nurses and nursing as a profession. To do so, I have interviewed and performed participant observation amongst Dutch nurses to develop a deeper

understanding of how they give meaning to and experience ‘value’ as such within Dutch society. This thesis will outline how both the lack of a permanent raise in wages and an absence of political recognition contribute to an experience of valuation. In international debates, neoliberal reforms and discourse create a layered perception of value and representation regarding the care work of nurses.

In this discourse, this thesis positions itself to contribute to the field of anthropology. The study of care work, particularly nurses, has not received much attention in recent scholarly works. Within anthropology, when nursing is studied, it commonly approaches this topic within the context of migrant workers exercising their profession trans-nationally (i.e. Mills 2003). However, very little attention is paid to the social dynamics of nurses within European societies. More recently, ‘nursing’ has been commonplace in economic anthropology as one of multiple ‘essential jobs’ (Graeber 2018), rather than being the referent object of study on its own. First, we will discuss how this thesis positions itself ontologically in the discursive approach before moving on to a comprehensive description of the academic positionality of this research.

Ontological Positionality

This thesis positions itself within the discursive approach, rooted in an ontological symbolism. The discursive approach – commonly referred to through ‘discourse’ (Hall 1997) – includes many schools and sub-schools (Demmers 2017, 125). Over the past decades, discourse analysis has become a prominent research method among the social sciences and humanities (ibid.). Whether this follows individualist (agency-based) or structuralist schools of thought, each case refers to people and how they are understood as ‘doing things with words’ and other modes of communication and actions which ‘give meaning’. A discourse, according to Hall, “[...] is a group of statements which provide a language for talking about – i.e. a way of representing – a particular kind of knowledge about a topic” (Hall 1997, 201). Put simply, discourse is considered a social practice, a way to employ language to create new realities.

In his description, Stuart Hall (1992, 201) refers to the French social theorist Michael Foucault and his ideas on the production and consolidation of power. Foucault believed that power is inherently a practice of language. Discourse, defined as a series of statements (Foucault in Hall 1992) or as a particular story of reality (Demmers 2017), makes it possible to construct a topic in a particular way and make people believe it (Hall 1997, 201). Indeed, power is projected through making people ‘inhabit a particular version of reality’. This closely

resembles what Robert Benford and David Snow (2000) call ‘framing’ in their analysis of the creation of social movements. They argue that much of the incentives necessary to ‘make people do things’ lie in creating perceptions and possible acceptance of meaning (2000, 613). A ‘frame’, on its own, resembles a particular version of reality, and the idea behind ‘framing’ is defined as the phenomenon of meaning-making at the level of reality construction (ibid., 614). This entails that, when we understand a frame as a particular version of reality, ‘framing’, as such, can become the practice of generating (or actively creating) new realities. By this, they imply a degree of agency in the creation of popular narratives. However, the efficacy of such frames is positioned within the structure-agency debate.

Ontologically, the discursive approach departs from ideas of structuralism or agency and aims to synthesize the two (Demmers 2016, 114). According to Vivienne Jabri (1996), a prominent discourse theorist focusing on creating meaning to project power through nationalism, militarism and conflict, the discursive approach is deeply rooted in symbolism. For Jabri, structuralist and agency-based approaches provide a de-facto controversy while they can, and perhaps should, complement one another. Indeed, the discursive approach offers a framework to understand the interaction between the individual agent (i.e. a politician, a nurse or a union worker) and where the agent positions itself through meaning within larger societal structures. As such, one does not need to apply either a structuralist or agency-based approach. Instead, this thesis acknowledges various interpretations of reality and positions itself within how power is created using frames, discourse and symbolism.

To study discourse, as such, is to study a social phenomenon wherein social texts (i.e. written work, popular narratives) are used to construct meaning and representation. They do not merely *reflect* popular perception but can simultaneously actively *construct* a version of those things. They *do* things (Demmers 2016, 133). This thesis approaches the central concepts of work, labour, and experienced valuation through the active creation of symbolism and meaning via discursive practices by various actors such as nurses, politicians and union workers. Next, I will briefly elaborate upon the academic contribution this thesis aims to make.

Academic Relevance

In 1958, Hannah Arendt notes how “[...] the modern age has carried with it a theoretical glorification of labour and has resulted in a factual transformation of the whole of society into a labouring society” (1958, 4). As part of her influential work, *The Human Condition*, Arendt provides a distinction between labour and work, offering a contrast between the Marxist notion

of the individual as a *homo faber* who considers human work to have value in itself. She introduces the idea of the *Animal Laborans*. The *Animal Laborans* is an individual who understands labour purely as a means to safeguard existence and sees goods manufactured by humans as having no inherent value but instead reduces them to their practical utility (Arendt 1958 in Klein 2012, 7). In other words, *Homo Faber* performs work to feel human through human work, whereas *Animal Laborans* puts in the effort to sustain life.

In the continuation of this distinction, Arendt also draws a juxtaposition between the concepts of *work* and *labour*. She describes labour as “[...] repetitive, never-ending, thus consumed as soon as it is produced without leaving anything lasting behind” and work with “[...] a beginning and an end. It leaves behind an enduring artefact” (Arendt 1958, 98). Thus, the human condition to which labour corresponds is that of sheer sustainment of biological life. The human condition to which work activity corresponds is the positionality within the world, in the context of meaning and fulfilment. Consequently, we might say that working as a nurse dances on the relationship between labour and work. Maarten, an Amsterdam based nurse, formulates this dance as follows: “[...] providing care is about the relationship between me and the one I care for. There is dependence and even a power relation there, so we carry a great responsibility. The meaning our work has is essential. That is where the value of our profession is created.”²

Arendt’s understanding of labour and work within the realm of the human condition is a constitutive part of economic anthropology. This subfield of anthropology has generally been concerned with uncovering exchange systems, production, reciprocity, and value (Malinowski 1984; Mauss 2002). The term ‘value’ is commonly used to refer to economic affairs, meaning “[...] all those human endeavours in which people are paid for their work or their actions are otherwise directed toward getting money” (Graeber 2018, 234). When asked about such market affairs, Maarten readdresses his notion of nursing within neoliberal structures. He notes that, within these systems, an altruistic meaning for care work is usually taken advantage of, implying that the experience of meaningful work is enough of a currency. Thus, ‘value’ refers to the market value of a commodity that can, in turn, be compared to – or exchanged for – something else. Taking this perspective of value into account, even healthcare could become a commodity by understanding care in traditional economics of exchange.

² Maarten – IC nurse, interview with author. Interview on 25-4-2021. Utrecht, The Netherlands

However, according to Graeber, a series of other spheres influences human's motives for work, such as politics, honour, family or religion (2018, 236). Thus, considering how value is created in care-work, a distinction between intrinsic and extrinsic motivation can be made. Through his research, Graeber postulates an inverse correlation between the societal contribution of one's work and the respective financial compensation. In other words, "[...] the more your work helps and benefits others, and the more social value you create, the less you are likely to be paid for it." (2018, 239, 243). In short, there appears to be an accepted notion that intrinsic motivation – as an embedded aspect of work that is defined to 'contribute to society' – could compensate for monetary rewards. Put simply, work that is 'morally righteous' in contemporary neoliberal society is more easily framed as 'valuable work', and its value to society should be rewarded on its own.

Such framing relates closely to the generation of meaning through the power of discourse. If one defines one's work as 'valuable' through the creation, narration and amplification of prevalent symbolism, then similar lived realities will be an inevitable consequence. In other words, value or valuation of work is actively created through meaning-making processes, which moves beyond mere understandings of commodity and financial compensation. The academic relevance of this thesis lies within the discursive approach by aiming to develop a deeper understanding of the interplay between various interpretations of value and valuation of work within the object of study, that is, nurses in Dutch society.

Epistemology, methodology and the 'Field.'

This research is primarily based on data gathered through ethnographic research methodologies. Since ethnography is both informed by theory and a particular scientific paradigm, the function of this research is to engage in conceptual debates by testing them via research participants among whom the researcher is engaged. However, O'Reilly (2012) elaborates how ethnography is an inductive process, meaning that its design evolves as the study progresses and the empirical data determines how theory is sustained (2012, 11). Thus, although I entered the field with a population and topic in mind, nurses' lived realities were leading in the conceptual debates of this research.

Since the Covid-19 pandemic, nurses have become more challenging to approach, given their required vigilance not to contact too many people for health reasons. As such, gaining access to Dutch nurses as a research group required a degree of creativity. Since I had no fixed physical location during this research, I had to find other ways to contact participants. For this

research, public historian Hugo Schalkwijk can be considered a ‘gatekeeper’ or ‘key informant’ – the central informant who enables access (O’Reilly 2012, 114). Schalkwijk has previously worked in a hospital before specialising in the history of the Dutch nursing profession. In the early phases of this research, I reached out to him based on his field of interest, searching for common ground between our research interests. Throughout the research, he has provided me with contact details of nurses and relevant information on the topic.

These contacts, combined with some healthcare professionals through my network, set the base for an initial participant group. What followed was a method of snowball sampling employed to use the existing contacts to gain access to further contacts among my research population (O’Reilly 2012, 44). With several participants, I remained in touch after the initial interview. Through WhatsApp, I encouraged participants to share news articles, images, or ‘afterthoughts’ to reflect on the interview(s) I had with them. This created a more informal conversation and provided thought-provoking images that I later used in my photo-elicitation.

I have conducted twenty semi-structured in-depth interviews of an average of 1,5 hours with Dutch nurses throughout my research. Because I aim to understand societal valuation as a whole, I consciously reached out to nurses from multiple parts of the country of differing ages, genders and backgrounds. As a result, the data from this research consists of conversations with nurses from the regions of Brabant, Twente, Arnhem, Utrecht, Leiden and Amsterdam. Their work varies from Intensive Care Units to Emergency rooms, Long department, Oncology and Gynaecology. Out of all nurse participants, three are male, and seventeen are female. Finally, ages vary from 23 to 62 years old. However, the base criteria to which all participants adhere is that they have been active during the Covid-19 pandemic, received the *zorgbonus*, were personally witness to the mass applause and currently work in a hospital.

Due to this geographical variety of the nurses, the stories and perspectives shared in the first months of 2021 originate from multiple sites in the Netherlands. Generally, an ethnography provides insights into stories and people, among which the ethnographer has performed close observations. However, this research can be partly defined as multi-sited ethnography because the research conducted varies across multiple settings, locales and cities. As formulated by George Marcus (1995), the notion of a multi-sited ethnography incorporates all-ways in which ethnographers can conduct fieldwork in more than one site. The essence of a multi-sited ethnography is to “[...] follow people, connections, associations, and relationships

across space” (Falzon 2009, 2). Dutch nurses operate within a particular health care system that takes shape under neoliberal policy making.

Furthermore, because of the Covid-19 pandemic, subsequent lockdowns, and social restrictions, this research has taken place through a combined approach of interviewing at home, either digitally or through house visits, participant observation in a hospital, exploring cyberspace discourses and internet-based communications. Although neoliberalism is an ideology and economic principle not confined by Dutch borders, health care policies and systems are. As such, this research is partly multi-sited within the Netherlands but still confined by Dutch borders because I followed a set of participants across both the physical and the cyber realm. I use the word partly because I follow people (e.g. nurses) and a phenomenon (e.g. societal valuation) across space in this research. By using The Netherlands as a broad but confined site, nurses from this research all experienced the reaction from the Dutch government to the virus, receive similar compensation, and all experienced the mass applause for health care ‘heroes’ in 2020.

On top of the geographical site, this research's second ‘site’ was the online sphere. As said, most of the data were collected while the Netherlands were still in a strict lock-down. However, this is not research of an online setting but research in the online environment. A commonly used phrase was “you don’t understand the surroundings of our work without actually being there”, expressing the added value of ‘being there’. Thus, as soon as the number of Covid-19 cases on the IC units allowed it, I could do some small acts of participant observation. Participant observation is the method “[...] through which one takes part in the daily activities, rituals, interactions, and events of a group of people as one of the means of learning the explicit and tacit aspects of their life routines and their culture” (DeWalt and DeWalt 2011, 1). Unfortunately, I have no medical background. Thus I could not participate in nurses’ daily practices. Instead, in the week of 7 June 2021, I ‘shadowed’ one of the nurses I had met during a previous interview and kept in touch with over this research period. With the approval of the hospital, I assisted her in tasks that required little to no training, such as collecting towels and help with the turning and washing of patients. Because nursing can be a highly embodied and intimate experience, this experience provided me with a far more incorporated understanding of the lived reality in this line of work. Nonetheless, the ‘informal conversations’ I had on multiple spontaneous occasions in the halls of the hospital combined with those I overheard in the coffee room authentically illustrated that the topics of this research consider contemporary and relevant issues that concern nurses.

To triangulate data, both the interviews that I conducted online and the offline interviews in the later months of the research had the component of ‘photo elicitation’. By using this method, I used visual images to elicit comments. As a more inductive approach, the images are all provided by participants of this research through WhatsApp conversations. Usually, they were sent as an example of a typical image towards nurses that circulates in the media and society. As sociologist Marisol Clark-Ibañez argues, such images can spur “[...] meaning that otherwise might have remained dormant in a face-to-face interview” (2004, 1513).

Additionally, one of the nurses from this research, an amateur photographer, used her skills to report the work she and her colleagues did during the pandemic. These pictures provided her with a way of representing the closed-off and – according to her – often sensationalised world inside hospitals. Throughout this research, I used her photographs to support “written data by illustrating the argument more forcefully or profoundly than words” (O’Reilly 2012, 171-172). Using these images and pictures throughout the interview may not have provided me with new information. However, it has exposed meaning for the interviewees by triggering an initial reaction, followed by a shared exploration of the dynamics behind these responses.

Ethics and Positionality

I am not a nurse. Nor do I have any form of medical background. Thus, my initial understanding and ideas of the profession were based on stories shared in the media, previous experiences and my surroundings. Ethnography is both a product and a process that enables the researcher to understand how valuation models are constructed and experienced. However, in line with DeWalt and DeWalt (2011, 93), all social researchers and research are inherently biased.

Consequently, it is imperative to address how my previous experience has influenced and created a referential framework for fieldwork and writing. At the age of 19, a severe stroke of one of my parents resulted in long hours at the IC unit of an Amsterdam-based hospital. The nurse was my first point of reference for information or support through highly emotional moments before surgery and insecure hours before test results. This, unavoidably, affected my image of the value of nursing before conducting this research. I experienced how nurses combined very technical skills with very human moments of support for the patient's relatives they care for.

Likewise, I did this research in my home country. I was born in the Netherlands and had my education here. In this capacity, I participated in the mass applause on the 17th of March 2020. According to O'Reilly, ethnographic research aims to gain an insider perspective (2008, 110). Following this rhetoric, an outsider can distinguish and read a society or group's 'unconscious grammar' (111).

Nonetheless, Kirsten Hastrup (1987) argues that distinguishing between 'cross cultural' and 'parallel cultural' contexts is more beneficial than between 'home' and 'away from home'. The combined positionality of being a young woman from a Dutch background with the experience of the IC unit as a family member did provide me with some basic knowledge of nurses' working environment and the Dutch health care system. Yet, this knowledge was profoundly basic, and the realm of health care as a nurse was entirely unfamiliar to me. I was unaware of the development of the profession, financial compensation and stereotypes. Based on my position within the field, this research is 'parallel cultural' in line with the definition of Hastrup (1987).

A parallel cultural perspective or even a partly insider perspective simultaneously has advantages as an ability to gain access as I had have more "[...] linguistic competence with which to ask more subtle questions on more complex issues, and are better at reading nonverbal communications" (O'Reilly 2008, 114). Nurses used many Dutch expressions to formulate how they gave meaning to specific events, such as "*onbekend maakt onbemind*". This Dutch expression explains how a lack of knowledge or experience about a topic leads to a lack of valuation and appreciation. I could have conducted the interviews in English. However, this would have come with the unintended consequence of missing how meaning can be communicated in one's native language. Thus, my position as a native Dutch and 'parallel cultural' researcher both created previous unconscious perspectives on nursing and the advantage of a deep understanding of cultural expressions in the Dutch language.

Concerning ethical considerations, Grassiani (2019) acknowledges how anthropological research implies causing 'no harm'. This principle is founded in the American Anthropological Association (AAA) 'code of ethics' (AAA Statement on Ethics, 2012). Through the duration of this research, I had to consider various interpretations of this code. First, it involved obtaining 'informed consent' (DeWalt & DeWalt 2011, 215). I approached most nurses after being referred through their network or by making use of the snowball effect. At first, I considered approaching hospitals for potential participants. However, I refrained

from this method to avoid the possible influence of hospital hierarchy on the conversations I had with nurses. Only on the occasion of participant observation, I communicated with the hospital. Even after the interviews, some nurses showed concerns regarding their details on their hospitals and organisational structures. Although I have not explicitly used this information in this research, I have used pseudonyms for all the nurses.

Additionally, I have anonymised the names and exact locations of their hospitals. To keep a point of reference, I refer to the largest city in the surroundings of the referent hospitals for geographical reference. Finally, I have always communicated the aim of my research with nurses who participated in this research, together with anonymity and their freedom to cancel their participation at any time.

Outline

The first chapter of this thesis provides an outline of neoliberal influences on the health care system within the Netherlands, combined with a brief historical background of the development of the work field of nurses. This chapter will further elaborate on the notion of work within capitalist value production to further understand these dynamics. The dynamics then will be underlined by the idea of the nurse as a ‘professional’. Here I consider the changes in the nursing profession: from an unpaid caretaker to a professional. Within this process, the *Witte Woede* protests in 1989 are highly referenced by participants in this research regarding contemporary relevance. Finally, in this first chapter, I argue that work and care are intrinsically shaped by the societal structures in which they operate. As such, the societal valuation of nursing is shaped mainly by neoliberal reforms and work under capitalism. The Covid-19 pandemic exposed (and enlarged) these existing fault lines.

Consequently, I will provide more context concerning the Covid-19 pandemic as a ‘health care crisis’ and the subsequent changes in the work of Dutch nurses. Nurses are often referenced as at the centre of the Covid-19 crisis, with a significant media presence. At the same time, they experienced a high risk of working, a high workload, and stress during the first wave of the pandemic. As such, I can introduce concepts such as ‘frontline workers’ regarding nurses.

In the second chapter, I will analyse the notion of nurses and societal valuation through discourse. This notion is highly affected by framing in stereotypical ways that consider nurses a – for example – Florence Nightingale. Nightingale is understood by participants as an image

of vocational work. Caring would be soft and in contradiction with financial compensation. In line with Foucault's notion of discourse, I argue that the language used to address nurses creates power dynamics and stereotypical frames (Hall 1992, 201). I will elaborate upon stereotypical ascriptions commonly present in the current time. This illustration, I believe, will provide ethnographic realities vis à vis a contentious image shaped through society.

Chapter three will expand on value in several ways in which it can be experienced. In this part, I will address 'value' in terms of financial compensation. Financial compensation takes shape through the meaning nurses give to the Health care bonus and structural compensation of their work. The second is social value, in terms of actual contribution and how the work provides meaning. I will start by explaining the mass applause as a sudden high societal valuation of Dutch nurses due to the nature of the crisis. Suddenly there was an experience of 'social value' in terms of Fraser (1994, 74). The final form of value is the experience of political representation among nurses. Among participants of this research, there were two noteworthy remarks that of "*niets over ons zonder ons*" (do not talk about us but with us) and the perspective of "*ik doe gewoon mijn werk*" (I am just doing my job). While illustrating various views on nurses on the importance of political valuation, the political backlash and aspects of valuation will be considered in this section. Finally, I address the sustainability of valuation and work. There is a lot of frustration because 'nothing changed through Witte Woede in 1989', and now nothing might change after Covid-19. This will be considered in contrast to the idea that nurses are naturally un-political as caretakers.

Chapter 1. The larger system of care work

“Last year, my colleagues and I faced an ever-increasing workload. This is not why we decided to work in health care. We did not become nurses to do what we have been doing this past year under these conditions. So, some societal valuation through mass applause is much appreciated. But our prime minister can put his applause in his pipe and smoke it. My neighbour can’t help it that Dutch nurses are structurally undervalued. The people who make these policies can.”³

Jules is a nurse at an IC unit in the northern Netherlands. We are having coffee in her home in Haarlem. She shared her experiences of March 2020 when her neighbours left their houses to applaud her in the street; some even called her name while clapping. At the time of our interview, in April 2021, she is confined to her home due to a burn-out. To her judgement, Jules positions herself right in between the debate in relation to political decision-making regarding healthcare in the Netherlands. In the past decades, political decision making has significantly affected the ways nurses experience and give meaning to their work.

This chapter introduces the socio-political context surrounding Dutch Nurses' topic and their professional valuation within Dutch society. First, this chapter briefly examines the more recent history of neoliberal reforms in the Dutch healthcare context to provide a deeper understanding of developments in the healthcare system to which participants throughout this study often refer. Secondly, it will evaluate how such reforms have played a vital role in healthcare workers' collective perception and framing and its valuation within society. Finally, this chapter assesses the development of nursing explicitly as a profession and how it was affected by recent structural changes explained in the previous section. This chapter argues how existing fault-lines of developments in the Dutch healthcare system, and their effect on nurses' care work, are exposed and re-enforced within the Covid-19 pandemic.

1.1 Neoliberalism in the Dutch public sector

Value, that is, valuation of the work of nurses, is placed with the structures of larger societal structures and changes. The most notable within the lens of value is the global development of a neoliberal era where a “[...] capitalist logic of value has taken hold of the world” (Tsing 2013,

³ Jules – IC nurse, interview with author. Interview on 20-04-21. Amsterdam, The Netherlands

22). Similarly, economic historian Karl Polanyi (2001) argues that capitalism has restructured the relationship between the market and society (2001, 79). Within this new relationship, human society - including labour, money and land - has become an 'accessory of the economic system' (ibid.). Yet, Fraser (2017) contests the market-society dichotomy, arguing that this binary categorization places every aspect not considered 'the market' into a *blackbox category* named 'society' (2017, 4). As such, 'society', that is the social fabric of a nation, is positioned *outside* of 'the market', seemingly removing the 'human' from the market.

To understand care work within Dutch society, we need to address where the dichotomy of market and society becomes blurred: the public sector. The idea of the public sector includes public goods and governmental services such as health care. Within a public sector, social policies are seen as a means through "[...] which a society protects and enhances human life and dignity" (McGregor 2001, 82). Along with education and social welfare, healthcare is considered one of the pillars of social policies organised through the public sector (ibid.). Within the context of globalisation, health care reforms shaped by a neoliberal ideology occur systematically and repeatedly. According to Harvey (2007, 3), neoliberalism, to this end, has "[...] become hegemonic as a mode of discourse. It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in, and understand the world."

This 'neoliberal turn' (Harvey, 2007) is characterised by a series of proposed economic practices. It starts with the idea that any form of human well-being is best achieved through individual entrepreneurial freedoms in a framework of institutions that provide strong private property rights, free markets, and a withdrawal of the state (ibid.). Thus, in public spheres, Polanyi's proposed advancement of 'the market' has indeed become the hegemonic mode of discourse.

Consequently, the day-to-day activities for nurses have increasingly become affected by practices associated with market effects. Neoliberal ideas of effectiveness, cost-efficiency and time-optimisation have significantly altered the daily routine of nurses. To them, it appears as if their work is filled with the ticking of boxes, checking lists and requirements, all of which is extra work for no other reason than to serve as administration for insurance companies. In line with this trend, the Dutch public sector has been subject to neoliberal reform since the eighties (Tonkens 2016, 9). Tonkens explains how the public sector is increasingly organised as a (semi-)market with citizens as self-reliant individuals (2016, 8). These reforms,

while rather extensive, carry three main implications for nurses. The first is that, within the past decades, their salary has primarily remained the same. Secondly, advancements in science and technology have increased nurses' technical and scientific know-how requirements without subsequent fair compensation. Finally, due to the individualist approach initiated by former PM Balkenende and later reinforced by current PM Rutte, the entrepreneurial spirit in the Netherlands has allowed for more individual responsibilities among nurses to be carried by the nurses (Timmerman, 2018, 44). There have been numerous protests in the Dutch public sector of those who work in these sectors, such as doctors, police officers, and judges (Tonkens 2016, 10). They all have similar objectives: to oppose the marketisation of the public sphere and the trend of work in the public sector as organised in terms of targets, efficiency and economic principles (ibid.).

These developments, in turn, imply the transformation of public services into marketable products (Tonkens 2016, 8). Tonkens' analysis of the Dutch public sector aligns The Netherlands with global trends of neoliberal reforms in the public sector. Generally, this and the increase of efficiency and production (Dugay 2000; Marquand 2004; Moore 1995) result in corrosion of public interest because an emphasis on profit and efficiency rarely coincides with incentives to work for the collective (Sandel, 2012). A 25-year-old nurse from Brabant describes how she was shocked by the number of protocols she had to follow in her day to day work⁴. Together with the workload, she doubts whether she can always provide the care patients need under these circumstances. Neoliberal practices thus have a risk of turning an inherently human profession into one prominently focusing on production, efficiency and 'lean' operating principles. Similarly, Jules explains how:

“If a patient is admitted into the hospital, I have to check boxes on six or seven lists. He is only hospitalised for a day, so I know he will leave tomorrow. Why do I have to do all that work? It only shows his scores for that specific moment. If there is a complication and he stays for three weeks, then it makes sense. But it just doesn't make sense in a one-day admission. What's the reason for such a protocol? I don't even ask those questions and just fill in the forms. It is completely useless, but that's the risk of protocols.”⁵

⁴ Jip – Oncology nurse. Interview with author. Interview on 18-02-21. Eindhoven, The Netherlands

⁵ Jules – IC nurse, interview with author. Interview on 20-04-21. Amsterdam, The Netherlands

Jules' experiences, similar to other nurses, indeed demonstrate a systemic problem that surrounds the valuation of nursing in Dutch society.

1.2 Care system in the Netherlands

Within this frame of neoliberal trend in the public sector, care and care work are subject to increasing marketisation in Europe (Aulenbacher et al., 2018). In the Netherlands, 'care' became an increasingly hot topic when the Dutch welfare state was downsized in the 1980s. The prevalent belief system among policymakers back then was that neoliberal reforms would increase efficiency, benefit innovation and end treacly bureaucracy (Tonkens 2016, 9). However, with the implementation of numerous new legislations in 2006 (i.e. the *Zorgverzekeringswet*, the *Wet Marktordening Gezondheidszorg* and the *Wet Toelating Zorginstellingen*), the Dutch government explicitly created a health care system based on regulated marketisation. According to these laws, insurance companies are obligated to negotiate prices and quality of healthcare with the health care providers (Van Weel et al., 2012, 13). In this regard, insurance companies are considered the patient's brokers in [...] negotiating the best care for the best price (ibid.). According to Marcel Levi (2018, 148), this makes the insurance companies a de facto manager of health care, which can have dubious consequences for healthcare prioritisation. They do not provide actual patient care but instead focus on monetary incentives.

Although the long waiting lists from the previous *Ziekenfonds* (or: collective health insurance fund) seem to have vanished, the bankruptcies of the Slotervaart and IJsselmeer hospitals in 2018 were interpreted as signs that the new Dutch health care system had failed (NRC, 2020). A critical report (Rijksoverheid 2020c) from the Dutch inspection for healthcare points at marketisation as the main reason for lack of proper care and eventually bankruptcy (ibid.). Pressure from insurance companies for lower prices and mismanagement through conflicts of interest of board members caused chaos on the work floor. Through the forced termination of contracts and sloppy transitional management, both the hospital employees and the patients suffered the consequences. This prompted immediate action among some former employees and nurses from the Slotervaart and IJsselmeer hospitals. They protested the hospital's closing by emphasising the need for care regardless of market forces by sharing texts such as *Zet de Zorg niet op Zwart* (or: 'don't turn off care') (Nursing.nl b). Thereby they implied a disparity between the notion of care and the notion of market forces that might cause the bankruptcy of a hospital. The IJsselmeer and Slotervaart cases were a recent but initial

indication of severe consequences of neoliberal reforms and marketisation on the public good of care.

The impact of neoliberalism affects the lives of patients and workers alike (Abramovitz and Zelnick 2010). However, most studies focus on the effects on the health and well-being of patients. Therefore, less is known on the impact of neoliberal (dis)investments on health care and nursing work (ibid., Gonçalves et al. 2010, 647). The research of Gonçalves and colleagues (2010) demonstrates how a neoliberal model within hospital work directly results in higher staff turnover, increase in workload and, for new workers, increasingly precarious contracts. The authors state how a production-based model in nursing distances nurses from their work objectives: the care for human beings. One of Jules's colleagues, Inge⁶, explained how an inspection of an insurance company could disrupt everyday care work. They have to temporarily tick an extra box on an extra form to secure specific hospital funding. She facetiously added that no one that spends some actual time on the work floor could tell you how this contributes to better patient care or working conditions. This comment illustrates the variations in perceptions that prevail among nurses vis-à-vis the insurance companies and their representatives. The realities on the work floor vary, according to participants, significantly from those employed by these insurers.

The larger debate on the efficacy of market forces for health care, the neoliberal public reforms since the eighties, and the two hospitals' bankruptcy also raised discussions on the health care systems (Rijksoverheid 2020c). Reforms would have tainted the balance between administration and patient care as well as workload. While the relationship between nursing and politics is not commonplace among those who chose the health care profession, many nurses are now finding themselves slipping into a nexus between the two.

“It is expected from you that you can handle a certain number of patients at the same time. They are admitted; I have to put time into reporting, into administration. There are a lot of expectations of being a nurse. If we want more *handjes aan het bed* (ed. people to divide the work), there has to be enough money to pay them, a shortage of hands is usually a shortage of financial means.”⁷

⁶ Inge – IC nurse. Interview with author. Interview on 16-03-21. Amsterdam, The Netherlands

⁷ Laura - Oncology nurse. Interview with author. Interview on 09-03-21. Helmond, The Netherlands

In this explanation from Laura, a 24-year-old nurse from Brabant, she explains how financial cuts, in her experience, create unnecessary pressure on the work floor. In these terms, Laura illustrates how ‘care work’ is increasingly politicised without the input of actual care workers. Put simply, neoliberal reforms are continuously referred to as a root cause of contemporary grievances among nurses, which were amplified during the Covid-19 pandemic. According to Laura, now that the system has been ‘liberalised’, much of its efficiency and financial capacity is spent evaluating finances on a case-by-case basis in part through insurance companies.

In such a way, the dominant discourse here is the collective grievance among nurses towards neoliberal practices of ‘ticking boxes’ and ‘following protocols’ rather than spending more time with patients as deemed necessary by the nurses themselves. Such discourse highlights a collective skewed power relationship between the nurses and their apparent de-facto manager. To dive deeper into the complexities and role of language within this grievance-based discourse, we must first explore the concepts of work and labour in the development of nursing as a profession.

1.3 Perceiving Essential Work

Keeping in mind this first exploration of neoliberalism in Dutch health care, this next section continues by adding the conceptualisations of ‘work’ and ‘labour’ in the context of varying ontological interpretations of the human condition. The majority of nurses within this research explained how the incentive of ‘money’ does not dominate their work and their motivation to work. Instead, their reasons for working as nurses are grounded in more intrinsic motivations such as ‘feeling that your work matters’ or ‘being able to help others’. Their use of the word ‘money’ [*geld*] refers to both neoliberal dynamics of their work (i.e. marketisation) and their respective financial compensation. We can understand this juxtaposition between value in terms of ‘money’ and ‘meaning’ in Hannah Arendt’s notion of work and labour (1958).

The nexus between care work and ‘money’ is a consequence of capitalist value production, as described by Kathi Weeks in *The Problem with Work* (2011). Capitalist value production refers to how productive values decide what counts as work. Leaving so-called ‘reproductive work’ traditionally largely unpaid to make waged labour possible (Weeks 2011, 24). Reproductive work is defined as historically situated in the household to meet daily needs for care and raise new generations (ibid., 28). Nurses, in their capacity as care workers, provide a striking example to support this statement. Although there are exceptions, such as doctors,

Graeber continues by addressing how the ('poorly paid') nurses in hospitals may be more responsible for positive health outcomes than the higher paid doctors (2018, 244).

As such, what Maarten and many of his colleagues consider 'meaningful' is creating social value, something care work offers in their view. In considering the concept of 'meaningful' as a synonym for 'helpful,' and 'valuable,' and 'beneficial', value of care can be created beyond capitalist means of producing value (Graeber 2018, 236). This is exemplified by Petra, an IC Nurse from Leiden Academic Hospital:

“My favourite part of working as a Nurse in the ICU is the care and guidance you can offer to the families. You see, patients in the ICU are rarely approachable because they are generally kept in an artificially induced coma. So you don't get to know the patients as such. You do meet the families that come and visit, which you'll need to attend to. I think that is one of my strongest assets. I have a good sense of empathy and understanding for what a family goes through seeing their loved ones like that. Imagine you get a phone call, and your son has been in an accident. He was brought to intensive care, and you need to come at once. Those are the patients for whom I can offer the most. I find the deepest meaning in providing comfort, guidance or even closure to families in times of ad hoc notice, or even crisis situations.”⁸

By addressing nurses and their work in a framework of value, they provide a complementary account of work to the existing capitalist theories of 'value of work'. This idea adheres closely to Hannah Arendt's definition of work rather than labour since work leaves behind an enduring artefact (1958, 98), in this case, a symbolic one of continuous remembrance and impact. By addressing healthcare and its shifting perceptions in crisis, the value of work can be regarded – on the one hand - as ascribed by an external locust of meaning givers, such as recognition in political spheres, the positionality of 'value' and its interpretations within a market-oriented neoliberal structure, as well as valuation through civil engagement from society. On the other, the participants themselves framed their valuation through their interaction, offering a narrative of value as portrayed, defined and lived, within and through their actions.

⁸ Petra – IC nurse. Interview with author. Interview on 04-03-2021. Leiden, The Netherlands.

As such, defining ‘value’ among nurses within these larger societal structures is an intersubjective process both from within and among nurses and by external meaning givers. The following section explores the functions of nursing and its perceptions in such larger structures of society.

1.4 Nursing: the development of a profession

Historically the development of Dutch nursing as a profession is tied to English historical reforms. Starting in the second half of the nineteenth century, influential British figures such as Elizabeth Fry and Florence Nightingale created a respectable image for nurses as ‘saviours in times of need’ (Wiegman 1993, 67). According to Nanny Wiegman, this form of mythologising nurses concealed that working in a hospital is complex and demanding work done by middle- and lower-class women (ibid.). In 1924, nursing became a protected profession according to Dutch law that required certification (van der Peet, 2021). In 1966 this professionalisation of nursing was characterized by an official change of the Dutch word of *verpleegster* to *verpleegkundige*. This new official language refers to nursing within the Dutch as a professional that provides care based on skills and knowledge gained through experience and education (ibid.).

However, only after 1980, nursing became further embedded into general health care systems as a profession generally accepted within hospitals' organisational structures. However, the phenomenon of nursing has been continuously subject to technological and social changes. Until 1997 many nurses were educated through the so-called ‘in-service’ education. In-service refers to the incorporation of a learning path when one starts working as a nurse directly. As Anke⁹ points out: “Back in the day, the head nurse would give me a bedpan and simply say, clean up and shut up.”

With a few exceptions, all nurses from this research are educated in this trajectory. Anke describes her education in a nursing home in Leiden through a significant contrast with contemporary nursing: “I worked in nursing homes with the classic old school head nurse. A very sturdy older woman would school the younger girls in basic tasks such as cleaning the patients”.

Interestingly, before these developments of the late 20th century, one would think that Western society had undergone plenty of significant events that would have highlighted the

⁹ Anke – Neurology nurse. Interview with author. Interview on 08-03.21. Leiden, The Netherlands

importance of nurses and nursing in society. Consider the Spanish Flu, in this period, from 1918 to 1919, no medicines or vaccinations were available. Therefore, a great deal depended on nursing care (Robinson 2020, 350). According to Robinson, that pandemic strained nurses to the limit. Yet, they demonstrated the ability to mobilise and maximise their efforts in combating the virus. Temporarily. The status of nursing was elevated, and their roles in the community and public health were more visible (ibid.).

Similarly, the second world war is still characterised by contributions made and the classic gender division of male soldiers and female nurses. For example, Hemmingway's *A Farewell to Arms* situates the protagonist Henry within the Italian frontlines where he falls in love with Catherine, a nurse. The contributions made by nurses to the second world war are described as a 'powerful combination of character and competence' that took women away from more traditional female roles and expectations (D'Antonio 2002, 7).

More recently, the HIV/AIDS crisis was another event that would have highlighted the degree of contributions made to society by nurses. Dutch historian Hugo Schalkwijk (2020) explores the role past epidemics had on societal perceptions of nurses. Nurses act as advocates to patients, contribute to equal access to care and have a central role in providing care to infected citizens, regardless of race, gender or sexual preferences (Schalkwijk 2020, 20).

Unfortunately, the importance of the nursing role, as such, is often overlooked or at least quickly forgotten. According to Hugo Schalkwijk, this is because the role of nurses is often disregarded in historical writing. As such, he argues for more active documentation on the contribution of nurses. Thus, significant social and historical events such as war and the outbreak of Spanish flue or HIV/AIDS underline the importance and the role of nurses that is generally overlooked (Schalkwijk, 2020).

Relating this to this thesis' framework of valuation, the general forgetfulness of the role nurses have played throughout history continues to depend on the fleeting valuation ascribed in times of crisis. The question remains whether nursing and the 'year of the nurse' will remain inscribed in the population's minds, memorialising the role played in a global pandemic, or whether this soon shall be forgotten. For now, it is worth noting that history has shown that the valuation in terms of societal appreciation is temporal within the minds of the general population.

We may conclude from this, looking back to Hannah Arendt's idea of work and labour, that among nurses, there is a genuine interpretation of their efforts as work, being one of the

lasting artefacts in the context of meaning. Yet, in the eyes of the population, or at the very least, historiographers, nursing remains a performance of labour, never-ending, rapidly consumed with little remaining within the population's minds (Arendt 1958, 98). However, amid the referent group of study, more recent historical events remain 'valuable' within their memories. In the following section, I will elaborate upon contentious practices regarding nurses and nursing in recent years.

1.5 Contention among Dutch nurses in the 21st Century.

On 5 September 2019, Dutch healthcare workers mobilised to protest working conditions and low wages, which was adopted mainly in political spheres such as socialist parties and labour unions. One of these labour unions is called *NU'91*, founded after the *Witte Woede* (Stolk 2019) protests of 1989. Loes van Vugt (2016) describes the first protest movement among Dutch nurses, *Witte Woede* ('white anger', referring to nurses' white working garments). This 1989 protest movement filled the streets of The Hague with protesters dressed in white (Lambrechts, 2020). The recently retired nurse Janine* attended the protest was recollected as something she had never seen before.

“Oh yes, I remember that the turnout was huge back then. It was something new because, normally, we could not go on strike. People would die, you see, if nurses stopped working. But I was fed up, my salary had not grown for a decade, and we were working ourselves to the bone, I was tired, and I felt I reached a breaking point.”¹⁰

The protest was prompted by a small message in the Dutch newspaper *De Volkskrant* by a health care worker named Gaby Breuer. Her statement said: “[...] police officers make very little money, health care workers make even less. It is time for action” (Van Vugt 2016, 27). Breuer's message became part of a movement named *Verplegenden en Verzorgenden in Opstand*¹¹ (VVIO) that aimed to contest policies of low wages, though working conditions and generally low societal valuation of health care workers (ibid.). As a consequence of their actions, a new union was founded after a merge of VVIO and *Nederlandse Maatschappij voor verpleegkundigen* (NVM) in 1991, named NU'91. In 2019 Dutch health care workers aimed to repeat the *Witte Woede* protests with new protests under the slogan '*Witte Woede gooit de Zorg*

¹⁰ Janine – Retired nurse. Interview with author. Interview on 21-06-2021. Utrecht, The Netherlands

¹¹ This translates to “nurses and care takers in protest”.

op Zwart' (or: 'white anger puts health care in black' – referring to a standard reference of financial stability) (Stolk, 2019).

The slogan relates to discontent among nurses concerning the marketisation and precarious levels of valuation towards their work in contrast with profit-oriented decision making executed primarily by insurance companies. Furthermore, central issues in the recent protests include low wages and suffrage under heavy workloads. More pertinently, the reach from present nurses towards past nurses through reinventing original discontent signifies that “[...] nothing really changed since then” in Janine's words.

The first protest in 1989 was prompted by a message in Dutch newspapers. The 2019 protest was organised through social media (NOS Nieuws, 2019). The use of social media illustrates the importance of social networks for mobilising protest movements. Combined with decades of government policy and public debate regarding the value of healthcare work(ers), this new case illustrates ongoing contestation and contesting modes of framing central issues. Such contested frames within The Netherlands are shown by an increase in aggression against Dutch health care workers. The initial response of symbolic appreciation by mass applause in March 2020 was heavily contrasted by an increase in aggression toward health care workers in September 2020. According to social investigations conducted by NU'91, 60% of all healthcare workers experienced increased aggression during the past few months due to resistance towards governmental measures against the pandemic (Nursing.nl 2020). Thus, in response to the COVID-19 outbreak, health care workers, specific nurses, experienced both an increase of appreciation and an increase in a backlash from governmental measures. The spokesperson of the Dutch federation of health care workers said the following:

“It is regrettable how we live in a society where such things happen when you call out to the people for support to those who are going through a hard time” – (Hotse Smit, 2020)

Recent scholarly works already commented that the COVID-19 pandemic highlights “[...] unsustainable fault lines characteristic of contemporary capitalism (Brown and Pearson 2020; Stevano et al. 2020; Thomason and Macias-Alonso 2020). Suppose we reconsider Jules from the beginning of this chapter. In that case, we can understand how neoliberal structures and political decision-making influence the experience of valuation, especially in the light of previous political dissatisfaction and the development of the nursing profession.

Neoliberal market work has severely affected the feelings of valuation among nurses. More specifically so, when we account for Janine's¹² experience of over four decades of dedication to nursing work combined with a rather bleak outlook towards improvement, we can understand the sentiment of hopelessness among nurses looking towards the future. The working conditions and workload prior to the covid-19 pandemic were already critical, bordering on desperation. Jules' burn-out is no exception, as numerous nurses experienced similar complaints. In my research, I spend time on the Covid-19 IC unit in an Amsterdam-based hospital. The following is an extract from the conversations held among nurses there to illustrate this point

Midway into their workday, during their break, some nurses gathered in the breakroom to have coffee and catch their breaths outside of the continuous care. On this Monday morning, a colleague that had been gone for months because of a burn-out popped in as the first day of her reintegration just to meet her colleagues again. While the returnee was still somewhat cautious upon re-entering the building, her colleagues sympathetically gathered around her to display understanding. "Oh my god, I completely understand how you feel. I feel exhausted as well." This returnee was one in a series of many to come back after burn-outs or over-exhaustion. Once the break was over, I was left with the returnee, and one nurse in the corner of the room remained seated. She got up and walked over to us, and she whispered: "Take good care of yourself. I've been back for a couple of weeks now, and before you know it, you'll be burned out again. Because now that the panic is over, we're going to have to play catch up with the regular health care. It's pretty far from over, so make sure you're ready to return when you do."

Seemingly, it would appear as if a 'return-to-work' culture characterised mid-2021 after burn-outs. A collective sentiment of distress is followed by acceptance and the continuation of 'business as usual' after burn-outs. The commonplace phrasing of "I've been back for [...] (i.e. one week, a month)", referring to 'coming back' after a burnout, is illustrative of this point. When inquiring about the underlying reason for so many burn-outs, it is not merely work-load per se. The Covid-19 pandemic and all its subsequent implications were, for many nurses, the final straw that broke the camel's back. Precisely so is the reason that Jules is currently still

¹² Janine – Retired nurse. Interview with author. Interview on 21-06-2021. Utrecht, The Netherlands

confined to home with a burn-out. Still, societal perceptions of ‘the nurse’ and care work create specific frames of meaning to their work.

1.6 Conclusion to Chapter One

This chapter has elaborated upon the cultural and historical background in which nurses find themselves in Dutch society until the Covid-19 crisis of 2020. Furthermore, it established an inherent controversy within the intersubjective practice of ‘valuation’ towards an essential job such as contemporary nursing through various frames. On the one hand, economically – and often politically – ‘value’ implies being framed as material, tangible and, perhaps most commonly, monetary. On the other, as exemplified through ethnographic accounts, value in a job also lies within the symbolic context of this job being narrated through the notions of ‘meaningfulness’ and ‘leaving something behind’. Subsequently, such extended valuation also carries different interpretations, either framed by the nurse themselves through the creation of their own lived realities or subject to appreciation – valuation – from external sources. The realities surrounding value are widespread and therefore not confined to a clear demarcated definition. This allows for numerous interpretations, frames and counter-frames, and the creation of certain realities. In the next chapter, we will elaborate on how these frames create and influence power dynamics.

Chapter 2. Heroes and Florence Nightingale

“I do not mind when one of my patients calls me *zuster*¹³, especially from elderly people. The profession of nurse has changed a lot in the past few decades, so that I won’t blame them. However, it is a completely different story when the media refers to my colleagues and me as *zusters*. That irritates me. I mean, we’re not nuns or Florence Nightingales. I am educated, my work is complex, technical and not everyone can do it. I’m a professional”.¹⁴

We all have certain expectations when it comes to specific groups of people that are not our own. Most of us have an idea of ‘the kind of person’ who collects trash, writes commercial texts or cleans our office. Similarly, there are many exciting and sometimes mythologising beliefs and perceptions of those who work in hospitals and provide care for us when we need it. When it comes to nurses in The Netherlands, the notion of care, valuation and money is highly affected by the framing of what it *means* to work as a nurse. We might envision a Florence Nightingale-like resemblance of an angelical, vulnerable and graceful figure, or perhaps as a ruthless and efficient harridan or even imagine a sexualisation of nurses reminiscent of popular Halloween costumes.

This chapter traces ways in which discourse and framing create expectations for and among nurses that, in turn, influence societal valuation. Such framing in an idyllic image of the nurse is emphasized by using words such as ‘heroes’ and ‘frontline workers’ in the Covid-19 outbreak in 2020. However, the rising tensions that these new words complement were already in place before the pandemic regarding the vocational Florence Nightingale image. Such practices can be understood as the ‘framing’ of work, as such, and performed labour. A ‘frame’ refers to a specific worldview or a lens through which someone views the world (Snow and Benford 2000, 614). This notion of a frame as a way to give meaning corresponds to the concept of discourse. Michael Foucault looks at discourses as precursors for representation (Hall 1992, 201). Discourse, in other words, can be understood as textual passages connected by writings and speech.

This chapter will illustrate how discourse analysis and frame analysis are inherently related, given that frames and discursive practices shape rules and practices that produce

¹³ A nun-like reference to nurses in the Netherlands. Commonly employed to refer to the sweet and supporting nurse by the bedside. Often interpreted as demeaning when employed by doctors or policy-makers

¹⁴ Ellen – Long unit nurse. Interview with author. Interview on 13-05-21. Arnhem, The Netherlands

meaning (Hall 1992, 202). Additionally, Benford and Snow argue that meaning and shaping rules through frames can be *actively produced* (2000, 627). So, I argue that discourse, the creation of meaning and social practice – and societal valuation as a product – are produced through the contestation of multiple frames through social interaction. By discourse, I mean particular ways of postulating the category of ‘nursing’ and ‘the nurse’ through frames that come into existence and give meaning to a grander social body. Discourse never consists of just one source of information, action or statement. It can cross a range of texts that may lead to different forms of conduct within various institutional sites of society — establishing a social relation with other objects, not given by mere materiality of their labour (Laclau and Mouffe 1979, 80). The everyday acts of putting on the scrubs, handling the technology, diagnosing and caring for patients have no fixed meaning. The social practices and the language or ideas attached to them – discourse – give them meaning and make this profession an institutionalised object.

2.1 “We’re not nuns or Florence Nightingale”: Frame of vocationalism

In her passionate speech at the beginning of this chapter, Ellen formulates the idea of a caring female non-professional in terms of being a *zuster*. Here she refers to the language used to give meaning to the nursing profession. This research addresses the anthropology of care work and positions the subject of study within more extensive societal (structural) valuation processes. Previous research has focused predominantly on nurses with the underlying acceptance of them being female (Hagey et al. 2001; Morse 1991; Hoff, 1994; Spitzer 2008). The notion of femininity is embedded in the meaning of *zuster* as it has its origins in the Dutch word that refers to catholic nuns. Contemporary anthropological research, in turn, primarily focuses on the feminised transnational service economy (Mills, 2003). While the anthropology of care predominantly emphasises discourses along racial and gendered dynamics (Standing 1989; Cook and Trundle 2020; Smith 2020), Thomason and Macias-Alonso (2020) argue that the pandemic sheds new light on “[...] caregiving as critical work that is under-valued and under-paid” (2020, 705). In other words, the covid healthcare crisis positions the healthcare workers not necessarily along racial or gendered lines. Instead, participants argue, in one of higher societal value vis á vis low wages, making it resemble a struggle related to valuation in neoliberal systems.

When it comes to the representation of nurses, the discursive *zuster* narrative precedes the outbreak of the Covid-19 pandemic. The representation of the nurse as *zuster* regularly occurs in terms of Florence Nightingale. Nightingale is understood by participants as an image of vocational work. Despite the history of nursing, many nurses now actively distance themselves from this image: “[...] we are not some small devoted club of women, who simply just love to care for our fellow humans”¹⁵, Jules explains in an elaboration on the work ethic of nurses. She complains about continuously seeing this vocational vision in newspapers, social media and her social circles. She feels as if any job in the line of caring would be soft and in contradiction with financial compensation. In her perception of vocational interpretations, she implies an inherent dichotomy between ‘value’ as monetary and ‘valuation’ as one ascribed through ‘meaningful’ work.

The embodied characteristics of nurses are, as with any group, not homogeneous. Both Petra and Ellen constantly nuance their own words concerning the nun-like language used regarding nurses. They address the reality that the majority of female nurses walk around in the halls of their hospitals. In their article Cook and Trundle (2020) address the gendered dynamics in work associated with care. Although both men and women work as health care workers, female workers represent the majority of the global healthcare workforce (Smith, 2020). In the Dutch case precisely, according to 2019 survey data, a mere 14% of the nursing workforce identifies as male (CBS 2019). Beyond the very distinction that most healthcare workers are female, Cook and Trundle (2020) claim how the structures of healthcare are severe “[...] underfunded stressed and compromised” as they argue how systems of care are abused for political goals. They refer to the politicisation of the vocational narrative rather than professionalism as a political tool for governance.

Consequently, the systematic underfunding of care work reproduces structures of inequality along particular strands of work which, implicitly, are carried out unequally across gendered lines. Guy Standing (1989) argues how – in general – labour in care and the associated European market of healthcare has been ‘feminised’ because it increasingly appeals to vocationalism, traditionally associated with the ‘sweet and caring’ *zuster*. According to many nurses in this research, there is a specific ‘type of person’ drawn by the idea of meaningful work, and in reality, these people are primarily women. Standing describes this tendency concerning more stable, regular and unionised work traditionally done by men (1989, 599-

¹⁵ Jules – IC nurse. Interview with author. Interview on 20-4-21. Amsterdam, The Netherlands

600). He addresses the irony that after decades of efforts to integrate women into the workforce, the result has been for all work to adapt to these characteristics of feminised work, including that of men (ibid., 583). Thus, regardless of the actual gender of nurses, the idea of nursing as feminised creates a lasting image of care work that is soft and vocational.

Consequently, Fraser (1994) argues that care work still has ‘no social value’ and must “[...] be sloughed off to become a breadwinner” (611). Social value in this regard is created by ‘waged labour’. Fraser refers to the need for a welfare state that should allow everyone to combine paid work with unpaid (care) work (ibid.). Thus, nursing remains primarily associated with the domestic and unpaid sphere, a remnant of times past.

The second connotation of the word *vocation* is that of vocation. Related to the features of Hannah Arendt’s concept of work (1958), such as individual fulfilment, work can be understood as *vocational*. According to Karolyn White (2002), nursing is best understood as a vocational occupation. She argues how, although older models of vocation (i.e. an embodied job motivation through the values and ideals of the occupation) are replaced mainly by models of work with ‘market imperatives’ such as individualised, profit-driven incentives, the notion is still present in care work (2002, 280). In referring to Lawrence Blum (1993), White explains how vocation incorporates a particular level of personal engagement and identification (2002, 282). Many nurses understand the word vocation as old-fashioned and politicised to the extent that it might be used to replace financial compensation.

“Teachers, fire fighters or nurses are professions that have been around for a very long time. You have a certain intrinsic drive to follow this path. However, a lawyer might have a similar connection to their profession. So if we see intrinsic motivation as a calling or vocation, then why do we value some more than others?”¹⁶

In this example, Bianca contemplates how calling her work a vocation relates to financial compensation. Although she emphasises her engagement, she also addresses her wish for compensation. Thus, in assessing the nexus of vocation vis á vis work, one can understand how nurses’ work falls under the nomenclature of societal value and a ‘calling’ as under the reward-based aspect of commodified capitalist society. However, in interviewees’ experience, it would seem they cannot co-exist or at least cause constant tension. While the hour-for-hour

¹⁶ Bianca – Neurology nurse. Interview with author. Interview on 17-02-21. Twente, The Netherlands.

compensation indicates a commodification of healthcare, its emphasis on morale and societal contribution reinforces the continuous ‘undervaluation’ in monetary terms.

Nonetheless, as we have seen before, many nurses believe in the ‘kind of person that works as a nurse’. Nurses explain how people who work in healthcare have a heart of a passion for this line of work. “It should fit you as a person, but it also has to be a bit of a calling (ed: or *roeping* in Dutch). Most people don’t start working in healthcare for a pay cheque. It is the type of person who wants to be of service to others”, Amir¹⁷, a nurse from the region of Amersfoort, says. After a previous career in consulting, he changed his career path to becoming a nurse. In this quote, he explains how he is primarily motivated by intrinsic values. We got in touch through social media. In the online sphere, he is very vocal helping others find their positions within care work. In our online interview, he explains how his line of work allows him to come home to his wife and children with the feeling of having done something to help another person. However, Amir does continue to add the contrast with financial compensation. “Of course, our wages should be higher. Based on our contribution and experience, you would expect higher compensation”.

As Hall (1992) notes, all social practices entail meaning and meaning shapes and influences what we do. As a result, all nursing practices and their subsequent perceptions have a discursive aspect to them. Not only does this discursive aspect entail the current ‘hero’ narrative, but nurses, in general, have been subject to oversimplified yet distinctive stereotypical framing practices.

A 2008 study titled ‘Celluloid Angels: a research study of nurses in feature films 1900-2007’ (Stanley, 2008) examined 280 films from 1900 up to and till 2007 with female nurses as dominant characters and how these characters were profiled. The study argues that over the past hundred years, films have predominantly shown nurses as either self-sacrificing heroines, threatening or evil characters, subservient characters or, rather commonly, overly sexualised individuals on the prowl for rich doctors (ibid.). According to the author, nurses need to be aware of how these images impact the way nurses and nursing are perceived (Stanley 2008, 94).

Similarly, the movie *Meet the Parents* from 2000 offers another stereotypical yet strikingly telling oversimplification of the nursing profession, this time in light of male nurses.

¹⁷ Amir – nurse. Interview with author. Interview on 12-04-21. Nurse from Amersfoort

In the first movie of the *Focker* franchise, actor Ben Stiller portrays a bumbling male nurse at the comedic expense of the audience, being looked down upon by the father-in-law character portrayed by Robert De Niro. The running joke is that nursing is a feminised profession and that a male nurse causes doubts in De Niro's character towards Stiller's capability of being 'the man of the house' in taking care of his daughter.

In 2012, Stanley followed up on the original research and continued an analysis of male nurses in feature films entitled 'Celluloid Devils: a research study of male nurses in feature films' (Stanley 2012). Analysing 13 feature films with male nurse protagonists concluded how male nurses were often negatively portrayed, emasculated, incompetent, and effeminate.

Both studies show very few films portray the nursing profession through the lens of clinical competence or professionalism. Featured films continuously reinforce the running stereotyping of the Florence Nightingale-Esque feminised nurse, often at the comedic expense of the nurse character. Suppose policymakers, civil society or even nurses give meaning to nursing as a vocational practice by using language that refers to the *zuster* narrative. In that case, this is a profoundly political act that gives way for the perpetuation of feminised systems with under-paid labour. However, *zuster* is simultaneously not necessarily a contentious term opposed by all nurses. It refers to a sense of heritage and the intrinsic motivation they have for doing this work. Thus, we can see power dynamics both in the words we use to describe nurses (e.g. *zuster* vis à vis *verpleegkundige*) as in practice (e.g. working for low wages).

2.2 "I'm just doing my job": The frame of heroes and frontlines

In March 2020, when the first Covid-19 infection was reported in the south of the Netherlands, a Facebook event resulted in mass applause for nurses around the country. The applause was organised to show public support for 'our heroes'. From March onwards, nurses were referred to in terminology commonly ascribed to wartime. Scholars describe the use of such words as a 'hero narrative' (Cox 2020; Stokes-Parish et al. 2020). Generally, this narrative surrounding care during the pandemic has been evoked to praise nurses for their extraordinary work during the Covid-19 that are substantially greater than those encountered in 'normal' circumstances. "It was very unreal and a bit uncomfortable. It felt like a recognition, a 'thank you', and it added to the excitement and adrenaline", Inge explained her first sentiment to the mass applause to me.

Inge and I meet at her house in Utrecht. After our first cup of coffee, the table in front of me is filled with cards that display texts such as “you’re my hero” or “not all heroes wear capes” and images of nurses with superman outfits or capes. She works at the IC unit and has been active as a nurse for the past 12,5 years. Although she is involved in pursuing more political and societal recognition for her work, the feeling of 2020 was slightly uncanny in her experience. The sudden attention for her work reminded her of the British soldiers going to war in WOII. She explained it as a feeling of being ready for battle and standing strong together. However, “[...] I simultaneously felt uncomfortable with the sudden change in attention”, she explains. Even at that specific moment, she felt that the use of the word ‘hero’ was strange because, in essence, she did not do anything other than the work she had been doing for the past twelve years. “Indeed, the workload is more than usual, but it is still just my job”, as she put it. Additionally, Inge felt a double layer in the use of the word hero. According to her, being a hero comes with an expectation of “having to handle or fix this entire crisis”.

In line with Inge’s sentiment, Shan-Estelle Brown and Zoe Pearson (2020) provide a more pressing emphasis on the hero narrative in their article ‘Human Sacrifices, not Heroes’. According to the authors, this narrative is used to rationalise public acceptance of health care workers’ heavy burden. However, they argue that heroism is associated with selflessness, and these health care workers are not voluntarily taking these risks (such as infection from the COVID-19 virus) (Estelle Brown and Pearson 2020, 2). As such, the authors consider that the emphasis on heroism, selflessness and sense of ‘duty’ leaves little wiggle room for decision making among nurses, implicitly making their work coercive.

A similar attitude was shared during my participatory exercise in the IC unit of an Amsterdam-based hospital¹⁸. I was assisting that day, and while I was taking off my surgical gloves after washing a patient, another nurse I had not previously met was standing next to me to fetch cleaning supplies as she unexpectedly shared her thoughts on “the whole hero thing”. She formulated what many others expressed in previous interviews: “[...] of course most people just wanted to show us some support, that was nice. But there was a double layer. Because we got applause and we were heroes, we suddenly had to perform regardless of the risks and well-being. That was a lot of pressure.” Consequently, the language used to refer to nurses in times of an amplified need for their work created an obligatory notion of duty to provide care, regardless of the consequences among nurses and care workers in general.

¹⁸ Field notes based on participant observation. Amsterdam based hospital on 07-06-21

This coercive layer surfaced in a discussion between hospitals and the labour unions V&VN and NU'91 on the holiday leave in the spring of 2021 (V&VN c, 2021). As the Covid-19 cases grew, nurses were asked to give up any remaining free days, their legal property, and continue to work. In April 2021, many nurses were facing burn-out due to the workload and intensive months of treating Covid-19 patients. Through these formulations hinting at coercion and 'duty', we can understand a conceptualisation of frontline workers ascribed to nurses. Caitríona Cox (2020) addresses this narrative as problematic due to limits of the 'worker's duty to treat'. The duty to treat refers to a 'fundamental ethical principle within healthcare', to provide care to the best of the providers' ability (Voors 2000, 640). The framing of health care workers as heroes fails to acknowledge the importance of reciprocal duties from society through appropriate compensation and through the underlying implication that all healthcare workers have to be heroic, it can have adverse psychological effects (e.g. fear and anxiety) on workers themselves (Cox 2020, 510). Most nurses in this research admit that – to an extent – the applause in 2020 was justified due to the intensity of the work. Without exception, the feeling of risk while working with Covid-19 patients, the overwhelming workload and stress during the first wave of the pandemic. According to Cox, the hero narrative, as such, does acknowledge the value of health care workers but does nothing to address reciprocity in the form of financial compensation (ibid.). Such a narrative is often complementary to justifying the minimal monetary compensations for health care workers and creating the narrative of a vocation instead of a profession.

Despite the various interpretations of the 'hero narrative', the use of words such as 'hero' or 'frontline workers' contributes to producing knowledge, collective memories and national heritage through language. These memorable terms, combined with events such as the mass applause of March 2020, shape how we see meaningful historical periods and, in this case, the contribution of nurses to the Covid-19 pandemic. Such powerful messages form particular frames employed to shape our collective history. Thus, the 'hero narrative' is a striking example of how language is vital in producing meaning that we collectively adhere to, and perhaps more importantly, what we value.

2.3 “I’m a professional”: frame of professionalism

Within academic debates, nursing is generally regarded as an 'emerging profession' or a 'semi-profession' (Ayala 2020, Cutcliffe & Wieck, 2008, Hiscott, 1998, Hood & Leddy, 2006, Porter, 1992, Reed 1993). This notion of a semi-profession refers to the historical base of nursing in

the aforementioned nun-like unpaid sphere. According to Ayala (2020), this is rooted in a religious doctrine on professions that substantially impacts the separation of a professional and a non-professional workplace. Due to the origin of nursing, nurses are generally framed as part of the non-professional workplace (Ayala 2020, 11). Those who remain in this non-professional workplace are perceived as uneducated but are laying claim to an almost “vocational calling underpinned by a person’s ideology” (White 2002, 280). This juxtaposition is broadly experienced among nurses in this research. Although Amir and some other nurses express sentiments regarding such an ‘almost vocational calling’, all explicitly express they want – and feel they deserve – to be framed as a professional in both public debates, media, policy circles and by their direct surroundings.

The framing of non-professionalism can originate in nurses’ self-interpretation and societal view of the profession (e.g. Stanley, 2008). An example is drawn from the portrayal, as mentioned earlier, of nurses in featured films over the past century. When it comes to experiences of societal perceptions, nurses express a lack of recognition for the continuous development of their work. According to interviewees, others tend to underestimate their work. Interestingly, a neurology nurse from Twente said the following:

“Most people don’t understand what it entails to be a nurse. They have no clue what I do during a day of work. They say: oh, you’re a nurse, so you’re probably cleaning butts all day”¹⁹

As coarse as it may sound, the ‘butt-cleaning’ is a common sentiment expressed to describe societal perceptions of nurses. ‘cleaning butts’, while partially true and rather graphic, is commonly used to refer to perceptions that downplay the complexities of nursing in the modern age. Societal belief is that nurses act as the, sometimes over-sexualised, assistants of doctors and spend most of their time washing patients (Stanley 2008; Summers and Summers 2009). However, many nurses emphasise that this is a part of their job. Most even value this as a crucial and worthwhile time to provide care and spend time with the patient. This time is held dear and where they find a large part of the meaning in their work. However, in practice, they work with the doctors, and both have their field and line of work in caring for the patient. They provide medication, are the first actors to make diagnoses, and act as first responders in emergencies. Especially on the Intensive Care Units, this work is highly complex, requires

¹⁹ Bianca – Neurology nurse. Interview with author. Interview on 17-02-21. Twente, The Netherlands.

much technical know-how and involves high levels of responsibility. Suzanne, an experienced nurse from Utrecht, illustrates this as follows:

“First, we deal with all sorts of insurance-related issues day in, day out. That’s already a burden. When you have one or two patients in your care at the ICU, you need to deal with everything that concerns their care. You need to know how to connect, disconnect, set up and monitor medical machinery. Switch out bed pans, IV bags, change sheets, clean patients. Add to that the incredibly delicate respiratory techniques, increasing amounts and levels of complexity in medication, and more. And then there is that heart-lung machine as well...”²⁰

Understanding the technical side of the profession that Suzanne highlights, it comes as no surprise that Ellen argued: “I am a professional, I am educated, and I worked hard for this title. I might have an intrinsic motivation for doing this work in particular, but I still want to be addressed as a professional”²¹. Instead of limbo between profession and non-profession, the nurses who participated in this research operate in a fluid space that always involves the professional workplace as a foundational component. However, there is a simultaneous component of a calling in many cases that is underpinned by a person’s ideology. This ‘ideology’ is based on a wish for meaningfulness, as mentioned above, by helping others.

The participants in this research, while varying in interpretations and lives experiences, all tend to attempt the narration of a counter-frame in combating the sole ascription of *zuster* towards their profession. Through understanding lingering stereotypical perceptions, contemporary nurses are laying claim to their preferred mode of perception. In elaborating how they would choose to be framed, nurses give preference not solely to the notion of professionalism but through a balancing act of understanding nursing as a nexus between vocational and professional work. This frame of professionalism is underlined by most participants in day to day conversations, online activities, writing commentaries and, in some cases, as we will see in the next chapter, by striving for more influence on the work floor and political recognition. Framing, considered an act of creating a narrative that affects the language used to refer to a group (Benford & Snow 2000, p. 617), is being practiced by nurses themselves. The effectiveness of such frames leaves room for debate, but nurses are becoming agents of their narrative.

²⁰ Suzanne – IC nurse. Interview with Author. Interview on 29-04-2021. Utrecht, The Netherlands.

²¹ Ellen – Gynecology nurse. Interview with author. Interview on 13-05-2021. Arnhem, The Netherlands.

In refusing to adhere to a popular discursive narrative, practices of counter framing may take place. Snow and Benford define counter-frames as aiming “[...] to rebut, undermine, or neutralize a person’s or group’s myths, versions of reality, or interpretive framework” (Snow and Benford 2000, 626). Thus, a counter-frame of heroes and frontline(s)-(workers) put forward alternative meanings or interpretations of the respective group.

2.4 The impact of stereotypes

This chapter has elaborated upon three distinct interpretations ascribed to nurses' meaning through particular framing practices. The first, being the selfless and caring *zuster*, put into the context of Covid-19, became the second, namely, ‘the hero’. The third, as a laid claim to by nurses themselves, is one of professionalism. However, all three indicate a degree of simplicity, and as discussed at the end of the last section, nurses prefer a more nuanced combination of the three. This is partly because the consequence of such simplistic - bordering on stereotypical - descriptions does not help in offering a sustainable degree of valuation.

“It’s funny... nurses are getting a lot more visibility and attention, but throughout this, they often display a stereotypical nurse in a skirt and apron. But, luckily, children do see that the nurses work hard and get recognition. Lots of people spoke out about their appreciation as well. But, if the politicians don’t do something sustainable in showing appreciation, all this is going to fade away again...”²²

As such, appreciation is deemed non-sustainable. As the number of Covid-19 infections went down, a Dutch newspaper re-addressed the issue of valuation that was considered very popular in the first months of the pandemic.

“Corona turned them into heroes. Soldiers at the frontlines. Saviours in a time of need. Although they thought nurses would finally receive the societal valuation they deserved, the mass applause stopped, the supporting billboards disappeared. The existing stereotypes turned out to be more persistent than the temporary hero status.”
Het Parool. 31th of May 2021

Many nurses share this point of view. Nurses are often referenced as at the centre of the Covid-19 crisis, with a significant media presence. Understanding the frames through which nurses

²² Maarten - NU91 union worker and IC nurse. Interview with author. Interview on 26-04-2021. Utrecht, The Netherlands.

are perceived and portrayed enables us to analyse how meaning is created. This meaning helps and guides action, both from nurses as a group and from political decision-makers. According to S. Mohammed, E. Peter, T. Killackey et al. (2021), the hero narrative is even used as a tool for politicians and decision-makers to express their support for nurses while simultaneously concealing existing power relations that limit nurses and enforce certain types of behaviour (2021, 8). As said, discourse constructs the topic. It defines and produces the objects of our knowledge. It governs how we talk about it, our ideas that are put into practice: ideas regulate our conduct and the conduct of others. One of the nurses from the region of Twente formulated this with the Dutch expression *onbekend maakt onbemind* (literal translation: unknown makes unvalued), predicting that a lack of knowledge from their work and profession creates a lack of valuation. Most indicated that although the public attention might have provided insights into everyday reality, stereotypes and frames prevailed. Consequently, they expect little political valuation in terms of government recognition and financial compensation.

2.5 Conclusion to Chapter Two

This chapter has examined the manners in which discourse and framing shape perceptions of nursing. I have argued how stereotyping is a profoundly political act through the common perception of nurses, as present in media, films and political narrative, and how this offers a stereotypical yet distinctive oversimplified version of the selfless heroine, or the subservient sweet nurse in the public eye. Similarly, the overuse of the word ‘hero’ to describe the role of nurses in the Covid-19 pandemic does little to alter this already present stereotype and reinforces a notion of vocationalism rather than the perception nurses prefer, which is one of clinical competence and professionalism. Consequently, even though public attention towards nursing has significantly increased over the past year, the perpetuation of oversimplifying frames results in continued misconceptions and subsequent little expectations from nurses towards public valuation of the complexities of their profession. In the next chapter, we explore the intimacies of valuation as such and its implications.

Chapter 3. Valuation of nursing

After the first wave of the Covid-19 pandemic, the parliament debated extra compensation for those on ‘the frontlines’ of the pandemic. However, in June 2020, the parliament had already rejected the motion for a structural higher wage for health care workers (Tweede Kamer, 2020). In reaction to this political debate, the union founded after the *Witte Woede* protests, ‘NU’91’, started a petition to emphasize that health care workers deserve a tangible form of compensation after the applause in March. However, the chair of the union, Stella Salden, added how the underlying notion of political recognition is more important than a potential higher wage. According to Salden, health care workers “[...] want to see that political decision-makers take them seriously” (NU’91, 2020).

Maarten, a nurse who recently became active as a part of this labour union, expressed a similar sentiment. He describes a somewhat cynical perspective because, according to him, those who stand furthest from providing the care (i.e. political decisionmakers) are also those who have the slightest appreciation for the work of nurses; “[...] they have no clue what happens behind the doors of a hospital”²³. Consequently, public discourse and political debate surrounding the valuation of nursing fails to grasp the everyday realities and subsequent grievances present in the lives of nurses.

To understand the complexities of the lived realities for nurses regarding how they are or feel ‘valued’ as such, one needs to take a layered approach. As mentioned earlier, at the forefront of the discourse on nurses lies the public debate surrounding wages and discussions towards a covid-19 related bonus. This first layer, most commonly outlined by politicians in addressing nursing, can be framed as *monetary valuation*. This chapter will start by exploring financial valuation in the context of covid-19 through the perspective of nurses. It will argue that monetary compensation towards nurses (i.e. actual sums of money) is not simple cash-for-work compensations. Instead, they carry a deeply symbolic undertone for the nurses in this study. The remainder of the chapter will explore this associated symbolism by exploring other valuation layers brought forward by the participants. The second section explores the second layer: valuation through public opinion termed *societal valuation*. Third, diving deeper into the root of the valuation issue, I will argue how recognition by political decision-makers towards nurses has become a key point made by research participants. The third section will elaborate

²³ Maarten - NU91 union worker and IC nurse. Interview with author. Interview on 26-04-2021. Utrecht, The Netherlands.

upon political recognition as an additional layer of valuation and contextualise this within the concepts of discourse, framing and valuation as discussed in chapters one and two. Finally, this chapter will explain how the covid-19 has revealed existing underlying fault lines in the Dutch healthcare system and added pressure on these existing fractures.

When discourses come together and refer to the same topic – in this case, care work – and possess the same style and support the same strategy, they become discursive formations (Hall 1997, 201). The aforementioned layered approach is a discursive formation that refers to the institutionalisation of widespread acceptance of a specific popular frame as described in chapter two. These popular frames will often support particular political neoliberal goals or adhere to dated perceptions of nursing. Meaning and meaningful practice are constructed through discourse. The idea that nothing exists outside of discourse was central to Foucault's argument. Nursing does exist outside of discourse, but they have no real meaning outside of discourse. Discourse shapes how society talks about nurses and how political decision-makers act upon these ideas and create the value we give them. The power in such discourse defines how the world is categorised and perceived.

3.1 Monetary Valuation

This section addresses 'value' in terms of monetary compensation. Monetary compensation here is seen through the meaning nurses give to the 'healthcare bonus' and structural compensation of their work vis à vis the tangibility of cash as a single entity. In this section, the political backlash and valuation aspects are considered in examining the repetition of the word 'money' (*geld*) among participants. As mentioned, Thomason and Macias-Alonso (2020) argue that the pandemic sheds new light on "[...] caregiving as critical work that is undervalued and under-paid" (2020, 705). In other words, the 2020 healthcare crisis positions nurses along the lines of vital work and all its responsibilities vis á vis low wages. As such, discourse among Dutch nurses about 'valuation' indicates issues like exploitative and bread-and-butter themes. Specifically, the recurrence of the word 'money' carries multiple interpretations regarding the nurses' experiences of being paid fairly for the work done to sustain comfortable livelihoods in return for their efforts.

3.1.1 Money as a single entity

Concerning the valuation of their work, many nurses express this in terms of 'money'. Specifically, the lack of proper financial compensation for their increasingly complex and

technical. According to Pensioenfonds Zorg en Welzijn (2018) research, wages and salaries are a fundamental reason HBO-educated nurses leave the nursing profession. More recent research from NU'91 (2021) shows how 26% of Dutch nurses leave the job due to a lack of financial compensation and high workload (NU'91 b, 2020).

Petra lives in Leiden, and she's worked as a nurse for almost 38 years. During my conversations with Petra, she always makes an extra effort to emphasise the beauty of this profession before expressing any criticism towards the wages or working conditions. "Don't get me wrong, I always enjoy getting up and going to work, and my salary is fine, but I bought my house many decades ago, and my husband has a good income too."²⁴ Although Petra explains she is not the type to complain, she feels awful for her younger colleagues: "[...] many have to move to other cities that are further away from our hospital, from this salary, we as 'essential workers', simply cannot live in the big cities." In these words, Petra expresses a much-expressed sentiment. Nurses' salaries are insufficient based on current-day living expenses and the actual line of work. The experienced reasons for these poor salaries are argued in framing as sweet *zusters* or heroes, as discussed in Chapter Two. This entails the perception of providing care opposing the idea of 'money' and the experience of being framed as an 'essential worker' during the pandemic.

Kathi Weeks (2011) analyses such tendencies as a capitalist way of selling and buying labour-power. A nurse, in this instance, consents to give the use of her (or his) labour-power and, in return, agree to a specific amount of money. When the employment contract is signed, the 'commodity' of the seller is 'consumed' by putting the nurse to work. Weeks argues how due to these mechanics, the wage is the central mechanism to the 'lifeblood' of capitalist value production: the work (2011, 6). Petra's sentiment of an insufficient salary compared to her work thus seems to be rooted in a wage relation she had with the buyer of her work. Although this aligns with the lived realities of nurses on the most basic level, collective labour agreements on health care provide national agreements on wages and financial compensation for Dutch nurses. Any raise in salary would come from political negotiations between unions, politicians and hospitals. These negotiations resulted in the hospital strike of 2019. Now, in 2021 the aftermath of the pandemic is a central theme in new negotiations (Trouw 2021). However, due to the turmoil around the health care bonus, most nurses I encountered are cynical about the outcome of the debates.

²⁴ Petra – IC nurse. Interview with author. Interview on 04-03-2021. Leiden, The Netherlands.

3.1.2 Money as a symbol

The health care bonus can be viewed as a political reaction to the societal attention and valuation in the pandemic. The process of decision making surrounding the height of the bonus was, however, somewhat chaotic. As Petra explained: “[...] it went all wrong, nobody knew why they were getting it, how much, or for whom it was meant. Eventually, the hospital gave it to everyone. I suppose they had other things on their mind amid the pandemic”. Kathi Weeks explains how the relationship between wages and labour cannot be reduced to its outcome in terms of literal financial gain. The process and inequality provide an adequate approach to dimensions of work and its political relations of power and authority (2011, 21). In other words, the turmoil surrounding the financial reward system is viewed as endemic to the level of valuation of nurses. The Dutch healthcare minister addressed how the bonus was initially meant to value those in the battle against the virus (Volkskrant 2020). However, in the end, nurses see it as a consolation prize for the low wages.

For Jip, a nurse from Brabant, the *zorgbonus* was a ‘pacifier’. However, she did feel as if she deserved it. After all the cuts in funding, she and her team at the hospital took the hit of a national crisis. “Money is a form of valuation on my bank account”, she explains. According to many nurses in this research, the bonus is a political tool utilised to get out of the obligation of structurally higher wages. It is precisely such underlying processes and political relations of power that illustrates how, within the meaning that nurses give to the idea of money in terms of structural salaries or a bonus, it is symbolic of the degree of valuation among political decision-makers and society as a whole. Before diving into the political recognition aspect, let us first explore symbolisms and interpretations surrounding societal valuation in the next section.

3.2 Societal valuation

This section aims to explain the mass applause as a sudden high level of societal valuation of Dutch nurses due to the nature of the crisis. The Covid-19 pandemic is characterised by a sudden experience of increased ‘social value’ (Fraser 1994) that materialised in mass mobilisations directed towards a performance of appreciation by the population towards nurses. Nancy Fraser famously argues that reproductive labour (i.e. nursing), predominantly that which women traditionally performed, is indispensable to society. This means that without it, there could be no culture, no economy, no political organisation, it maintains the continuation of society as a whole (Fraser 1994, 80-86).

On top of the previously described professional requirements, care is a fundamental aspect of nursing. Care both entails substantial social, labour, and material resources and is an often-scarce resource. Within anthropology, the concept of 'care' examines the relation of care practices in their mundane and everyday meaning. Such practices refer to what is done in care (Mol et al., 2010), which varies in various social contexts and the needs of participants. In the case of nurses, providing care for patients contains a value in itself. As such, value in care practices is materialised in need to work on 'the good' of working in a field that actively helps ease the suffering of others. The daily rituals of working as a nurse aim to enable others to live valued lives (Mol et al. 2010, 13). This value of working for 'the good' in care can be seen in the practice of washing patients from the IC in an Amsterdam hospital below:

After changing into our scrubs, we look at the piece of paper pinned on the wall in the dressing room. Today we are scheduled to care for Mr Rohmah. Mr Rohmah has had a severe form of Covid-19. Due to his illness, he has been on a ventilator and in an artificially induced coma. After weeks of being confined to bed, his muscles are now too weak to be used, and he cannot move or speak. Inge explains to me that we need to wash Mr Rohmah today. As we put on our washing gloves, I see how Mr Rohmah tries to make sense of what is about to happen. His eyes widen, and he is trying to speak. "We are going to wash you now if that is okay with you", Inge says. He gives us a slow blink as if to give us his consent. Inge closes the curtain around the bed, and we remove his clothes, still trying to cover his private parts. I lift his arm to clean his armpit. As I do so, I look at his face to see how he's doing. He's looking at the ceiling with a look of anguish. Inge sees it too, and she leans forward and asks Mr Rohmah how he is doing. "it is still a bit uneasy to be washed, isn't it?". He gives her another slow blink. In response, she touches the top of his hand and gives him a smile²⁵.

A few weeks earlier, Inge explained that caring is as much about technical knowledge as it is about taking the time to be there for another person and knowing you spend your time in a meaningful way. As Inge pauses the practice of washing to communicate with Mr Rohmah, she translates the concepts of care to a mundane everyday act. As such, this vignette on Inge and Mr Rohmah illustrates an aspect of care that focuses on 'the good' and is simultaneously

²⁵ Field notes based on participant observation. Amsterdam based hospital on 07-06-21

an ‘embodied care practice’. In providing care, caregivers attune their bodies to give a highly intimate form of care. Twigg (2000) argues how the physical aspects of care such as bathing and toileting are commonly referred to as ‘dirty work’. A direct consequence of performing dirty work is that it persistently is left out of the conversation and, subsequently, remains relatively unseen by outsiders (ibid.). Although Twigg (2000) explains this dirty work as part of the hidden character of care work, the previously mentioned frame of nursing as an almost vocational calling exploits these embodied and dirty aspects of the work to stigmatise society perceptions of nursing. Yet, intrinsic motivation to ‘do good’ and intimate care practices remain a constitutive component of nursing.

At the exit of Inge’s hospital, a huge banner says: “Dear health care workers, thank you!” (See Attachment 1). This banner is a remainder of the aforementioned public attention for nurses and other health care workers during the peak of the Covid-19 pandemic. This was a renewed attention for the social of the fundamental social importance of care. Even outside of the context of a crisis, health care work has undeniable societal benefits. However, the valuation of these benefits is largely influenced by public perceptions. Similarly, work produces not only economic goods but also social and political subjects. Kathi Weeks (2011) argues that work constitutes a “[...] particularly important site of interpellation into a range of subjectivities” (Weeks 2011, 9), specifically as a key site of becoming classed. She continues her argument by addressing a work ethic in terms of a ‘productivist vocation’ (ibid., 59). As a result, work becomes a means for individual fulfilment (ibid., 60).

Bianca describes it as follows: “[...] if you’re extremely concerned with the amount on your pay check at the end of the month, this is not your line of work.”²⁶ She continued by adding she had started nursing to contribute to the lives of others, meaning that she, like many participants, simply wanted to ‘do good’. Participants describe this as a wish to contribute to society in their day-to-day work and to be able to help others. Thus, we can distinguish social value in terms of the interpersonal relation between the patient and the nurse and the nurse and society as a whole. In considering the concept of ‘meaningful’ as a synonym for ‘helpful,’ and ‘valuable,’ as well as ‘beneficial’, the value of care can be created beyond capitalist fault lines (Graeber 2018, 236). According to Sandel (2013), (health) care can be corrupted or even degraded when turned into a commodity. According to Bianca, within the realm of nursing, the market, in some instances, has to be kept at a distance from care work. Her argument illustrates

²⁶ Bianca – Neurology nurse. Interview with author. Interview on 17-02-21. Twente, The Netherlands.

how nurses are not necessarily homogeneous in their perceptions towards valuation. In some cases, the relationship with popular emphasis on wages risks polluting the perceived puritanical character of care work. More specifically, while nurses are generally acceptant that ‘they should earn more money’, they are sometimes divided on the level of emphasis towards this issue.

The explicit underlining of nursing emphasised this understanding of nursing as meaningful and valuable as one of the vital jobs during the health care crisis. The renewed public attention for the value of nurses had several connotations in the experience of participants. As I assisted Inge in her IC unit work, one of her colleagues stopped me to share her experiences with this societal sense of value. She explained a deeply felt sense of expectation. She experienced this amount of social value in her work, yet, now that the mass public seemed to come to the same conclusion, it is accompanied by a certain expectation. As she put it: “[...] you better continue to work your fingers to the bone until this pandemic is over. You are the only ones with the skill, and you were the first to be vaccinated. You’re our heroes. Act like it.”

Although this understanding of social value seemingly aligns with the intrinsic desire to ‘do good’, the intensity and the workload of the work during the Covid-19 pandemic prohibited nurses’ ability to provide care in a moral and meaningful way. According to Abramovitz and Zelnick (2010), understanding and concordance of moral values are vital for the health sector. In the nurses’ case, this is directly linked to an experience of fulfilment in their work. As such, value can be seen as a synonym for societal contribution or ‘doing good’. However, in terms of political representation, such an intangible value and meaning can be viewed as more expendable than others, regardless of their *actual* societal contribution. In the next section, I will address how social value in terms of an almost sacrificial caring nurse thus carries the danger of political misuse.

3.3: Political recognition

This section addresses the third dimension, namely political recognition and contextualises this in contrast to the sustainability of valuation and work. There is a high amount of frustration because ‘nothing changed through Witte Woede in 1989²⁷’, and now nothing is likely to change

²⁷ Janine – Retired nurse. Interview with author. Interview on 21-06-2021. Utrecht, The Netherlands

after Covid-19. This perception of minimal sustainability is considered in contrast to the idea that nurses are naturally un-political caretakers.

As previously mentioned, nurses have become more professionalised and higher educated. This simultaneously results in a higher awareness among nurses regarding their significance both in terms of societal contribution and care providing structures. However, even among nurses, there is a recurring image of the nurse as un-political due to their work's caring nature²⁸. In this sense, providing care remains separate from potential political acts such as going on strike and demanding more recognition of higher wages. Many nurses wish for more political credit but often explain why they and their colleagues generally don't engage in these acts.

3.3.1 Protest within the 'soft sector'

Suzan lives and works in the middle of the Netherlands. She has worked as a nurse since she was eighteen years old, and she is now almost sixty. When asked about nurses' protests in 2019, she explains she used to go to demonstrations when she was younger, but she's stopped joining the demonstrations in the last decades. According to her, it resembles the idea of 'fatalism', which describes the concept that human beings are powerless to change the outcomes of events and thus cannot influence the future. She was part of the protests in 1991, but they did not change her working conditions or provided any form of recognition.

Nancy Fraser notes how a lack of political recognition can be understood in terms of identity-based claims. Such claims generally “[...] take the form of calling attention to, if not performatively creating, the putative specificity of some group, and then of affirming the value of that specificity” (Fraser 2020, 74). When it comes to nurses, this putative specificity is created in terms of the previously discussed framing. Suzan understands this in terms of what she describes as *de softe sector* (the soft sector), where she refers to her group as being soft. However, in her use of the word, she refers less to the Florence Nightingale image of nurses and more to their (lack of) political actions: when the unions organise a strike or demonstration, those scheduled to work still show up to work. This responsibility for patients, in turn, is explained as a duty. This duty resonates with what Janine explained in Chapter one: “People would die, you see, if nurses stopped working.”. due to the line of work, not showing up to

²⁸ Suzanne – IC nurse. Interview with Author. Interview on 29-04-2021. Utrecht, The Netherlands

work as an IC nurse can have consequences of life and death. In combination with the (often also self-ascribed) identity of being a caring person, the result is low leverage in political decision making.

3.3.2 A lack of voice

Eric Tucker (2013) outlines creating voice and recognition for a group of workers in relation to strikes. According to Tucker, strikes have been viewed not merely as a manifestation of collective worker voice but as an activity that produces higher class consciousness, organisation and, ultimately, power (Tucker 2013, 5). As said, in November 2019, Dutch hospital staff went on a national strike for higher wages and lower workload. According to nurse Maarten, this was very illustrative of how much nurses' recognition and proper wages are alive. Yet, he understands Suzan's stance of fatalism. Regardless of the effort of the strike, there was little political response. A couple of months after this initial strike, political decision-makers used terms such as health care heroes and joined the mass applause.

On the 12th of August 2020, while a debate was taking place on structural higher wages for nurses, a couple of members of the Dutch parliament left the room. The departure of numerous parliamentarians occurred right before a vote was to take place on the debated issue. While the underlying reason for leaving parliament is still debated, the popular perception is that most ministers left purposefully to prevent a vote from taking place at all. The excuse was that the debate was not put on the agenda formally. According to parliamentary chairwoman Arib, walking away required an explanation, given through the previous justification. Labour unions considered the event has highly disrespectful towards the nurses given the time period.²⁹

Labour union NU'91 called this embarrassing after all the promises and applause. All participants nurses in this research named this political moment as symbolic for the lack of valuation among decision-makers.

Foucault rejected the idea that knowledge and power are solely confined to class interest – preferring to believe that other social forces are in operation as well (Hall 1997, 48). From

²⁹ Notes from Fieldwork; Maarten, Bianca, Suzanne, Ellen, Jip, and many others recalled this event.; NOS.nl: 'zorgbonden overweglopen kamerleden: Genante vertoning' – 13-08-2020.

this constructionist point of view, the lack of representation can result in an experience of a lack of ‘voice’. In this matter, Stuart Hall wrote,

“It is discourse, not the subjects who speak it, which produces knowledge. Subjects may produce particular texts, but they are operating within the limits of the episteme, the discursive formation, the regime of truth of a particular period and culture.” (Hall, S. and Jhally, S. 1997, 55)

This experience of a lack of political valuation can be understood in terms of a lack of voice. Within anthropology, *voicé* is a crucial site “[...] where the realms of the cultural and socio-political link to the level of the individual” (Weidman, 2014). As such, the concept of voice incorporates both the professional identity of nurses as their political power. At first, the outbreak of the Covid-19 pandemic appeared to be a break from the trend of nurses as largely politically ignored. Nurses had never experienced this extend of valuation from both the public and politicians. However, the symbolic display of political ignorance is experienced as a first sign of the appreciation of the mass applause. According to Ayala (2020, 99), a lack of voice among nurses has caused being unseen and unknown to become a perpetual problem for nursing. It seems that the lopsided nature of the debates of the 12th of August further emphasised the ability of politicians to ignore the lobby of nursing representatives and labour unions.

The nurse, as a subject of discourse, can hardly be detached from the discourse as such. The subject of discourse will constantly be subjected to it (Hall 1997). The nursing profession will always be admitted to the dispositions of power and conventions. Yet, as Hall puts it, the subject can become the bearer of the kind of knowledge the discourse produces. This entails that even within systems of discursive knowledge (i.e. popular perceptions of care work), nurses can be the object through which “power is relayed” (ibid). Thus, nurses are not completely apathetic in strengthening their voice and demanding a more favourable outcome in the coming negotiations on working conditions and wages.

Several nurses provided me with pictures from the halls of their hospitals, where organised colleagues hung banners with texts such as “From Hero to Zero”³⁰. Accordingly, two nurses published a protest on the Dutch Day of the Nurses – the 12th of May 2021. The song had lyrics such as “Today I want to protest your prejudice of my profession”, “stop ignoring

³⁰ See attachment 1: Images from photo elicitation.

our profession knowledge”, and “because of your expensive campaign, I get an old-fashioned image and a consequent low salary”³¹. According to Petra, - the IC nurse from Leiden – this is a display of claiming more ownership of nurses in their profession. As she put it: “[...] the political support was not sustainable, but it did wake up many of our colleagues to grasp more control of our area of work.”³²

Ayala notes a recent development of more leadership skills among nurses, which is at the core of the ‘nursing professional project’ (2020, 99). About this professional nursing project, their profession develops a more market-oriented scheme to gain control over their area of work. More control enables nurses to assure matters of self-interest in terms of power, wages and status. In the Netherlands, this includes a reflection on an old pattern of working relations in the hospital. In several Dutch hospitals, nurses have already gained a seat on the hospitals' board (OLVG, 2021). Nevertheless, the question remains of the degree of the long-term sustainability of valuation versus quick responses to the initial crisis of care.

3.4 Covid-19 as a crisis of valuation

The Covid-19 pandemic was, and is, in many ways considered a crisis. As seen before, objects or events do not have inherent meaning, but as established in Chapter two, individuals give meaning to events such as crises (Hall 1997, 202). According to Vigh (2008), “[...] crisis is normally conceived of as an isolated period of time in which our lives are shattered”. He argues that these moments are often seen as times of chaos or decisive change (2008, 5). However, he continues by adding that although crises are a “[...] short term explosive situation” (ibid., 9), they are, in fact, rather a condition than a decisive change. We can understand the pandemic as a condition that affects nurses’ lives and experience of work and societal valuation. The mass applause and general societal attention for nurses in the early days of the pandemic were met with much discomfort but also hopeful sentiments. Many participants considered it an opportunity to debunk stereotypes. As Floor, an IC nurse from Amsterdam said: “[...] all the news messages and reports on hospitals provided a peek behind the curtain of hospital doors, people got a better idea of our day to day surroundings and activities”³³ The media attention and daily images offered an idea of a future with more realistic public photos. Even politicians

³¹ See attachment 2: Protest song *Liever Geen Bloemen*

³² Petra – IC nurse. Interview with author. Interview on 04-03-2021. Leiden, The Netherlands.

³³ Floor – IC nurse. Interview with author. Interview on 19-04-2021. Amsterdam, The Netherlands.

who paid little attention to previous protests or civil discontent from the nurses' initiative joined mass applause.

The crisis phenomenon as tied to social change has been researched in various ways within anthropology (Beck and Knight 2016, 6). Bidney (1946) understands crisis as either a natural crisis or a cultural crisis. The natural crisis is defined as the disruption of social life beyond human control, whereas a cultural crisis results from a dysfunction in the dynamics of culture (1946, 537). However, the reality of the Covid crisis offers us more of a nuanced combination of both, providing a junction between the natural and the cultural. The spread of the virus and the impact of the illness on the human body are natural. Still, it exposed existing fault lines of neoliberalist policy in Dutch health care and discourse on those at the centre of fighting the virus.

We can consider the dimensions described above as the classical value conundrum often referred to as the 'diamond-water paradox'. This contradictory phenomenon, explained by, among others, the philosopher Adam Smith (1776a), tells the story of an existing contradiction in means of value thinking. In referring to water and diamonds, Smith explained how: "Nothing is more useful than water: but it will purchase anything scarcely; scarcely anything can be had in exchange for it. A diamond, on the contrary, has scarcely any use-value. Still, a very great quantity of other goods may frequently be had in exchange for it" (ibid.). However, in a period of water scarcity, one is likely to sell off its diamonds to acquire water. Smith continues by arguing that "[...] the real price of everything, what everything costs to the man who wants to acquire it, is the toil and trouble of acquiring it" (Smith 1776b).

3.5 Conclusion to Chapter Three

This chapter has established the intrinsic complexities of three distinct layers of valuation towards nursing. It has shown how, in the first layer, common narratives are directed towards valuation in monetary terms. However, 'money' is often intrinsically political, and the underlying processes beneath monetary compensation for nurses are illustrative of broader perceptions of valuation. The second layer, valuation in societal perceptions, is commonly portrayed towards a notion of 'doing good'. This idea risks reinforcing potential vocational stereotyping due to its intangible nature in contrast to monetary valuation. However, both layers of valuation demonstrate a degree of symbolism that 'acts of valuation' (i.e. *zorgbonus* or the mass applause) carry underneath general recognition of nursing. The third layer, political valuation, based on this research's data, demonstrates how the recognition by politicians and

society as a whole, that is, recognition for clinical competence and professionalism, is the preferred type of valuation by nurses.

A crisis, like the pandemic, reconfigures popular perceptions of what society deems valuable. The Diamond-water paradox, as applied to nurses' perception, shows a temporary redefining perception towards the role nurses play. However, the characteristic of this paradox is that, inevitably, society will return to its default settings, leaving valuation as such unsustainable. The question then is, how does one make valuation sustainable? Unfortunately, it requires a crisis for society to redefine what it considers valuable, however briefly. A similar argument can be made in the case of valuing nurses. Nurses expect the valuation to be fleeting based on experiences in the past and the general tendency towards misconceptions of their work by politicians and society as a whole.

Conclusion

This thesis has sought to explore experiences and meaning-making practices towards societal valuation and their work among Dutch nurses in the light of the Covid-19 pandemic. In doing so, I have approached this topic through a discursive approach, firmly embedded in an ontological lens of symbolism. In the first chapter, I sought to establish that the contemporary context of neoliberal society and marketisation were problematic *prior* to the pandemic. The current Covid-19 crisis has significantly highlighted the existing fault lines of Dutch health care reforms (Tonkens, 2016). In addition to this notion, this thesis has shown that the idea of valuation also carried prominent grievances in the wake of the pandemic, reignited through the contentious levels of appreciation.

The second chapter provides deeper insight into the social mechanics of discourse and framing practices that create new realities concerning nurses' societal valuation (Hall 1992, 201). It emphasised how particular framing modes (i.e. *zuster*, 'hero') underpin a deeply political perception that highlights controversies between vocational work and professionalism. These narratives, as demonstrated, are countered through nurses who lay claim to their narrative by refusing to adhere to stereotypes. Prevailing stereotypes do, however, undermine sustainable valuation for the complexities of modern nursing as a profession.

Chapter three took on a layered approach of valuation through monetary, social and political valuation. Monetary valuation carried a duality of interpretations, namely that of actual figures on a pay cheque, vis à vis the political symbolism of what a financial compensation can – or should – represent. While actual figures did not matter per se, a shared grievance among nurses was reignited through political debates. A dominant narrative surrounding societal value lies in the context of patient care and appreciation (Ayala 2020, 99). Although popular discourse discusses monetary compensation, this research finds that Dutch nurses remain adherent to a facet of vocationalism within their professional development; 'it's not about the money'. The prevailing grievance underlined by the pandemic was the misuse of vocational frames like 'hero' or 'frontline workers', implicating coercion towards their work, without apparent willingness for structural support systems among policy makers.

The Covid-19 pandemic has breathed new life into a reconfiguration of what we deem valuable as a society. Considering the Diamond-water paradox (Smith, 1776a), we were allowed to re-evaluate what we consider 'essential work'. This research has shown that nurses do experience the recurrent valuation spike, but they retain a degree of scepticism – if not

fatalism – regarding sustainable and structural changes. By considering these dynamics, this thesis offers a perspective of how language sustains and creates power within the anthropology of work. Simultaneously, it provides a link between the anthropology of care and economic anthropology in terms of creating value. Although valuation is often referred to in terms of financial compensation, the case of Dutch nurses offers a layered approach with money as a symbol for more extensive political recognition as endemic to societal valuation.

Similarly, the Dutch word *verdiene*n has a double meaning of both earn and deserve. Perceptions of what is deserved often contrast neoliberal outcomes of the realities of what is earned. The language used to refer to nurses shapes how much they earn and the experience of what they deserve through their societal contribution, knowledge, skills and social value. The framing of the nurse as a ‘hero’ initially aimed to emphasise increased appreciation for their work. Still, its stereotypical perception resulted in the ‘hero’ narrative falling within the same vocationalist frame, subject to political misuse. The ethnographic dimension of this thesis highlights how valuation is a layered discursive process and how nurses play an intrinsic role in creating political recognition.

Reflection: Limitations and Suggestions

Reflecting on the research question as stated in the introduction of this thesis, valuation of care work through the eye of Dutch nurses is a layered phenomenon entangled in neoliberal structures. This thesis is a step toward broadening the knowledge on the perspective of power within the anthropology of work. By exploring these entanglements of a neoliberal logic of value vis à vis social contribution, power relations constructed through language became visible. Yet, several limitations have an inevitable influence on this research.

First, the participant observation was relatively short. Therefore, I have not been able to experience the irregularity of the work or any extended effects. Nor have I experienced being an actual nurse by gaining skills that are required within this profession. Since very little research has been done on Dutch nurses, I highly recommend further immersion into nurses' lived realities and communities to gain more insights into this indispensable group of professionals.

Second, as said in the introduction, this research is a particular framework for valuing care work. Due to my background, I entered the field with a personal sense of valuation for nurses. Although this sparked an initial interest in the topic, the *a priori* decision to focus on valuation provided a frame even before entering the field.

Third, in addition to the previous point, a slight shift towards a perspective such as gender or class may provide other complementary outcomes. Such perspectives outside of the scope of this research might have a great deal of influence in shaping the way nurses give meaning to their work. Little anthropological research has been done on both the population, the context and the topics of Dutch care work. Thus, this thesis becomes a call for future (anthropological or ethnographic) research on the roles of gender and class in how the meaning and value of essential work is created through the language used to refer to nurses. While their efforts for valuation and representation are unfolding at the moment of writing, the social significance of their work makes further research pressing.

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Attachments

Attachment 1. Images from photo-elicitation



Attachment 1: From left to right: 1. From Hero to Zero banner: sent on WhatsApp by participant on 26-03-2021. 2. Art by Banksy: Banksy's 'game changer' depicting a boy playing with his new 'superhero' - a nurse, while batman and spiderman are tossed aside. Banksy left this image at South Hampton General Hospital on 6 May 2020. Sent on WhatsApp on 23-03-2021. 3. "Vitaal Werk, Vitaal Loon": sent on Whatsapp on 18-02-2021 4. Nurse with sign of silencing. Send on Whatsapp on 22-04-2021. 5. Super nurse. Sent on WhatsApp on 18-03-2021. 6. Banner with "Lief Zorgpersoneel Bedankt" (translate: Dear Health Care Workers, Thank you". Seen on the location of participant observation on 07-06-2021

Attachment 2. Text of protest song *Liever Geen Bloemen*

By Hilde Hiemstra en Mary Benjamins. They were shared with the author on 11-05-2021.
Published on day of the Nurse 12 May 2021.

See: <https://www.youtube.com/watch?v=JcWK6dTxDQ>

Dutch Version

*“Wat we in de zorg al langer hebben
is een groot personeelstekort”
Vandaag wil ik protesteren
Dat je mijn vak niet kent
Dat je me fout blijft framen
Dat je bevooroordeeld bent
Je beeld me af, stereotype
Ongeschoold, dienstbaar, lief
Hart voor de zorg en handen aan het bed
Alsof dat werkt en levens redt
Vandaag wil ik je iets leren
Dat ik werk vanuit observeren
Omdat mensen me fascineren
Ging ik ze bestuderen
Dus kap met bagatelliseren
Alleen mijn hart waarderen
Met gebak en geklap eren
Mijn vakkennis negeren
“Er staan in het ziekenhuis bedden leeg
nu, waar geen verpleegkundigen bij zijn
waardoor je daar geen patiënten kan
opnemen”
Niets van mijn kennis heb jij verbeeld
In je dure campagnes publiek bespeeld
Een verouderd imago aan mij toebedeeld
Dus wordt ik slecht gesalarieerd
Doordat jij mijn vakkennis niet vertrouwd
Kulprotocollen door mijn strot douwt*

English Version (My Translation)

*“What we have in healthcare is a large
shortage of workers”
Today I want to protest
How you don't know my profession
How you frame me wrong
How you are biased
You display me, stereotype
Uneducated, in service, sweet
Heart for care and hands to the bed
Like that works and saves lives
Today I want to teach you something
I work by observing
Because people fascinate me
I studied them
So stop downplaying me
Only value my heart
With cake and applause
Ignore my professional knowledge
“Some beds are empty, there are no nurses,
so you cannot take patients in”
You do not display my knowledge
In your expensive campaigns
An old fashioned image is given to me
So I get a low salary
Because you don't trust my knowledge
Push stupid protocols through*

*Mij als een lieve engel beschouwd
Gaan de patiënten en ik knock-out
“Elk team is operationeel met een tekort
aan collega’s”
Door jouw wantrouwen en beperkte zicht
De manager plant een te krappe shift
De verzekeraar heerst met controledrift
De ambtenaar, een foute wet BIG
Het imago van mijn vak is verkloot
De media ziet mij als een idioot
Tekort aan verpleegkundigen is groot
Er gaan mensen dood*

*In plaats van bloemen:
Geef ons een eigen CAO
Stop met de regeldruk
Betrek ons bij het beleid
Betaal ons op basis van opleiding en
ervaring
Belicht de deskundigheid
van verpleegkundigen en verzorgenden.
Een fout imago is een risico voor iedereen*

*See me as a sweet angel
Me and the patients are going knock-out
“Every team is operational with a shortage
of colleagues”
Because of your distrust and narrow vision
The manager plans a too tight shift
The insurance wants to control everything
The officials, a wrong set of rules
The image of my profession is a mess
The media sees me as an idiot
Shortage of nurses is big
People are dying*

*Instead of flowers:
Give us our own labour agreements
Stop implementing more rules
Involve us in decision making
Pay us based on education and experience
Highlight the expertise
Of nurses and care workers
A wrong image is a risk for everyone*

Attachment 3. List of participants and interviewees

During the fieldwork period I conducted semi-structured interviews with the following people:

<i>Name (pseudonym)</i>	<i>Occupation</i>	<i>Region</i>	<i>Date of interview</i>
Jip	Oncology nurse	Brabant	18.02.2021
Bianca	Neurology nurse	Twente	17.02.2021
Anke	IC nurse	South-Holland	08.03.2021
Laura	Nurse	Brabant	09.03.2021
Marieke	Emergency Room nurse	South-Holland	25.02.2021
Inge	Intensive Care nurse	Amsterdam	16.03.2021
Anke	Intensive Care nurse	South-Holland	04.03.2021
Jules	Intensive Care nurse	Amsterdam	20.04.2021
Petra	Intensive Care nurse	South-Holland	04.03.2021
Amir	Nurse	Amersfoort	12.04.2021
Maarten	Intensive Care nurse	Utrecht	26.04.2021
Charlie	nurse	South-Holland	16.03.2021
Suzanne	Intensive Care nurse	Utrecht	29.04.2021
Joyce	Nurse	Rotterdam	20.03.2021
Ellen	Gynaecology nurse	Arnhem	13.05.2021
Sanne	Nurse	Utrecht	15.03.2021
Floor	Intensive Care nurse	Utrecht	19.04.2021
Zoë	Gynaecology nurse	Arnhem	03.05.3021
Paula	Gynaecology nurse	Arnhem	09.05.2021
Janine	Retired nurse	Utrecht	21.06.2021