NEOLIBERALISM, GENDER, AND FRONTLINE COVID-19 NURSES

by

James T. Robbins

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Approved by:

_____
Dr. Nicole Peterson

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Dr. Andrea Freidus

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Dr. Emek Ergun

ABSTRACT

JAMES T. ROBBINS. Neoliberalism, Gender, and Frontline COVID-19 Nurses. (Under the direction of NICOLE PETERSON)

The COVID-19 pandemic presented new challenges to healthcare workers: with rising COVID cases, constantly changing guidelines, and an uncertain and rapidly unfolding situation, stress and burnout among nurses have risen as well. Narratives around work-life balance and burnout reveal some of the neoliberal systems and their effects on nurse experiences as well as how they are exacerbated by this pandemic. Coupled with the gendered nature of the profession, the experiences of frontline COVID-19 nurses are analyzed here in a critique of neoliberal feminist ideas and a neoliberalized and hierarchized healthcare system. By making visible these subtleties, better intervention into the experiences of nurses may be possible.

DEDICATION

I dedicate this thesis to my friends, my family, my gracious mentor, and to those whose voices have been unjustly marginalized.

…

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Thank-you to Dr. Andrea Freidus for your invaluable counsel, relentless faith, and patient support of this work, this program, and me. You are a leader and a champion to all of us and I'm so glad to call you my dear mentor and friend. Thank-you to Dr. Emek Ergun for your continued guidance, expertise, and support as a professor, mentor, and advocate. Thank-you to Dr. Nicole Peterson for your supportive coaching and scholarly direction, enriching intellectual perspective, and ongoing endorsement. Thank-you to Dr. Sara Juengst, Dr. Gregory Starrett, and the faculty and graduate cohorts of the Department of Anthropology and the Women's and Gender Studies Program at UNC Charlotte for their brilliant intellectual work, their incalculable contributions to my own, and their kind support and validation.

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Finally, thank-you to my family and friends. There are no words.

I hope to give as I have been given.

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CHAPTER I: INTRODUCTION

The emergence of the novel coronavirus pandemic of 2020 has brought with it challenges and struggles for many different groups in intricate, impactful, and disparate ways. Many businesses have widely suffered, people have become ill and died at alarming rates, the emergence of terms such as “social distancing” and “essential worker” have had heavy implications for particular groups, and politicization of the pandemic has created problems of failing policy and systemic responses to curb the impact and spread of COVID-19.

While the pandemic and its accompanying changes have no doubt impacted healthcare workers (HCWs) at all levels, nurses have experienced unique changes and challenges as they occupy the frontline of care work for individuals suffering from COVID-19. The care work associated with nursing has undergone shifting guidelines, shortages in PPE and staffing, and an increased workload which directly impacts the experiences of those nurses and their patients.

This project focused on a rapid qualitative assessment of the experiences of frontline COVID-19 nurses in North Carolina, the ways in which systemic changes have occurred, and some of the neoliberal and gendered power structures that affected nurses and their lives. Semi-structured interviews with 13 frontline nurses working in COVID-19 units of North Carolina hospitals document and understand these important experiences and disparities and answer the following question:

> “How has a neoliberalized healthcare system impacted the experiences of frontline COVID-19 nurses? And how has gender intersected with these power systems?”

CHAPTER II: BACKGROUND

COVID-19

SARS-COV-2, the Coronavirus, or more commonly known as (and specifically) COVID-19 is a novel virus that sparked the widespread pandemic of 2020 which mutated and maintained prominence through 2022 (continuing as of the writing of this piece) (CDC, 2022). On March 11, 2020, the WHO declared COVID-19 a global pandemic, and on March 13, 2020, a state of emergency was declared in the USA related to the novel COVID-19 outbreak (CDC, 2022). As of Jan 14, 2022, the WHO reported 318,648,834 confirmed cases of COVID-19 globally and 5,518,343 deaths (WHO, 2022).

The symptoms of this novel virus have been compared to those of the flu or the common cold, and in fact the virus from which this prominent strain originates is considered a form of common cold (Sauer, 2021). Key distinguishing factors include the presentation and severity of symptoms, the communicability and morbidity associated with COVID-19, and the lack of prominent research and medical data and guidance for handling and treating cases and outbreaks.

The situation of the pandemic is continually evolving and has resulted in massive systemic actions and policy changes to limit the impact and spread of the virus including vaccine developments, mask mandates, social distancing measures, and resource allocation measures. As of Jan 14, 2022, the CDC recommends the wearing of masks in public, social distancing of 6 feet between people, and limiting mass gatherings (CDC, 2022).

With this impact, many of the policies, resource shortages, and other changes have directly impacted the lives and work of nurses in the US healthcare system and brought out the important position and work which they occupy as well as the struggles they encounter; the work here thus explores.

Nurses in US Healthcare

Nursing, as a profession, is not new and many of its modern practices and principles originated from key historical pioneers (Oliver, 2018). Florence Nightingale is known for employing and promoting evidence-based medicine for the English army during the Crimean War and beyond. Based on her upbringing with statistics and physical/biological scientific practice, she became a figure and pioneer of nursing as a profession for much of the medical world following (Egenes, 2009). Before Nightingale, many “nurses" were wives of soldiers or poor women who volunteered or otherwise cared for the sick and wounded. However, Nightingale’s cleanliness practices and record-keeping significantly impacted survival during this time period (Oliver, 2018). Similarly, other women who were formally trained in such care work became well known for their more evidence-based approaches during the American Civil War including Dorothea Dix, Clara Barton, and Harriet Tubman (Egenes, 2009). Following Nightingale’s lead (and established institutions for nursing), proponents in the 19th century US pushed for formal education for nursing and succeeded in establishing the Women’s Hospital of Philadelphia as the first school of evidence-based nursing (simultaneously furthering the gendered public image of the profession). From then, programs and institutions of nursing have expanded to form different hierarchies and types of nursing (R.N., C.N.A., N.A.) while covering the expansive duties of nurses in the evolving US biomedical healthcare system.

During the late 19th and early 20th centuries, biomedical models (of Western medicine) pushed for training programs for HCWs (including nurses) in the biological and physical sciences, focusing on anatomy, physiology, and with the turn of the century, germ theory (Stapelberg, 2015; Wynter, 2003; Lewontin, Rose, & Kamin, 1984). This not only placed biomedicine in the position of (male-dominated) academically trained scientific practice thus limiting entry for women (by lack of access to academic institutions), but also placed patients in the context of disease-based medicine (as opposed to holistic-care humor-based practices).

This solidified important distinctions and interactions between doctors and nurses in US healthcare whereby doctors practiced theory and problem-solving and nurses were delegated with care work and record keeping (Oliver, 2018; Egenes, 2009). This also helped form a hierarchy of HCWs which persists into the present day placing nursing at or near the lowest status (as well as lowest pay and prestige) and doctors, administrators, and specialists at or near the highest status (as well as highest pay and prestige) (Foth, Lange, & Smith., 2018).

Nurses take on a greater proportion of the work done in healthcare, performing tests and maintaining treatments while also caring for the needs of patients including cleaning, food, charting, and many other tasks and requests from patients (Foth et al., 2018). Burnout has been reported higher among nurses than their doctor/administrator counterparts and the working hours, risk, and volume of tasks undertaken contribute to the issues which nurses experience (Bridgeman, Bridgeman, & Barone, 2018). A disadvantaged and troublesome position during relatively stable times of public health is exacerbated by health crises such as the COVID-19 pandemic.

Nurses in Pandemics

Infectious disease outbreaks have been well studied including how they impact HCWs in regards to treating patients as well as efforts HCWs employ to prevent disease transmission. Some recent such events include the 2003 SARS outbreak, the H1N1 outbreak of 2009, the Ebola outbreak of 2014, and now the COVID-19 outbreak of 2020 (Nickell et al., 2004; Imai et al. 2010; McMahon et al., 2016; San Juan et al., 2021). Literature covering the impact of these pandemics on the specific experiences of nurses reveals continuing themes of psychosocial stress, isolation, inadequate protective measures or resources, and burnout.

Nickell et al. (2004) reports significant increases in measures of emotional stress on HCWs during the 2003 SARS outbreak with nurses nearly doubling the average measures of other workers (25% average versus 45% for nurses on the GHQ-12-self-administered General

Health Questionnaire, “a frequently used and well-standardized measure of recent emotional distress”). Concerns about stressors beyond the risk of infection were found by Imai et al. (2010) in their review of reasons for HCW hesitance to work during the H1N1 pandemic including physical and emotional fatigue. The Ebola outbreak in Sierra Leone created a crisis straining HCWs, especially nurses, by isolating them from social groups, at times being shunned by family members and the broader community because of their proximity to disease. These exacerbated their own personal concerns, psychological trauma from the treatment of patients with Ebola, and exhaustion from being overworked and understaffed (McMahon et al., 2016).

During the COVID-19 pandemic nurses have reported fatigue, burnout, or disproportionate stress resulting from issues presented by the evolving situation, including the longevity of the pandemic. San Juan et al. (2021) found that nurses in the UK experienced increased emotional stress, instances of trauma, frustration from systemic issues and bureaucracy, and an increased desire to leave their profession. Shreffler, Petrey, and Huecker (2020) conducted a systematic review of psychological stress on COVID-19 HCWs between February and May of 2020 finding that not only are staff leaving their positions more readily, but rates of suicide increased, quality of patient care decreased (from lack of resources and time), and strains from a worsening situation created further coping challenges. Later studies have consistently connected low-staffing rates, reduced access to PPE, and lack of systemic support to decreased nurse morale and psychological distress (Lasater et al., 2021).

Nurses in pandemics serve as the metaphorical backbone of the healthcare system and especially hospitals by providing essential frontline care to patients. Nurses have been known to take on extra responsibilities during pandemics not only from the increased measures taken to treat and prevent spread, but also from procedures and tasks that would normally have been performed by maintenance staff or doctors/specialists who either will not or are unable to perform them during the crisis (Shreffler, Petrey, & Huecker, 2020; Nickell et al., 2004).

Simultaneously, they experience the greatest risk of exposure to the pandemic causing disease through their prolonged interaction and care of patients and also have experienced severe burnout from the emotional and physical toll of their profession disproportionate from their colleagues (Alharbi, Jackson, & Usher, 2020; Dzau, Kirch, & Nasca, 2020). The continuing strain and struggles of nurses during the COVID-19 pandemic, and the underlying power structures which play into these issues, becomes the point of concern for the work done here.

Neoliberal Healthcare

Another important influence on the healthcare system in the US has been its economic position, or rather healthcare as a market good subject to the US economic structure. The US has been classically framed and explored as employing a capitalist economic system, however the theoretical question of what a capitalist system entails has historically been and continues to be a topic of debate (Waterhouse, 2017). Capitalism has broadly been framed as an economic system which functions by the allocation of economic resources and movement of markets free from government intervention. However, restrictions on businesses and individual abilities to do so have been employed in the US which previously ran counter to the ideals of capitalism including taxes, civil rights (pertaining to ownership of human beings/slavery), permits for ownership, registration systems of motor vehicles and firearms, union rights, and regulatory organizations such as the FDA and the FTC. Challenges to the ideals of capitalism have arisen starkly in the forms of Marxism, many feminisms, and socialism, though capitalism has remained a defining characteristic of the American economy (Foucault, 2008; Bromley, 2012; Waterhouse, 2017). In a privatized healthcare system that functions under the free-market ideals of capitalism, the allocation of resources often serves financial gains or public image. Neoliberalism is an economic system ideology which holds similar to capitalism and has been used to describe the US healthcare system (Snee, White, & Cox, 2020; Ganti, 2014; Gupta, 2020).

Neoliberalism has been described as a collective of individual actors, namely economists and political proponents, who argue for a kind of controlled market liberalism where democratic pressures do not influence the free movement of the market, but act to maintain them (Jackson, 2021; Harvey, 2007). In this framework, state governments or governing bodies work to maintain market equilibrium and enterprise by enabling enterprises to work in the market and individuals to work as self-enterprising agents. This differs from capitalism in that government engagement in the economic system is employed, but only to the extent of maintaining competition. Individuals, then, are expected to behave self-servingly by practicing effective self-management and self-determination in market engagement (Ganti, 2014; Ferguson, 2009; Foucault, 2008; Hoffman & Cowan, 2008). This individualistic engagement prioritizes individual action/rights over communal action/rights. Through individual self-interest, market equilibrium is thought to create social equilibrium. For the purpose of the arguments presented here, this framework of neoliberalism will be employed to reveal the ways in which promoting self-enterprise and self-determination in this neo-capitalist economic framework becomes problematic for the experience of these nurses.

Power is enacted in neoliberalism by encouraging or even forcing market enterprises and individuals to treat themselves as their own unit within a market competing with other units (Morningstar, 2020). Neoliberal proponents and systems encourage self-interest and disregard social strata/structures as less important to the outcomes one creates for themselves. Recognizing the position of organizations here, Hoffman and Cowan (2008) state: "organizations are tremendously influential in determining how American workers negotiate the demands of employment and the demands of the rest of their lives" (p. 228). A Foucauldian framework in exploring these structures may be useful to understand the presence of these power relations in the experience of COVID-19 nurses. Political and organizational structures establish the organization as a power agent to the benefit of the nurses and the nurses as self-

enterprising agents in their life outcomes but frames these relations in the mode of self-governance and individual responsibility. Foucault (2008) formulates this through the concept of neoliberal governmentality whereby governance is enacted through self-enterprising in a free market but controlled through ideological frameworks that displace responsibility from power structures while maintaining their influence. This neoliberal governmentality forms nurses as self-governing agents responsible for their experience of the conditions of their work and their broader lives. This reinforces the superseding power structures which create and enforce the contexts which stress nurses initially and maintain their supposed unique position to address this stress.

Literature criticizing the neoliberal healthcare system brings up concerns about the effects which neoliberal healthcare has on the mental and physical health of HCWs, especially nurses, where practices which focus on individual empowerment actually create further stress for biomedical subjects (Snee, White, & Cox, 2020). This intersects with ideas of care work and nursing as feminized where the female-gendered profession experiences a particular kind of neoliberal framing that places the struggles nurses experience both in gender discrimination and in the power hierarchy of their work (which are inseparable) on the expansive list of responsibilities which they take on in their work (Wrede, 2010). Further, these ideas impact their ability to provide appropriate care to their patients and lead to further disparate impacts on other disadvantaged populations (Sakellariou & Rotarou, 2017).

Gender: Postmodern Theory as a Critique of Neoliberal Feminism

Because this work focuses primarily on sociopolitical power structures and frameworks in a profession which is female/women-dominated, it is useful to consider gendered aspects of these structures in the formation of care for nurses. A multitude of frameworks are appropriate and useful for understanding gendered experiences in nursing. Many liberal/radical feminist arguments point to systems of patriarchy and patriarchal institutions which disparage women's

experiences while marxist feminism considers capitalist economic structures in understanding gendered experiences (Bromley, 2012). Many other frameworks including psychoanalytic, anti-racist, and Queer feminisms may be useful in understanding these experiences. This research brings a critique of neoliberal approaches to gendered experiences (of nurses) and postmodern feminist ideas will be used and applied to analyze the experiences of COVID-19 nurses.

[1]Postmodern and Neoliberal Feminisms

Postmodern theory deals with social categories and how such categories become socialized into being within the social consciousness (Foucault, 2008; Butler, 1990). Butler writes about the categories and performativity of gender, bringing to light the important structures which instill ideals about gendered identity in the individual as part of artificial categories that systematically disparage women's and other groups' experiences: "In this sense, gender is not a performance that a prior subject elects to do, but gender is *performative* in the sense that it constitutes as an effect the very subject it appears to express. It is a *compulsory* performance in the sense that acting out of line with heterosexual norms brings with it ostracism, punishment, and violence…" (Butler, 1991). In this way, the category of "woman" is constructed in associations with care (implicit motivations), as substandard and opposite to the dominant category ("man"), and as natural (Dill et al., 2016; Butler, 1991). Its performativity is an ongoing enactment of such ideals through implicit associations reinforced by systems of power (including social constructs) (Butler, 1991). Several postmodernists expand this idea of gender as a set of socially constructed categories based on socializing mechanisms of power including

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[1] *Note on Limitations*

While this work focuses on the broad categories of gender (specifically woman-identifying people), the experiences of frontline nurses and those of other groups cannot be fully understood or spoken about without discussing intersections of race, class, ethnicity, indigeneity, geopolitical position, able-bodiedness, or many other factors of the human experience. While these issues are not the focus of this work, the author recognizes that no such work done solely on gender can appropriately capture these important intersectional distinctions and that further discourse on these different experiences deserve and require intense and appropriate consideration.

patriarchal, capitalist, and colonizer ideals about human beings and especially women as “the second sex” (Wittig, 1992; hooks, 1984; de Beauvoir, 1989; Wynter, 2003).

While postmodernists focus on decategorization in gendered issues and constructs, neoliberal feminists promote neoliberal approaches which frame issues confronted by women in the US capitalist system as able/needing to be addressed by individual agency and self-enterprise (Banet-Weiser, Gill, & Rottenberg, 2020). Popular works such as *Lean In* by Sheryl Sandberg (2013) have promoted the neoliberal idea that gendered issues and disparities should be confronted with unyielding hard work and self-agency/care. Such ideals are heavily criticized for devaluing systemic approaches to lessening gender divides and placing the responsibility for changing such issues onto individual women (Rottenberg, 2014). Neoliberal feminist ideals about “believing” in oneself, “leaning in,” or “persisting” may provide encouragement or empowerment for some in the face of gender discrimination/prejudice, however much of this discourse has been criticized as discounting opportunities for systemic change, discourse on group and organizational responsibility, or policy changes which confront feminist issues (Nash & Moore, 2019; Sjöstrand, 2019; Brice & Andrews, 2019; Rottenberg, 2014).

Nursing

Gender norms and ideas also inform the gendered nature of the nursing profession. Historically in the US, nursing has been thought of as a women’s profession. In fact, throughout much of the 18th and 19th centuries, it was one of the only professions which were socially acceptable for women to work (Egenes, 2009). In part, this was due to thinking of women as being inherently or biologically equipped for care work (Oliver, 2018; Dill et al., 2016). The category of “woman” was thought to have the inherent characteristics of intrinsic motivation for care, to be ill-equipped for masculine-associated work such as mining, business, or academia, and to have the social responsibility for mothering, domestic work, and marriage (Dill et al., 2016; Butler, 1990; Gupta, 2020). Thus, subject-identity formation for nurses (as care workers) is heavily implicated in the categories in which gender is constructed. This has been

accompanied by different forms of systemic discriminations which devalue nurses and the work they do (leading to comparatively lower pay, glass ceilings to entry into higher positions, and disproportionate work distribution) (Caro, Robbins, & Freidus, 2021; Gupta, 2020; Husso & Hirvonen, 2012). Likewise, gender norms pertaining to domestic labor may further disparage nurses in their experiences due to a disproportionate assumption of care-related household and childcare duties expected of them. However, research reveals these biological associations to be largely unfounded and attributes the disparities in work orientation to social phenomena of gender constructs (Lewontin, Rose, & Kamin, 1984; Butler, 1990; Dill et al., 2016). This issue of feminized care work has created both barriers to entry into the profession for male nurses as well as promotion and pay advantages for them into supervisory and administrative roles as men are seen as more authoritative (or socialized to be) and better suited to such work (including its financial benefits) (Evans, 2004; Gupta, 2020). Further, the implications of neoliberalism and neoliberal feminists frames the solutions and social changes for these issues as the responsibility of those disparaged by them by constructing them as self-enterprising and disregarding the value of systemic change.

It is also important to acknowledge nurses' subjectivities, regarding the gendered nature of care work, whereby women are expected to emotionally invest in their patients and leads to dependency and lack of autonomy with their places of work and further establishes their profession as central to their personal identities (Husso & Hirvonen, 2012). This gendered neoliberal subjectivity pervades the lives of frontline COVID-19 nurses in identifying them not only to the community as nurses, but also to themselves, and leads to stressors associated with community rejection, the ability to connect with family/friends, and their self-conceptions in the context of the pandemic (Robbins, 2021). The lived experience of being a "nurse" brings with it concerns around spread of disease which limits contact with others and entering public spaces.

CHAPTER III: METHODS

This study employed a common ethnographic method called a rapid qualitative appraisal. It sought to answer the following question: “How has a neoliberalized healthcare system impacted the experiences of frontline COVID-19 nurses? And how has gender intersected with these power systems?” Rapid appraisals are especially useful in times of complex health emergencies for their targeted rapid design for collecting and analyzing data in limited timeframes in order to assess and work towards rapid solutions/policy recommendations for complex situations (Beebe, 1995; Green & Thorogood, 2013; Johnson & Vindrola-Padros, 2017). This appraisal stemmed from a global collaboration with the Rapid Research Evaluation and Appraisal Lab (RREAL) at the University College London. RREAL is a rapid response research lab which “focuses on the development of rapid methodologies in health services research with an aim to understand and improve the organization and management of healthcare delivery around the world” (RREAL, 2021). This broader project by RREAL solicits researchers from 22 countries to rapidly assess the evolving COVID-19 pandemic specifically focusing on the perceptions of frontline healthcare works and holds regular meetings to present preliminary findings. This rapid appraisal focused specifically on frontline COVID-19 nurses working in COVID-19 focused units/wards in hospitals in North Carolina.

Data collection

This study was based on semi-structured interviews conducted through Zoom with 13 frontline nursing staff identified as working on COVID-19 hospital floors in NC. The Zoom interviews were recorded (both audio and video through the Zoom recording feature). The interviews focused on perceptions of the virus, their work and workplaces, ability to care for patients, their experiences with mental health, the impact of changes from the pandemic on themselves and their children, and what issues they perceived need further attention to improve their experiences (see Appendix A). These data are not expected to be representative of all healthcare workers/providers and staff across the country/region/world. Instead it is a purposive

sample meant to generate key themes that can be used to inform policy and procedures in a timely fashion (Beebe, 1995, Johnson & Vindrola-Padros, 2017). As a next step, these data can be used to develop a more comprehensive survey for distribution to a more representative sample. It can also be analyzed within the broader RREAL work, as a comparative study with any of these 22 other mirror studies, to create a global understanding - identifying differences and similarities that cross cultural and state borders, locating HCW experiences within the neoliberal healthcare economy, and intersecting gendered issues with care work in the COVID-19 pandemic (2021).

Recruitment

Recruitment of nurses occurred using respondent-driven sampling (RDS). Respondents were contacted through nursing schools of NC colleges and universities, nursing associations such as the North Carolina Organization of Nurse Leaders (NCONL), and through the social networks of the researchers. Potential participants were contacted through email, telephone, and flyer dissemination, given the details/procedure of the project, and inquired about interest in participating (see Appendix B). If expressing interest, participants were then sent the informed consent with verbal consent and solicited for time to schedule a Zoom interview of 30 to 60 minutes (see Appendix C). If the participant was willing, the interview was digitally audio recorded (all participants consented). At the end of the interview, the participant was asked to share the principal investigator's contact information with up to 5 colleagues that work in COVID units in NC. They were provided with a short description of the project to share with potential participants (see Appendix B). Once these recruited participants reached out to investigators that same initial process that began with key informants was undertaken and the participants were interviewed and asked to pass along the principal investigator’s information to up to 5 other people working in COVID units in NC. This continued until the project had conducted 13 interviews.

All recorded interviews were transcribed. All data was entered into an Nvivo program for qualitative analysis.

No identifiable information was kept once the data was collected aside from the (verbal) signed informed consents, which were stored in a password protected google drive file on the principal investigator's password protected university computer. All participants were given a number and pseudonym. E-mail addresses and phone numbers were erased from phones and computers (unless participants wanted an emailed copy of the final report). Audio and video files were stored on the principal investigator's password protected university computer in a protected google drive shared with the co-investigator and research assistant for no more than 3 years.

Key themes are discussed in the following sections including stress, fear, frustrations, "work-life balance," burnout, and subjectivity. The first section of data presents these themes using quotes presented in narrative organization. The second section focuses on subjectivity in a more detailed linguistic analysis. Following the presentation of the data is a discussion of the themes and their connections.

Positionality

For the purposes of this work, my positionality becomes relevant to the research and perspectives displayed here.

I am a white middle-class cisgender man-identifying male who was raised in a mix of suburban and rural lower- to upper middle-class USA-located homes by white, conservative-leaning, divorced, US-born, heterosexual parents of varying physical presence and poor mental health. I attended public secondary schools and a public university studying various social sciences including economics, psychology, sociology, and women's and gender studies.

My positionality in the privilege categories of white, middle-class, cis-male, and colonial native not only provide me access to many resources including my education and (relative) financial stability, but also inform the work presented here potentially shaping what research is

found, how it is interpreted, the emotional impact it has on me, what/how it is presented, and what/how it is received. My access and choice of disciplines further influence my positionality in this work by providing me access to certain nuanced understandings of these positionalities, their effects, and associated feminist theory. They further impact my positionality through the indoctrination I receive by learning in a system residing in and abiding by Western imperial nation systems as well as the ways of knowing which have been and are controlled or influenced by those same systems.

Other impacting factors of my positionality include my status as relatively young (25 years old by Gregarian standard), being relatively physically healthy (having few experiences as a hospital patient), and especially my lack of experience as or with nurses to any substantial capacity. I do not hold political alignment, but hold personal disagreement with the Trump and Biden administrations' positions and actions in the COVID-19 pandemic and the general federal, state, and local governments in which I reside for the ways they have handled the issues this pandemic has presented. I generally hold negative views of bureaucratic systems, mass capitalistic systems, and hold sympathy with groups who suffer disproportionately. This informs my decision to focus on gender and neoliberalism in this work and impacts the way in which I report on these systems and the research findings.

I understand mental health as both privileged and nuanced and recognize it as widely inaccessible especially to underprivileged groups. I do not consider myself to be of above average mental health, but understand my position has provided me access to resources which have aided in my coping with mental health issues and that such resources are significantly less accessible to less privileged groups as well as many of those without significant financial and sociocultural resources.

I recognize these positions and will work to account for their impact and where not possible to do so, make the effort to recognize such biases. I will also seek to understand and account for other positionalities which I have not recognized here.

This work also takes a form of colonization of the experiences of nurses by drawing from the narratives presented and assuming authority over them to form the conclusions herein. The distance of the researchers from the positionality of nurses further alienates the viewpoint of this work and creates the potential for conflict or disconnect from the real lived experiences and attitudes of the nurses interviewed. Although this conflict is understood, the work done here is believed to contribute important theoretical insight into the experience of these nurses and their struggles. Further consultation with nurses may improve the scope of this framework.

CHAPTER IV: DATA

Part 1, Key Themes Emerging from the Data

Fear, Stress, Isolation

Narratives of frontline COVID-19 nurses showed the impact that the COVID-19 pandemic had on their lives and experiences. Nurses described how the pandemic affected their work and workplace. Amidst the pandemic, nurses were often the most physically close to COVID-19 and had greater risk of exposure than many. They expressed fear about a number of COVID-related issues (references[2] (ref) = 25). One nurse described a conversation with a coworker:

> "And this other nurse is like, 'I can't take care of a COVID positive patient,' she's like, 'I have this patient who's COVID positive.' And she's like, 'I'm too scared to do it.' And I said, 'Well, you want the homicidal one?' She's like, 'Yeah, I'll take the homicidal patient.' [chuckles] She preferred a homicidal patient over this guy who had been discharged from the ICU, was on two liters nasal cannula, was recovering from COVID, had been through the worst, was on his way home, he got discharged home two days later, and she was too scared to take that patient." (HCWP13)

This quote represents the degree of fear that many nurses felt in their workplaces and towards COVID-positive patients. Similarly, another nurse described her fears and anxieties that revolved around both her own health and the health of her partner and her children:

[2] References (ref) here refers to the number of coded instances of the theme found in the collective data (including multiple references by the same interviewee).

> “I think there have been ups and downs but in the beginning, I was really fearful. I think it was the day that I heard that that 42-year-old Mount Sinai nurse manager died from COVID. And all he had was mild Asthma. So I was really fearful. My husband has mild Asthma. He's 42. I have three small children. I was really afraid. But that was when we knew less about how it's spread and the severity of it. You know all we were seeing on the media was New York. So I didn't take care of any COVID patients until probably late April, early May. And by then I realized that... And I had anxiety, I had never experienced in my life. I'm not an anxious person. I'm not really high strung. But lots of sleepless nights. Even if I wasn't specifically thinking about COVID, I would have racing thoughts and just... I don't know.” (HCWP19)

This nurse demonstrates one way in which work and life-related stressors are connected and how the fear of exposure to COVID-19 created fear of harm to loved ones. This will inform further discussion about the etiologies of burnout and work-life balance in deconstructing the separation of “work” and “life.” This nurse is specifically identifying the multifactorial nature of her anxiety. Sleeplessness, for her, is associated with COVID but not limited to it.

One unique aspect that heightened the stress and fear nurses felt beyond their own risk to themselves and their loved ones was the risk they knew their colleagues were taking and the potential infection all of them faced on a daily basis. A nursing director (the sole male participant) described the emotional impact and fears about his coworkers:

> “And my first breakdown where I was sobbing in my desk was when the nurses started testing positive, and I really thought that I was gonna see people die and like my... I'm gonna get emotional. I thought I was gonna see my colleagues die and that was really tough.” (HCWP5)

The interpersonal concern for coworkers' well-being, as exemplified here, shows how this fear extends beyond the experience of the individual, an interpersonal and group-felt fear which affects nurses, demonstrating the need for an institutional approach to addressing nurse mental health.

Beyond the fear of just contracting or spreading the virus, nurses also discussed the stress of being lonely and isolated as a result of their efforts to try and shield those they loved from exposure to COVID. One nurse described this feeling of isolation that was a result of her measures to mitigate spreading the disease to her loved ones:

> "It's not so much worry. It's just more of you feel isolated because I can't see my family. I was worried about... At first, I was worried about bringing it home to my husband. Of course, I'm always very careful when I come home from work. But it was more of, I can't see my family. And if I do finally go see my family, I could be giving them something. And it was always a, I'm not gonna see my mom 'cause my mom takes care of my grandma. My grandma's 85. If she gets COVID, it will kill her and I can't be responsible for killing her." (HCWP9)

Nurses described being ostracized by family and friends for fear of the spread of disease. Again, we see here the anxiety and stress of the pandemic reaching beyond the confines of the hospital or "work" space to the mundane, everyday lived experiences they have at home.

In addition to the concerns for spreading the virus to loved ones, nurses experienced concern over and even backlash about their presence in public spaces and other frustrations with their communities (ref = 37). These experiences and concerns exemplify another manner in which "work" and "life" are inherently connected and how stress associated with burnout also comes from experiences outside of the workplace. They expressed frustration over being

praised by the community from a distance, and by some media which heralded them as heroes, but also being avoided due to their closeness to COVID patients. One nurse explained this contradiction:

> “It's weird that people will praise us for doing all of this fabulous work but then they look at you like ‘You're the virus.’” (HCWP6)

Another nurse expressed frustration about community perceptions of their work and their potential exposure to the virus:

> “And then you saw social media, people were posting things like, ‘Nurses are complaining they didn't sign up for this,’ and ‘Yes, they did.’ And I'm like, in no other... When soldiers go to war, they risk their own lives. Like me, going to work not only risks my life, but also my family members.” (HCWP19)

These quotes reveal how the condition of being a nurse creates in itself a subject of critical view by members of nurses’ communities and how these negative interactions they have in public are not only directly connected to this identity/subjectivity, but impact the mental well-being of nurses.

Many nurses expressed that they did not feel they had a choice but to continue working with COVID-19 positive patients citing a lack of financial resources, career flexibility, and moral obligation to act as care workers, such as this nurse:

> “And a lot of people have to make that decision like, do I come out of work? Or do I... What do we do? And if you're not in a position where you can afford to remove a whole source of income, if you're a single parent, then you're really just left to figure out the most safest environment you possibly can for your child and

> have to make tough decisions. And I just don't think that's a decision that healthcare workers should have to make." (HCWP2)

The lack of choice in exposure reveals one of the ways in which neoliberal approaches to social issues become impractical due to the structural issues associated with the struggles of these nurses. As institutions refused to recognize the nurses' right to choose to treat COVID-positive patients for these nurses, they removed their ability to address personal concerns for the safety of self and others. Further the lack of ability to leave their positions due to personal circumstances further added stress and burnout to their lived experience. The practice is also discriminatory as will be seen below. We will also see how their subjectivities as care workers also tie to them a labor market that is exploitative and leads to nurses caring the bulk of risk regarding exposure to the virus.

Nurses' concerns about community engagement and support also connect to the politicization of the pandemic and the disregard by some people of the infection control guidelines and mandates that evolved as more was known about transmission in an effort to reduce disease spread. A nursing director lamented about the actions of people in their community:

> "When I have been driving downtown or have had to go to the grocery store and I see the politicized side of this, I see people purposefully not wearing PPE. I see people congregating on purpose, because they think this is a hoax. It's very disheartening...So has it affected me? Yes, and do I feel less about some people now? Yes, unfortunately. So I feel some shame about that internally, because I feel like I've become much more judgmental." (HCWP5)

This exemplifies another way in which the subject-identity of being a nurse impacts personal experiences outside of the workplace. Personal struggles and experiences affect the

worldview and perspectives of others and this, in turn, impacts moral and emotional well-being. Another nurse expressed feeling disappointed in people who refuse to wear masks:

> “I go up and down. I am disappointed to see that a lot of people still don't wear masks, and I guess I'm just disappointed in the idea of someone not considering the person next to them. I'm just shocked. Even months in, we're more than halfway through the year and we still have to have this conversation and remind people, ‘Put your mask on,’ or, ‘Do you have a mask?’ or, ‘I'm not wearing a mask. I don't have it. Well, sometimes you don't know if you have it. And even if you don't have it, you could get it. And just the lack of consideration for the individual, the common person next to you, is just what I'm kinda disappointed in.” (HCWP2)

Frustration with community responses and backlash adds to an already increasingly stressful and precarious position. The fear associated with the risk of exposure and the stress of the changing conditions within the broader community and the community responses to nurses were compounded by difficult and unpredictable work environments.

Changing Work Configurations and Work Relationships

Many of the nurses noted an increased workload (ref = 74) and lack of choice in assignments to COVID patients (ref = 10). One travel nurse spoke about the lack of choice they had in their assignment to work on the COVID floor:

> “In this particular case, because COVID was so new to everyone, I was hired as I said, for the Med-Surg Short Stay, and that was what the contract was. And then when they switched it over to COVID, I really didn't have any input, it was just expected of me. But when they extended it, they did ask, ‘Are you okay with it?’

> [laughter] So yeah, by that time, I had already been there a while and I was okay with it. [laughter]" (HCWP11)

In addition to feeling like they did not have agency in determining their work responsibilities, they also talked about the overwhelming workload. One nurse explained the burden of caring for so many critically ill patients at one time:

> "The other problem I see is that at the beginning, we only had two patients per shift, or it was a two-to-one ratio, and now it can be four-to-one. And it's really tough having that many seriously ill patients and having to gown-in and gown-out and make sure that you're safe between rooms. And in the meantime, we also had an employee outbreak. So everyone was scared over that as well. So it's been a journey." (HCWP11)

The changing and increasing responsibilities, the lack of choice in assignment, the fear of exposure, and the concern for the well-being of others greatly contributed to nurses' suffering mental health challenges. Institutional directions primarily dictated the added responsibilities to nurses (as has been done historically). Nurses, because of a host of factors including economic necessity but also a subjectivity shaped by care work, keep them in the labor market that they know negatively impacts their mental well-being. Yet, it is a "sacrifice" many are willing to make. Another nurse also noted the deep emotional impact of caring for dying patients while navigating constantly changing work protocols that created more labor, risk, fear, and stress:

> "The emotional aspect of it that I deal with are way worse. It's like... Because we are having quite a few people dying now, and you carry that and you think about those people and you try not to bring it home, but you are the last thing these people see. They don't get to see or touch their family. And that's hard. Some people don't understand what that's like and can't imagine what that's like, but

> these people are dying alone, or we're the last people in there holding their hand dying. And that makes you feel some type of way…But CDC guidelines keep changing and changing. Literally, they keep giving us more room to play with as time goes on. It changes every single time I go back. If I work three shifts, I'm off two days and I go back, something has changed every time I go back." (HCWP18)

The nurses exemplify the interpersonal experience of suffering and how these experiences further impacted their mental health. Many of the interviewed nurses indirectly pointed out neoliberal structures which contributed to their frustrations (ref=22). One nurse described how their administrators avoided protective measures for an aversion to paperwork and added work:

> "They were there long enough that you know that was hospital acquired, it can't be they came in with it and it just went... 'Cause you get all those negative tests and they're like, "No, they developed pneumonia and they were... " They don't wanna admit it, like administrators don't wanna go through the paperwork, 'cause I know my director said for when there was an outbreak of six nurses who got COVID, he said it took 30 hours to do the contact tracing, over six people. And when you have... It's just a lot of work. And administration is just like, "We don't have the time to do this." But I think as far as unionization, they're like, just because you don't want the time and money or the publicity, you need to be more protective of your care workers instead of thinking, "Oh, that was a false positive, we don't need to do all that."" (HCWP13)

The unwillingness of administrators to address nurse safety shows how nurses are seen as a scapegoat of hospitals and have their physical well-being dismissed out of a desire to avoid

extra bureaucratic labor. Nurses also commented on their frustration with other staff's unwillingness to aid in COVID patient care which resulted in them taking on the greater share of work in their units (ref = 30) and further expressed a sense of being undervalued (ref = 21). One nurse vented on many of the ways in which tasks continually fell onto their shoulders as other staff refused or were unable to perform their responsibilities:

> "And then in our COVID unit, housekeepers weren't coming up for a while… we were given buckets and expected to mop the floors and use a cleaning... 'Cause there was no housekeeper… We can't do it all. They recently just made us do all the phlebotomy blood draws, 'cause Phlebotomy used to do them… Then when COVID hit, they said, 'Oh, you can't hire anyone.' And people left… And now they're just really short and behind with staff. And so their solution is the ICUs and the step-down nurses will do the blood draws." (HCWP13)

Further, a travel nurse described being overwhelmed as they were assigned treatments, therapies, and lab draws on top of their regular duties:

> "We do all the work… We got more of the respirator hoods, we had a limited supply of hoods. And so the doctors wouldn't go in without one, and they weren't going in, they weren't even coming up to the floor. But this month, we got a supply of hoods in, and now the physicians are going into the rooms, finally. At the beginning, we were taught how to do… respiratory therapy treatments because the respiratory therapist wouldn't come in the rooms. We were told, 'There was no need for physical therapy because it was too dangerous for the physical therapist to come in.' And in some cases, these patients who were coming to us post-ICU were de-conditioned and they absolutely needed physical therapy, but they weren't coming in and doing it. We were told... We were taught

> how to do lab draws because Laboratory wouldn't come in the rooms. Yeah, it was ridiculous. So yeah, nurses are... We're doing it all." (HCWP11)

This quote reveals the discriminatory nature of these hospitals towards their healthcare workers where nurses have little-to-no choice in their assignment, are given a greater share of responsibilities and risk, and are left to take on extra care work when other hospital workers refuse to do their own. Taking the brunt of the care work, many of the nurses described feelings of exhaustion and a desire to leave the profession. A nurse educator expressed feeling burned out as such:

> "I'm burned out, I'm honestly thinking about leaving the nursing profession. I'm to that point… I was putting in 60 hours a week at the beginning, and it's taken its toll, and things are still changing. They're not changing as rapidly, but there's emails going around today about convalescent plasma, and are we getting the right consents and things like that? So, you roll something out you get the staff all on board. I've been rounding one-on-one with nurses, checking in with each person almost every day and answering their questions. But when things keep changing, and sometimes we're not as organized as we should be at the corporate level or the administration level, or I don't have support from managers like, I need it... Some of my managers are very supportive, some of them aren't." (HCWP14)

Nurses are being overwhelmed by systemic issues and workloads which otherwise would have been mediated by other healthcare workers, thus leading to a widespread experience of "burnout." This pattern of being assigned not only the majority of care-related tasks but also taking on greater exposure and risk reveals an overt devaluation of nurses as healthcare workers as well as some level of disregard for their well-being and safety.

Insufficient Compensation and Limited Work-Place Benefits and Support

As a way to address stress and employ coping strategies, nurses spoke on some of the workplace-provided benefits they had been offered (or not offered) (ref = 36) and some of the self-care activities they desired or had attempted to employ (ref = 22). One nurse, when asked about employer-provided COVID-related benefits, reported:

> “Nothing. [laughter] As a matter of fact, here's a fun fact. I was hired in February for a Short Stay unit at a certain amount of money. The nurses that they brought in, the travel nurses that they brought in for COVID contracts are getting twice as much as I'm getting. I don't even know how to... I'm really speechless, but I don't really even know how to process that fact.” (HCWP11)

Another nurse described how the benefits they were provided were ineffective:

> “So they have an employee assistance hotline, but nurses are notorious for not wanting to get care. So why am I gonna call somebody else up and tell them about my problems, that's not related to me at all, and that works for my same workplace? I would rather go to the mountains, I would rather go to the beach, I would rather go to an art museum and stare at old paintings for a day to offload my stress, than talk to somebody else about it.” (HCWP2)

The poor compensation and ineffective care benefits provided to nurses reveal how the neoliberal approaches to caring for workers are ineffective at addressing nurse well-being. In providing only services which place the responsibility of self-care and management onto nurses, and not addressing structural concerns that create the struggles in the first place, such as appropriate compensation, agency in assignment, sufficient PPE, child care, and equitable responsibilities, these institutions instead perpetuate nurses’ struggles. The pandemic further exacerbates these struggles by restricting the available self-care activities to nurses.

One nurse cited a bureaucratic change when discussing the lack of compensation for her work:

> "And they [the hospital] gave pandemic pay for nurses to stay home, which kind of frustrated me 'cause I'm like, "I'd like pandemic pay. I'd like to stay home." But no, I'm taking care of COVID patients and the people on the heart tower are getting paid 75% to stay home, while as I don't get a day off, and I'm taking care of these COVID patients. Which I found frustrating, that we're not getting hazard pay but yet they were helping to pay other people that weren't taking these patients, to stay home." (HCWP13)

Another nurse described feeling generally ignored by management and the support they received as insufficient:

> "We've had a psychiatrist who's only doing tele visits with his patients, and I think that's very hard, especially as far as mental health goes, to get people to talk to you via computer. But our upper level management completely ignored the fact that we're stressed, and didn't even make an effort to check on us. We had outside organizations sending us food all the time, which was really nice, but as far as our upper level management, they would kind of... Ignored us until we started saying, 'Hey, this sucks. We're not getting any kind of support. We're all stressed out…' I feel like we should probably get some sort of hazard pay even just for our regular shifts if we're taking care of COVID patients, just for the extra burden. Give us something for performing our housekeeping duties, for our lab... We have a lot of extra work that we're carrying out and... Yeah, it's... Yeah. I'm upset by it but.." (HCWP19)

Adding to the stress of many nurses was the lack of assistance in dealing with COVID-related circumstances that made their work and home life stressful. In particular, many of these nurses had children who were no longer going to school because they had shifted to online learning. Nurses were deemed essential and mandated to work but the necessary support services were just not provided or were inadequate. One nurse acknowledged that their employers did not make childcare support available, especially in the early days of the pandemic explaining: :

> “I think with childcare is a big issue right now because of COVID, and I think having some type of child care availability for staff is number one. That child care affect your staffing numbers greatly, because if your baby doesn't have a place to go, you can't come to work and that just... It just the bottom line. “ (HCWP2)

With the limits in support and coping mechanisms, the changing policies and impact of the pandemic, and the changes in their workplace, nurses’ abilities to manage their stress and practice effective “work-life balance” was diminished and their mental health took a toll. These narratives exemplify the impracticality of the artificial separation of a “work” self and a “life” self and reveal how neoliberal approaches to self-care were insufficient and harmful to nurse mental health during the COVID-19 pandemic.

Efforts in Maintaining Mental Health and Work-Life Balance

The increased workload has intensified stress and burnout, but managing their mental health among the increased stress is difficult for nurses, especially in the midst of the pandemic. Following, the “work-life balance” is invoked as a formation of this self-care. However, the maintenance of this “balance” is described as seemingly insurmountable (ref=22). The structures which have increased stress for nurses are also decreasing their opportunities for

coping. A nursing director commented on attempting to maintain a “work-life balance” using a vacation:

> “And I'm trying to find a work-life balance, so I have a two-week vacation coming up, I'm totally disconnecting from the hospital, I'm not even... I'm leaving my phone on my desk and my computer charging on my desk, I'm not even taking it home. So I'm looking forward to that.” (HCWP5)

However, disconnecting may not be such an easy task when the activities one might try are limited by COVID-related measures as one nurse educator showed:

> “It's emotional and it's taking a toll, and not even just at work. The pandemic as a whole takes a toll on, I think, everyone. You can't go listen to music, we used to love going to concerts. Well, I haven't been at a concert since last year. Things like that, where even on your time off, when you're trying to get away from work and get away from COVID, it's still there. I refuse to eat inside a restaurant, that just freaks me out. I'll eat outside, at the picnic table, but I will not go in a restaurant and sit down, take my mask off. It's not just work, it's life too, that's just taking a toll for sure.” (HCWP14)

Of concern here is the idea of a “work-life balance.” As employed above, this notion provides that there is a necessary and artificial separation between the self at “work” and the self at “life” and that these boundaries are and should be maintained by the individual. The individual may tend to this separation by manipulating circumstances towards a healthy living context, but one’s “work” is often conceptualized as out of the control of the individual. Therefore, the maintenance of this “work-life balance” usually falls within changing circumstances outside of the nurses’ work in order to accommodate the stress and demands of the work. The nursing director shows this in presenting what “work-life balance” is to him in that

those things associated with his work are being left behind in pursuit of an act of self-care, though we see how this idea is problematic for many nurses with the nurse educator's statements following. Because of their status as nurses and because of the pandemic, many nurses are unable to escape the impact of their work on their lives outside of their hospitals where many of the activities are unavailable or dangerous during the pandemic. This neoliberalization is further capitulated within the subject formation that nurses articulate in their narratives in that, when identifying oneself within their profession, the separation of that work-self and a life-self dissolves. Another nurse described an extensive self-care routine oriented towards managing the stress of her work:

> "But at the end of day, I don't believe we have the ultimate control. And I work out, I love to work out. I spend a lot of time outdoors taking in the fresh air because I'm shut in for so many hours. I do that on my days off. On top of my faith, staying active, taking care of myself, treating myself well. When I became a nurse, I started reflecting on what I do for myself, because I'm sitting here preaching to my patients, educating my patients, and I'm going to McDonald's and eating garbage, but I'm telling them they have to be on a cardiac diet. And I'm like, 'I'm gonna be on a cardiac diet eating like this.' So really, practicing what I preach and taking care of myself is the best thing I can do. Weightlifting really helps me mentally, but going out and staying in the fresh air and enjoying life and accepting life for what it is, for the people that can't do that in these situations, that's really where I find my peace the most, being grateful. That's the way I stay sane" (HCWP18)

Although this routine is spoken of positively, it accompanies a great deal of commitment and effort on the part of the nurse which may not be generally practical and further fails to

address the underlying causes of her increased stress. Another nurse noted a focus on limiting working hours (by not taking extra shifts) as a form of self-care:

> “I normally would pick up extra hours, I'm not doing that, because I don't wanna get burnt out. So the things that I would normally do at work, like pick up an extra shift here or there, it's not something that I'm interested in doing right now. I probably could do more, more self-care but there's not anything in particular that I have been doing besides talking it out.” (HCWP6)

However, not every nurse has the opportunity to reduce their hours or their workload in response to the increased pressures and fears. In addition, when examining the nature of nurses' subjectivities, many feel they have to continue during stressful times to make up for the hours others drop or for the increased patient load. Another nurse exclaimed a lack of opportunity to practice self-care and how this compounded their exhaustion:

> “I think that people are also just so emotionally burnt out because they can't... You can't take breaks. You can't really go out to dinner and relax, you can't really take your vacation time and do anything with it, and I think that I've noticed that I've had a lot more, I guess, counseling sessions with my employees about what's going on that's impacting their work than I think I normally would. I think that we're just at a point where everybody is just very emotionally burnt out just by being. Just by existing in this sort of time where things are very uncertain, things keep changing. It's hard to... I don't know, bond with people with the masks and the eye protection, and even something as simple as just walking past someone in the hall and smiling at them as you pass by, that's... I still do it…” (HCWP8)

Here, nurses are being overwhelmed by systemic issues and workloads which otherwise would have been mediated by other healthcare workers.

Gender, Nursing, and Care

Nursing as a profession has always been gendered, and some nurses spoke on gender directly as they discussed their experiences. One nurse commented on the assumptions about nurses and doctors as gendered subjects:

> “And it makes it funny because the doctors are wearing them, everyone's wearing the green scrubs. And there's a physical therapist on the floor and she was talking to this doctor, thinking it was the nurse. I'm like, ‘That's Dr. McKay, she doesn't... You need to talk to me.’ [chuckle] Which I guess is one of those biases, she just saw a female and assumed it was the nurse and I was like, ‘Oh no, no.’” (HCWP13)

The same nurse also described an awareness of the gendered nature of the nursing profession and how that has impacted compensation, taboo around pay discussions, and other expectations:

> “Nurses are getting hired that have less experience than me, but come as an experienced nurse. There's new hires and then if you have some experience, and they're getting paid about the same as me. I know someone who's come, 'cause she came just two years and she's like, ‘Yeah, this person who has the same amount of nursing experience as me is getting paid more than me because she started somewhere else and then came here.’ And she's like, ‘Why are we just preventing…’ We feel like they don't want us to talk about pay when we really should be talking about pay and saying, ‘Hey, this is not fair.’ And I think that's part of the union push. But you get nurses who've been nursing for 10 years or

> one of my NUSs is like, ‘Well, when I started nursing, my pay was $18 an hour.’ And I'm like, Well, who cares? It's 2020. That's irrelevant what your pay was when you started. The point is, What is your pay today compared to everyone else's pay? And are you being appreciated for your skills? And I used to be a teacher, and there's a profession, once again, female-dominated, where pay has been pushed down. They always say, ‘Well, you're not a teacher for the pay.’ And I'm like, ‘But you got bills.’ 'Cause my first career was education. So I think there are some people that you've just been taught not to talk about pay and we haven't been trained to talk about pay and we've been told it's a taboo, it's crass, it's not nice to talk about money. But at the same time, we're hurting females because somehow in the male culture, they're allowed to talk about it, they're allowed to do something. But in female predominant jobs and women, we're not allowed to advocate for our pay. I don't know if you've noticed that? Maybe it's something being older, I noticed this.” (HCWP13)

The gendered nature of the profession draws further attention given the circumstances which nurses describe as taking on more of the care responsibilities during the pandemic as well as greater risk. This historical association of women with care work further problematizes the discriminatory practices of hospitals towards nurses as being gender-based. Nursing as a profession has also been associated with care work and many interviewed nurses expressed care attitudes (ref=25). One travel nurse described the staff they work with as reason for remaining in the profession:

> “The COVID floor has been fabulous. We have... The teamwork is amazing. It is amazing. If you walk into a patient's room and you need a med that you don't have, you get on your phone and you call another nurse to bring you that med, and they don't hesitate. Nobody says, "Oh, wah, wah, wah." No one gripes.

> They'll bring you what you need. Everyone knows that when you're all suited up in the room, you don't wanna come out and un-suit and go to the med room. Everyone supports. It has been amazing. I'm one of the... I'm probably the oldest nurse there. When the unit was put together... As I said, I was hired for this unit. It was a brand new unit on the floor, and they had hired a whole bunch of new nurses to man this unit. I may be the oldest nurse there. I know, on any shift, I'm always the oldest one, and I'm kind of the mom. And I've held hands, I've held nurses' hands, I've comforted the nurses, and they'll come to me when they have questions." (HCWP11)

Another nurse described great appreciation for the support they received from the other COVID nursing staff:

> "But I think this fall, because starting clinicals and that, I have really great co-workers who... We don't care. We give each other hugs. We give each other support. I think that helps 'cause nursing has always been stressful, so it's not like it's... There's new stresses, but in some ways, there was a break with these patients who can go to the bathroom, take care of themselves, and I wasn't used to it 'cause I had very high... Most of my days before, I was just exhausted. And all of a sudden it's like, 'Oh, this is a little bit easier.' But then there were other things that were just crazy and ridiculous, like lack of housekeepers or other problems, but we just go. You just roll with the punches and it's two 12-hour shifts is the thing that gets you through." (HCWP13)

This focus on others as a motive for remaining in the profession reflects an intrinsic motivation and solidarity that is associated with care work and deeply embedded in nurse

subjectivities. Another nurse described their commitment to their oath and to helping their patients as reasons for remaining in the profession:

> “Because I took an oath. When we graduate we take an oath. And that's saying, ‘I'm compassionate about this. This is what I really want.’ And I feel like it all reflects back to my faith honestly. I feel like we're... I'm called to serve people. We're supposed to love one another, and that is what I do. I believe I'll be protected. If something happens, then it happens, but I would like to know that I was doing what was in someone's best interest, and I was protecting people and doing what I agreed to do. I knew when I went in this profession that there would be things like that.” (HCWP18)

This commitment to an “oath” further exemplifies the intrinsic motivations which nurses hold for remaining within their profession despite the discriminations and struggles they experience. Nurses also described how the increased workload affected their ability to care for patients such as this travel nurse represents:

> “They keep on adding on to your tasks. So now you do this, oh now you need to do this plus this, but you still work with the same amount of shifts and it's sad because the time that you have to spend with the patient, and sometimes not just to go over there and give 'em medication or push something in the IV, hang a new antibiotic, but to spend with a patient, talk to the patient, hear, learn. Sometimes it's getting smaller and smaller because they're piling on more tasks and more charting.” (HCWP3)

In this case, and others, an overwhelming workload is preventing nurses from connecting emotionally with patients which they consider an important part of the care experience. They are concerned for the quality of care for their patients but are prevented from

providing the needed care by the tasks which overload them. These care attitudes and the community of nurses as these narratives present also connect to how nurses establish their identity within their profession.

Part 2: Subjectivity

Nurses describe their concerns about “work-life balance,” but also reveal how their work and identity as nurses affects their lives directly. The following includes both full quotes and a more detailed linguistic analysis of the interview data to better understand how these interviewed nurses identified themselves within their profession by establishing their subjectivity as nurses.

(HCWP18), a nurse who lives with their elderly grandmother, described anxiety about bringing the contagion home and the potential spread to family:

> “I was very nervous. Everywhere I went, I was just nervous. What if I'm just young and strong and I have a great immune system and I'm carrying it? What if I infect somebody else?...That's my biggest fear is bringing it home to her.” (HCWP18)

Here, a personal connection to disease based in the condition of being a nurse/healthcare worker is connected to the risk this nurse poses to others. Another nurse frustratedly explained feeling disparaged and ignored:

> “We never asked to be called heroes, because I don't think we are... This is not what we signed up for, by the way. Nobody signed up to nurse during a global pandemic. But it is part of our job, so we do it because we're caregivers, and that's what we do, is we care. But nobody is caring for us, and throughout the whole pandemic, really, it feels like no one's been caring for us because we're

> the ones that nobody wants to see, because we're the plague rats. We're the ones that don't have the outlets that we need to offload our stress, and so it piles and piles and piles and piles, and you get nurses that are like, ‘Screw it, I'm leaving.’" (HCWP9)

Exemplified here and in other quotes presented in this data, nurses present their identity within their profession (their subjectivity). Many nurses like HCWP18 expressed a fear of acting as carriers of COVID-19 and bringing illness to their family. This fear connected directly to their status as nurses though many felt they either did not have a choice but to work with COVID-19 or held a moral obligation as care workers.

Many interviewees also expressed frustration with their position and identified themselves in their subjectivity when expressing their disparaged position such as HCWP9 with statements like “we do it because we're caregivers, and that's what we do.” This formation of themselves as nurses and as care workers reveals the pervasion of their profession into their lives as they connect their identity as nurses to many of the struggles which they experience. This phenomenon is discussed in more detail in a linguistic analysis of 2 interviewees below.

The data below originates from selected recorded and transcribed interviews. The first nurse in question will be referred to with the pseudonym “Nurse Jackie” and other identifying information may be changed for confidentiality.

This interaction concerned Nurse Jackie’s experiences during the COVID-19 pandemic, her thoughts and opinions, and changes she witnessed. The following quotes come from a particular segment concerning end-of-life care, training, and community attitudes. Being asked about her own experiences and concerns with her work and community, Nurse Jackie expresses her frustrations about mask-wearing in public and other protective measures:

Transcript 1

1. *I get frustrated,*
2. *I come up I'm...*
3. *Look I'm-*
4. *people call me Gestapo.*
5. *I will go to people in that*
6. *grocery store and I'll say to them*
7. *"You need to be wearing your mask."*
8. *People go or I'll call the manager and says*
9. *"You have a sign in the door that says people need to wear a mask and there are people here without a mask." "Oh who?" And I said you need to stop people at the door and say "Here's a mask for you and provide a mask if they don't have one."*
10. *And if they wanna come in they need to wear a mask.*

Nurse Jackie shows her concern and frustration as a nurse and how that comes out when not at her workplace (at local stores, online, etc). Further, her expression is shown in the expanded line 9 without pause and the formation of a non-specific figurative speech subject to which she responds with lines 7 through 9. Her concern is directed towards the actions of others about the safety of others and she presents herself as a moral authority here, but in the context of this interview is also connecting such authority to her nurse subjectivity. This subjectivity becomes apparent as Nurse Jackie presents her thoughts on further care and prevention during the COVID-19 pandemic:

Transcript 2

1. *As a healthcare worker*

2. *I tell you one thing that's frustrating...*
3. *When people don't believe*
4. *that this is spreading*
5. *and they don't understand*
6. *that*
7. *we're trying to help other people stay safe because*
8. *we cannot*
9. *saturate*
10. *the hospital...*
11. *The hospital has so many beds*
12. *and if everybody gets sick*
13. *and we don't have enough beds*
14. *What are we gonna do?*

In Transcript 1, Nurse Jackie uses the subject pronoun “I” to indicate personal experience and responsibility in the narrative, however in Transcript 2, Nurse Jackie begins to use the pronoun “we” to indicate not only communality of experience within the presented narrative but also a connection to the subjectivity of the “healthcare worker.” This identity formation here (also happening in line 1 with self-identification) points to the subject position from which Nurse Jackie presents herself (such as with HCWP9 above). Each nurse interviewed used the pronoun “we” in a similar fashion in an average of 200 instances per interview. Nurse Jackie makes the connection to nursing more explicit:

Transcript 3

1. *Let me tell you*

2. *as a nurse*
3. *and I talk to a lot*
4. *of coworkers*
5. *it's very frustrating to see people with no medical insurance who are*
6. *not denied*
7. *medical care*
8. *I believe in that*
9. *but*
10. *I don't believe that you keep on coming back*
11. *when you're not doing your part*
12. *when we release you…*
13. *You know?*
14. *So*
15. *if we tell you*
16. *you can't eat food with salt*
17. *you can't drink too much water*
18. *you can't do this*
19. *you need to take your medication*
20. *you need to watch your blood pressure you need to watch your sugar*
21. *and you go home and you do nothing and You come back again...*
22. *That's very frustrating for us…*
23. *We're not here to just fix you and fit you*
24. *It's not like a car.*
25. *You take it to the mechanic*

26. *mechanic fix*
27. *you go back and you ride again*
28. *No you have to do your part*
29. *to maintain your health*
30. *We're not just gonna keep on fixing every time you get sick*
31. *send you home and*
32. *then you come back again.*

Nurse Jackie establishes her viewpoint in lines 1 and 2 of Transcript 3 with “Let me tell you as a nurse” and goes on to detail her frustrations with patients using “we” pronouns and indirect reported speech which further tie her profession to her identity (establishing her subjectivity within nursing). The “you” pronoun use is used here to refer to the figurative patient and the “we” denotes herself and other nurses.

These narratives show how nurse subject-formation occurs throughout the life of Nurse Jackie and how she negotiates this during a complex health emergency. She recognizes herself as an identity subject “nurse” beyond simply as a profession.

Another interviewee, here dubbed “Nurse Espinosa,” demonstrates this plainly in their narrative. Nurse Espinosa identifies themself in their profession and connects it directly to their personhood, their care attitudes, and their reasoning for remaining in the profession:

Transcript 4

1. *Um…*
2. *In m-my role as a nurse*
3. *I mean that’s that’s just*

4. *A no-brainer, um…*
5. *I think I committed to take care of*
6. *to taking care of patients..*
7. *no matter what.. um*
8. *And the day I had to put*
9. *that PPE on*
10. *and go into that first room*
11. *I paused..*
12. *And, I… (sighing)*
13. *I made a decision to do this and*
14. *if I don't*
15. *who will? (Tearing up)*
16. *So*
17. *my role as a nurse*
18. *And, and*
19. *my role as a human being..*
20. *those are my main decisions.*
21. *Those.those are my factors to stay*
22. *because if I don't stay*
23. *others won't stay.*
24. *And, I have to be a role model for that*
25. *and I have to go to sleep at night*
26. *knowing that I did everything that I can do to the best of my knowledge*
27. *and..*
28. *if I abandoned that*
29. *I don't think I'd be able to live with myself.*

Nurse Espinosa presents themself “as a nurse” establishing their subjectivity in lines 2 and 17 and also connecting this to their humanity in line 19. In connecting themself to their work and the importance it held for them, Nurse Espinosa is emotively showing a sense of personal importance in their identity as a nurse. Their subjectivity as a nurse is further exemplified in lines 5, 6, and 24 through 29 where they connect their care attitudes with their identification within their profession and further make a value statement about their role as a model for others in remaining not only within that identity, but centered within a care-oriented value system.

CHAPTER V: DISCUSSION

Neoliberalized "Work-Life Balance" and Burnout

These nurses exemplified in their narratives many of the ways their experiences have been shaped by neoliberalized concepts and structures. The COVID-19 pandemic brought on many struggles which they faced under the changing provisions set out by organizations which are revealed to hold private interests and which prioritize self-enterprise and personal responsibility over corporate or systemic responsibilities and policies.

These narratives exemplify the challenges and adversity which nurses experienced and how these issues were inflamed by the effects of the COVID-19 pandemic. Increased workloads and responsibilities, community ostracization and ignorance, and a lack of appropriate resources or recognition have contributed to the disparaging experiences which these nurses display.

One idea of concern here is that of a "work-life balance." The concept of "work-life balance" necessitates this artificial separation of the self at one's "work" and the self within one's "life" and stipulates that such boundaries, the associated self-care, and the balancing act invoked within are (and should be) maintained by the self-empowered individual (in this case, the nurse). Such an artificial separation suggests that the worker becomes separated from all experiences and intrusions of their job upon entering the "life" context and exempts the employer from responsibility in the experience of burnout or intrusive stress resulting from improper "work-life balance." The individual may tend to this separation by manipulating circumstances towards a healthy living context (such as with self-care and "work-life balance"), but one's "work" is often conceptualized as out of the control of the individual. Therefore, the maintenance of this "work-life balance" usually falls within changing circumstances outside of the nurses' work in order to accommodate the stress and demands of the work.

The narratives of these nurses reveal the artificiality of this separation and problematize its usefulness as a conceptual framework. They described stress associated with work involving patients, resource limitations, and colleague relations. They also described stress associated with family/friend connections, community attitudes and reactions, and mental health struggles. These concerns were understood to be resulting from organizational structures, bureaucracy, and a lack of proper support (from community, government, or personal relationships), but were often accompanied by a framework that allied a lack of personal ability to address their issues. These data suggest that the nurses have been indoctrinated with the "work-life balance" narrative, speaking on it in their experiences, but also giving details on how the stress from their work, their status as nurses, and the commitments required for their work would impact their lives.

This "work-life balance" was referenced in their narratives while indicating a lack of personal efficacy to address the issues which they had associated with superficial structures. This concept is problematic in that its construction (and thus strategies employed to maintain it) takes a *neoliberal* approach by employing that the lack thereof is something which comes from a personal lack of coping ability and personal management (highlighting personal agency and detracting from systemic issues) and which must be addressed by proper self-care and personal responsibility. Such a neoliberal formation places the responsibility for managing stressors associated with the workload and the pandemic onto these nurses (thus drawing attention away from structural change). Because of their status as nurses and because of the pandemic, many nurses are unable to escape the impact of their work on their lives outside of their hospitals where many of the activities are unavailable or dangerous during the pandemic.

Understanding the neoliberalized "work-life balance" concept also requires understanding the effects of this concept on its subjects (here, frontline COVID-19 nurses). Research has found that healthcare workers experiencing burnout can suffer long-term mental

health issues that can negatively impact patient care (Bridgeman, Bridgeman, and Barone 2018). This burnout concept comes under scrutiny, though, by Hoffarth (2017) in its reframing towards a discourse of self-care and self-management. There is a limited, but growing body of literature that critiques burnout as attributed to neoliberalism (Mueller and Morley 2020) and which can be identified in the historical framing by Hoffarth (2017) and the narratives found among healthcare workers during COVID-19 (San Juan et al. 2021; Vizheh et al. 2020). Here, burnout is framed as an experience of the individual resulting from excessive work or otherwise a lack of "work-life balance." This framing institutes a neoliberalized understanding of the experience of burnout by labeling it as individually focused and therefore the responsibility of the individual to address. Further, this burnout concept has been scrutinized for its confinement to the workplace context or as something which exists only in relation to work and without consideration for circumstances, influence, or other stressors from outside of the workplace (Bianchi, Schonfeld, and Laurent 2019; Gauche, de Beer, and Brink 2017). As these nurses express burnout, many situate the burnout within their workplace but do not connect their narrative about stressors outside of the workplace directly to their experience of burnout. The narratives from COVID nurses reveal the interplay between their work and non-work activities as well as how these lines become blurred through their identity as "nurses" and through their expressions of their experiences involving interloping aspects of their lives.

Through these neoliberal constructions of burnout and "work-life balance," the resources provided to nurses for coping with the stress associated with the pandemic and the work they perform are intrinsic representations of the personal responsibility to address said burnout and maintain said "balance." Such constructions lead to a lack of attention to structural and organizational issues which underlie the issues confronted by nurses during the pandemic. Such issues include ineffective intercommunication between stages of hospital hierarchy, the systemic devaluation of nursing and nurses, the impact of identification as nurses on the social

lives of nurses, the emotional trauma associated with primary care work, and a lack of cultural understanding of the hospital and its structures/history.

Neoliberal language and structures allow for this ignorance and lead to perpetuated and even worsened experiences of burnout and stress. Throughout the pandemic, these experiences have become amplified and brought forth a need for attention to the underlying causes of these disparate experiences and burnout narrativized by frontline COVID-19 nurses. This neoliberalization is further capitulated within the subject formation that nurses present in their narratives in that, when identifying oneself within their profession, the separation of that work-self and a life-self dissolves.

Subjectivity, Performativity, and Gender

Nurses also experienced significant stress and complications because of their subjectivity (their identification with their profession) which complicated their lives outside of the workplace (within the conceptual “life”) and were unavoidable. This subjectivity pervades the lives of these nurses in identifying them not only to the community as nurses, but also to themselves as this identity, and leads to stressors such as those associated with community rejection, the ability to connect with family/friends, and their self-conceptions in the context of the pandemic. The lived experience of being a “nurse” brings with it concerns around the spread of disease which limits contact with others and entering public spaces. This also further challenges the concept of a “work-life balance” whereby the very identity of nurses with their work directly affects their conceptualized “lives.” This disconnect from dominant narratives creates a contention that further impacts the lived experiences of nurses and especially their ability to maintain coping mechanisms.

The pandemic brought on many fears for these nurses for their own personal safety and well-being, that of their personal social circles, as well as for their patients and coworkers. They exemplified in these narratives intrinsic care attitudes and personal moral concerns for the care

of others. They exemplified both a willingness to commit self-sacrifice as well as frustration with lack of autonomy to choose risk. These characteristics bear a resemblance to gendered constructions of women as self-sacrificing, subservient (to patriarchal or neoliberal/capitalist systems), passive, sensitive to the experiences of others, and nurturing. I argue here that this identification of nurses within their professions is closely interrelated with the experience of gender performativity as Judith Butler theorizes (1990).

Like with subjectivity, performativity posits that individuals identify themselves within a gendered construction, but also actually create that constructed gender in the repeated stylized acts which are learned and associated with that gender. Similarly, these nurses are identifying within their profession, a socially constructed norm of what it is to experience and be a nurse, and in that act are creating that structure. This is capitulated by the ways in which nurses identify as care-centric individuals in their professions and identify personal ways in which they connect their identity to being a nurse.

This connection of the narratives here, the characteristics associated with nursing (a gendered profession), and socially constructed gender characteristics underscores the significance of the social position of these nurses as well as the connection of performative gender and the subjectivity claimed by nurses in these narratives. Nursing as a profession has been associated with women as long as it has been a profession, but also associated with the majority of care work within healthcare settings and historically underpaid. Nurses perform the majority of hands-on tasks with patients and day-to-day labor, but are regarded as near the lowest level of their workplace hierarchy and receive disproportionately lower compensation or dispensation in the case of personal welfare.

Gender, Devalued Nurses, and Neoliberal Feminism

Several nurses here expressed frustration towards colleagues and their administration for their disproportionate power in deciding their risk in coming into contact with patients. Several narrativized that doctors, therapists, and even maintenance staff held the ability to avert COVID-designated rooms and floors before nurses had a say. This attitude reflects a disregard for the well-being of nurses as well as a systematized undervaluing of nurses as individuals. As administrative practices prioritized the concerns of non-nursing staff and engineered primary responsibility, caretaking, and thus risk associated with COVID patients to nursing staff, this gave the implicit and understood idea that nurse well-being and safety was of a lower priority. The undervaluing of nurses as primary care providers is further capitulated in the addition of work to their daily duties and the absence of hazard pay or other relative increases in pay. Nurses described performing procedures such as lab draws and therapies outside of their usual scope of practice due to the absence of doctors and respiratory therapists on their wards. Importantly, some of the interviewed nurses did express that their fellow hospital staff did in fact continue to provide care and support them during the outbreak, however, a majority of interviewees had experienced otherwise.

This systematic devaluation of nurses follows a pattern of devaluation of female/women-dominated fields, contributing to the well-cited gender wage gap as well as other gender-based discriminations. The systemic issues associated with the experience of women-identifying workers have often been left out of or unregarded by neoliberal feminist conversations (as Rottenberg (2014) notes). As neoliberal feminists regard such issues as resolvable by the individual through self-care, self-enterprise, and *leaning in*, as Sheryl Sandberg (2013) purports, they simultaneously silence and perpetuate the systemic and bureaucratic structures which disparage women in the workplace. This is done by calling attention away from systems that devalue women-associated work and education and which disregard inequities in childcare,

health-related issues, and implicit/explicit discrimination, and instead placing the responsibility for overcoming such inequity on the self-enterprising individual (as neoliberal systems/proponents do).

Nursing as a profession that has been systematically devalued is an effective example of how systemic discrimination against women-identifying persons is built into bureaucratic and neoliberal systems. Nurses perform the majority of care-related tasks (as women in the US have been historically expected to do), yet they receive a significantly lower salary than their healthcare counterparts. They are given the greater burden of risk and work (especially during health emergencies) and receive little comparable compensation. Their concerns seemingly go unaddressed as they have little choice in their assignments and their personal support systems are lessened by the pandemic. Further, the nurses interviewed here have been expected to manage the difficult circumstances and burnout through their own self-care, perpetuating the neoliberalized narrative of practicing effective “work-life balance” and having both be severely strained by their status as nurses. They recognize that such ability to overcome their circumstances has been systematically taken from them and that they have little other choice, often quoting a great care for their patients and coworkers as reason for staying if they do.

CHAPTER VI: CONCLUSION

Narratives of frontline COVID-19 nurses revealed a changing and stressful set of circumstances which uniquely impacted nurses. They expressed fears of exposure to the pandemic-causing disease, a concern for the welfare of loved ones, coworkers, and patients, increased workload, discriminatory hospital practices, frustration with lack of participation of other care workers, increased burnout, and a diminished ability to practice self care. These narratives also revealed the ways in which conceptions of “burnout” and “work-life balance” were situated in a neoliberal formation of self-enterprise and self-care and which became problematic for the experiences of these nurses. This is further capitulated in the ways in which

nurses establish their subjectivity within their profession and how this subject-identity formation is connected to gendered formations of nursing. The neoliberal approaches to mental health for this women-dominated field were revealed to perpetuate the systemic issues which create disparate and difficult circumstances for these nurses. By creating room for the conversation around systemic change and diluting the neoliberal narrative, future nurses might benefit from a reformation of the structures, ideas, and institutions which have historically discriminated and disparaged their profession and its practitioners.

This research contributed to understandings of the experiences and struggles which nurses face, utilizing narratives during a novel pandemic to show how the issues they face worsened in the context of a novel pandemic, and revealing neoliberalized structures/concepts and gender-based discriminatory practices and subjectivities which convolute nurses' lived experiences. Future research might expand on this to incorporate cross-hierarchical perspectives (such as administrators and doctors), racial and other background/position-based disparities, and non-hospital-based nurse perspectives. Questions into the efficacy and impact of hospital hierarchies and the potential for structural changes which would counteract the neoliberal nature of these institutions should be considered in future research.

REFERENCES

Alharbi, J., Jackson, D., & Usher, K. (2020). The potential for COVID-19 to contribute to compassion fatigue in critical care nurses. *Journal of Clinical Nursing*.

Banet-Weiser, S., Gill, R., & Rottenberg, C. (2020). Postfeminism, popular feminism and neoliberal feminism? Sarah Banet-Weiser, Rosalind Gill and Catherine Rottenberg in conversation. *Feminist Theory*, *21*(1), 3-24.

de Beauvoir, S. (1989). *Le deuxième sexe*. Vintage.

Beebe, J. (1995). Basic concepts and techniques of rapid appraisal. *Human Organization*, *54*(1), 42-49.

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2019). Burnout: Moving beyond the status quo. *International journal of stress management*, *26*(1), 36.

Brice, J. & Andrews, D. (2019). *SheBelieves*, but does she? Complicating white women's understandings of the postfeminist-neoliberal empowerment discourse. *Leisure Sciences* 41:1-2, pages 127-144.

Bridgeman, P.J., Bridgeman, M.B., & Barone, J. (2018). Burnout syndrome among healthcare professionals. *Am J Health Syst Pharm.* 2018 Feb 1;75(3):147-152. doi: 10.2146/ajhp170460. Epub 2017 Nov 28. PMID: 29183877

Bromley, V. (2012). *Feminisms Matter*. University of Toronto.

Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge. ISBN 978-0-415-38955-6.

Butler, J. (1991). Imitation and gender insubordination. In Fuss, Diana (ed.), *Inside/out: lesbian theories, gay theories.* New York: Routledge. ISBN 978-0-415-90237-3.

Caro, L., Robbins, J., Freidus, A. (2021). Burnout Among COVID-19 Nurses. [Unpublished journal article].

CDC. (2022). Center for Disease Control. www.cdc.gov

Cottingham, M. D., & Dill, J. S. (2019). Intergenerational dynamics among women and men in nursing. In *Gender, Age and Inequality in the Professions: Exploring the Disordering, Disruptive and Chaotic Properties of Communication* (pp. 58-75). Taylor and Francis Inc..

Dill, J., Erickson, R. J., & Diefendorff, J. M. (2016). Motivation in caring labor: Implications for the well-being and employment outcomes of nurses. *Social Science & Medicine*, *167*, 99-106.

Dzau, V. J., Kirch, D., & Nasca, T. (2020). Preventing a parallel pandemic—a national strategy to protect clinicians' well-being. *New England Journal of Medicine*, *383*(6), 513-515.

Egenes, K. J. (2009). History of nursing. In G. Roux & J. A. Halstead (Eds.), *Issues and trends in nursing: Essential knowledge for today and tomorrow* (pp. 1–26). Sudbury, MA: Jones & Bartlett.

Evans, J. (2004). Men nurses: A historical and feminist perspective. *Journal of advanced nursing*, 47(3), 321-328.

Ferguson, J. (2009). The Uses of Neoliberalism. *Antipode* 41 (1): 166-184.

Foth, T., Lange, J., & Smith, K. (2018). Nursing history as philosophy—towards a critical history of nursing. *Nursing Philosophy*, 19(3), e12210.

Foucault, M., and Michel Senellart. (2008). The Birth of Biopolitics: Lectures at the Collège de France, 1978-1979. *Basingstoke, England: Palgrave Macmillan*.

Ganti, T. (2014). Neoliberalism. *Annual Review of Anthropology*, *43*, 89-104.

Gauche, C., de Beer, L. T., & Brink, L. (2017). Managing employee well-being: A qualitative study exploring job and personal resources of at-risk employees. *SA Journal of Human Resource Management*, *15*, 13.

Green, J., & Thorogood, N. (2013). *Qualitative methods for health research*. Sage Publications.

Gupta, K. (2020). *Medical Entanglements.* Rutgers University Press.

Harvey, D. (2007). *A brief history of neoliberalism*. Oxford University Press, USA.

Hoffarth, M. J. (2017). The making of burnout: From social change to self-awareness in the postwar United States, 1970–82. *History of the Human Sciences*, *30*(5), 30-45.

Hoffman, M. & Cowan, R. (2008). The Meaning of Work/Life: A Corporate Ideology of Work/Life Balance, *Communication Quarterly*, 56:3, 227-246, DOI:10.1080/01463370802251053

hooks, b. (1984). *Feminist theory: From margin to center*. South End Press.

Husso, M., & Hirvonen, H. (2012). Gendered Agency and Emotions in the Field of Care Work. *Gender, Work and Organization* 19(1): 29-51. doi.org/10.1111/j.1468-0432.2011.00565.x

Imai, H., Matsuishi, K., Ito, A., Mouri, N., Kitamura, N., Akimoto, K., Mino, K., Kawazoe, A., Isobe, M., Takamiya, S., & Mita, T. (2010). Factors associated with motivation and hesitation to work among health professionals during a public crisis: a cross sectional study of hospital workers in Japan during the pandemic (H1N1) 2009. *Public Health*, 10(672), 1-8.

Jackson, B. (2021). Putting Neoliberalism in Its Place. *Modern Intellectual History*, 1-14. doi:10.1017/S1479244321000032

Johnson, G. A., & Vindrola-Padros, C. (2017). Rapid qualitative research methods during complex health emergencies: a systematic review of the literature. *Social Science & Medicine*, *189*, 63-75.

Khasne, R. W., Bhagyashree S. D., Hitendra C. Mahajan, & Kulkarni, A. (2020). Burnout among Healthcare Workers during COVID-19 Pandemic in India: Results of a Questionnaire-based Survey. *Indian Journal of Critical Care Medicine* 24(8):664-671.

Lasater, K. B., Aiken, L. H., Sloane, D. M., French, R., Martin, B., Reneau, K., ... & McHugh, M. D. (2021). Chronic hospital nurse understaffing meets COVID-19: an observational study. *BMJ Quality & Safety*, *30*(8), 639-647.

Lewontin, R. C., Rose, S., & Kamin, L. J. (1984). *Not in our genes*. New York: Pantheon Books.

Malach-Pines, A. (2000). Nurses' burnout: An existential psychodynamic perspective. *Journal of Psychosocial Nursing & Mental Health Services* 38, no. 2; ProQuest Central. 23

McMahon, S. A., Ho, L. S., Brown, H., Miller, L., Ansumana, R., & Kennedy, C. E. (2016). Healthcare providers on the frontlines: a qualitative investigation of the social and emotional impact of delivering health services during Sierra Leone's Ebola epidemic. *Health Policy and Planning*, *31*(9), 1232-1239.

Morningstar, N. (2020). Neoliberalism. In *Cambridge Encyclopedia of Anthropology*. University of Cambridge. http://doi.org/10.29164/20neolib

Nash, M. & Moore R. (2019). 'I was completely oblivious to gender': an exploration of how women in STEMM navigate leadership in a neoliberal, post-feminist context. *Journal of Gender Studies* 28:4, pp. 449-461.

Nickell, L. A., Crighton, E. J., Tracy, C. S., Al-Enazy, H., Bolaji, Y., Hanjrah, S., Hussain, A., Makhlouf, S., & Upshur, R. E. (2004). Psychosocial effects of SARS on hospital staff: survey of a large tertiary care institution. *Cmaj*, *170*(5), 793-798.

Oliver, N. (2018). The History of Nursing. In B. Scott & M. Thompson, *Transitioning from RN to MSN: Principles of Professional Role Development*. Springer Publishing. pp. 1-22. doi: 10.1891/9780826138071.0001

Reith, T. P. (2018). Burnout in United States Healthcare Professionals: A Narrative Review. *Cureus* vol. 10,12 e3681., doi:10.7759/cureus.3681

Robbins, J. and Andrea Freidus and Lennin Caro. (2021, August). The importance of community in the experiences of frontline nurses in North Carolina during COVID 19. *SFAA Newsletter.* 32(3)

Rottenberg, C. (2014). The rise of neoliberal feminism. *Cultural studies*, *28*(3), 418-437.

RREAL. (2021). Home. https://www.rapidresearchandevaluation.com

Sakellariou, D., & Rotarou, E. S. (2017). The effects of neoliberal policies on access to healthcare for people with disabilities. *International journal for equity in health*, *16*(1), 1-8.

San Juan, V. N., Aceituno, D., Djellouli N., Sumray, K., Regenold, N., Syversen, N., Symmons, S. M., Dowrick, A., Mitchinson, L., Singleton, G., Vindrola-Padros, C. (2021). Mental Health and Well-Being of Healthcare Workers during the COVID-19 Pandemic in the UK: Contrasting Guidelines with Experiences in Practice. *BJPsych Open* 7, no. 1: e15. doi:10.1192/bjo.2020.148.

Sandberg, S. (2013). *Lean In: Women, Work, and the Will to Lead.* Alfred A. Knopf.

Sauer, L. M. (2021). *What is Coronavirus?*. Johns Hopkins Medicine. https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus

Schiwy, F. (2007). Decolonization and the question of subjectivity: Gender, race, and binary thinking. *Cultural studies*, *21*(2-3), 271-294.

Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., & West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. In *Mayo clinic proceedings* (Vol. 90, No. 12, pp. 1600-1613). Elsevier.

Shreffler, J., Petrey, J., & Huecker, M. (2020). The impact of COVID-19 on healthcare worker wellness: A scoping review. *Western Journal of Emergency Medicine*, *21*(5), 1059.

Sjöstrand, S. (2019). *The Rise of Neoliberal Feminism*. Feminist Media Studies. 19:3, pp. 460-462.

Snee, H., White, P., & Cox, N. (2020). 'Creating a modern nursing workforce': nursing education reform in the neoliberal social imaginary. *British Journal of Sociology of Education*, *42*(2), 229-244.

Stapelberg, M. M. (2015). *Through the darkness: glimpses into the history of western medicine*. Crux Publishing Ltd.

Vizheh, M., Qorbani, M., Arzaghi, S. M., Muhidin, S., Javanmard, Z., & Esmaeili, M. (2020). "The mental health of healthcare workers in the COVID-19 pandemic: A systematic review." *Journal of Diabetes & Metabolic Disorders* 19(2):1967-1978.

Waterhouse, B. (2017). *The land of enterprise: a business history of the united states.* Simon and Schuster Inc.

WHO. (2022). WHO Coronavirus (COVID-19) Dashboard. https://covid19.who.int/

Wittig, M. (1992). *The straight mind and other essays*. Beacon Press.

Wrede, S. (2010). Nursing: Globalization of a female-gendered profession. In *The Palgrave handbook of gender and healthcare* (pp. 437-453). Palgrave Macmillan, London.

Wynter, S. (2003) *Unsettling the Coloniality of Being/Power/Truth/Freedom: Towards the Human, After Man, Its Overrepresentation – An Argument.* CR: The New Centennial Review

APPENDIX A: INTERVIEW GUIDE

UNC CHARLOTTE
Department of Anthropology
9201 University City Boulevard, Charlotte, NC 28223-0001

INTERVIEW GUIDE: HEALTHCARE WORKERS (HCWs)

Participant Demographics

Gender:
Age:
Education Level:
Role/Position:
Time in position:
Sector, brief description of facility

First, I want to ask about your work and the services you provide (Not COVID-19 specific)

1) **Background**
- Can you tell me about your role?
- Please briefly describe your normal daily tasks/responsibilities

Now I want to ask you about health services during COVID-19 outbreak

2) **Have you been in contact with COVID-19+ patients? Yes/No**

Probes:
- If so, in what capacity?
- Right now, approximately how many Covid -19 patients are being treated in your facility?
- Are you afraid of being infected – why?
- What psychological/emotional impact, if any, does working during this outbreak have on you?

3) **How has the COVID-19 outbreak affected health services in your department?**
4) **And your personal ability to do your job?**

Probes:
- Affected your normal daily tasks/responsibilities
- On the delivery of services to **non-COVID-19+ patients**
- What tasks are you able to do more or less effectively
- How do you manage the **isolation** of suspected and confirmed
- Has there been appropriate **transfer of patients** within and out of your facility (Explain the process)
- Has there been an impact on staff's ability to **make diagnoses** and act on them
- Adequate supply of drugs, equipment and **PPE (explain)**
- **Redeployment of staff**
- Reports suggest that **end of life care** as well as **palliative care** changed because of this pandemic.

- Do you have any experiences with end of life care in relation to the pandemic? Can you describe them and explain what has been different under pandemic circumstances?
- Do you have any experiences with palliative care in relation to the pandemic? Can you describe them and explain what has been different under pandemic circumstances?

- **Motivation** and capacity for (you) staff to work (probe: exhaustion, fear, anger etc.)
- **Psychosocial and moral support** – did they(you) receive any? Enough?

5) What were/are the preparedness strategies implemented by the hospital

Probes:

- Did you feel these strategies were enough/successful
- Did you receive any **training**? Explain.
  Sufficient - PPE training such as mental health and well-being training
- *?*

6) What are your thoughts/concerns about the pandemic? (in addition to x,y.z)

- Work
- Your personal life (personal health, family, responsibilities)
- The national effort
- The state effort
- The local (community) effort

7) How has it personally impacted your life **probe for mental health issues/stress

a. **Mental health support (to address risk of moral injury, trauma and developing severe mental health problems) and coping**

8) How could health services or the provision of care during this time or in future emergencies be improved?

Probes:

- Support to HCWs? From whom and How?
- Coordination and official guidance of COVID-19 response.
- Early detection and reporting.
- On-going health promotion and community education. E.g. potential sources of infection, safe practice?
- Mobilisation? E.g. identifying and coordinating trusted community volunteers and support?
- Disease outbreak control activities?
- Testing (public and staff)

9) What main factors influence your decision to stay in the HC workforce?

10) What factors would contribute to your deciding to leave the HC workforce?

11) Is there anything else you would like to mention that you feel is important?

Thank you for your time and for sharing your opinions and experiences with us.

APPENDIX B: FLYER

APPENDIX C: CONSENT FORM

UNC CHARLOTTE
Department of Anthropology
9201 University City Boulevard, Charlotte, NC 28223-0001

Consent to be Part of a Research Study

Title of the Project: A Rapid Appraisal of U.S. Healthcare Workers' Perceptions of Care Delivery in the Context of the COVID-19 Pandemic

Principal Investigator: Andrea Freidus, PhD, MPH, University of North Carolina at Charlotte
Co-investigator: Christin Wolf, Graduate MA/MPH student, University of North Carolina at Charlotte

You are invited to participate in a research study. Participation in this research study is voluntary. The information provided is to help you decide whether or not to participate. If you have any questions, please ask.

Important Information You Need to Know

- The purpose of this study is to provide a rapid appraisal that will explore healthcare workers' (HCWs) perceptions and experiences of responding to the COVID-19 epidemic in the United States.
- You will be asked to participate in a 30-45min telephone or zoom interview.
- The only foreseeable risk associated with this study is the potential for distress when discussing working with patients under a stressful situation. Benefits from this study may include assisting researchers and policymakers in understanding how to respond to the current COVID-19 epidemic and how to plan for future outbreaks.
- At the end of the interview, we will ask you to pass along the principle investigators contact information and project information sheet to up to 5 other emergency room providers or staff at any hospital across the U.S. that might be interested in participating. This is NOT a requirement to participate, but a voluntary action to help recruit additional participants.

Please read this form and ask any questions you may have before you decide whether to participate in this research study.

Why are we doing this study?

The purpose of this study is to explore the perceptions of emergency room providers and staff in relation to COVID-19 and their experiences treating infected and potentially infected patients. We are also examining emergency room providers and staff perceptions and experiences in relation to the suitability of care delivery models and infrastructure to deal with the epidemic.

Why are you being asked to be in this research study?

You are being asked to be in this study because you are an emergency room healthcare provider or emergency room staff that works in a hospital in the United States during the COVID-19 pandemic.

What will happen if I take part in this study?

The participant information sheet (already provided) and consent form will be provided in advance of your being interviewed, and with sufficient time to be able to ask any questions that you may have. Having had your questions answered satisfactorily, you will be asked to sign this consent form, scan it or take a photo of the signed form and email it back to the researchers before the interview. If you are unable to print and scan this document back, we will ask for a verbal consent. After reviewing the informed consent together over the phone and after having answered any questions you might have, the interviewee will ask for you to verbally agree or disagree to participate in the

study. In addition, you will be asked to verbally agree or disagree to be audio recorded. The interview will be voluntary, conducted over the phone or zoom, and will last approximately 30-45 minutes. During the interview we will ask you questions about your perceptions of the virus and the strategies currently being developed within your hospital to respond to the epidemic. We will take notes during the interview and also request to be audio/video-recorded to ensure the most comprehensive accounting of your experiences. There will be NO identifying information associated with the recording or the transcription. All information gathered will be treated as confidential by the study personnel and will be anonymous for analysis.

You time commitment will be about 45 minutes.

What benefits might I experience?

Benefits may include assisting researchers and policymakers in understanding how to respond to the current COVID-19 epidemic and plan for future outbreaks. There will be no direct benefit to you from participating in this study.

What risks might I experience?

Risks or discomforts from this research are very limited as this is a low risk study and all information will be kept confidential unless we learn of serious risk to patients or staff from the information disclosed.

How will my information be protected?

Information you provide about your experiences and opinions will be documented, but your name will not be recorded or used in any reports of the information provided. The information obtained from the interview will be stored in the University's password protected google folders. In the case of phone interviews, we will need to collect phone numbers, store them in a password protected file and then delete them after we have carried out the interview. We will ensure that any personal information gathered for this research study is kept confidential unless we learn of serious risk to patients or staff from the information disclosed.

We plan to publish the results of this study. To protect your privacy we will present all of the data in aggregate form from hospitals across the U.S. to avoid the potentially for inadvertently revealing any personally identifiable information. The results will be analyzed and written up for publication in scientific journals and for presentation at conferences. All information gathered will not be traceable to you or your hospital.

Other people may need to see the information we collect about you which is limited to agencies as required by law or allowed by federal regulations.

How will my information be used after the study is over?

We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The UNCC team will keep identifiable information about you only until the interview has been completed. It will then be deleted. Copies of the informed consent will be maintained for three years as required by law, but not storied with the data we collect. Your rights to access, change, or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. You can find out more about how we use your information by contacting the study team (contact information can be found at the end of this document).

After this interview is complete, identifiers will be removed from the data/information and the data/information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent.

Will I receive an incentive for taking part in this study?

There will be no direct benefit to you from participating in this study.

What are the costs of taking part in this study?
There are no costs to you for taking part in this study.

What other choices do I have if I don't take part in this study?
Taking part in this study is your choice. You may choose either to take part or not to take part in the study. No matter what decision you make, there will be no consequences to you in any way.

What are my rights if I take part in this study?
It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer.

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you may have experienced due to your participation in the research, please contact the research team. UNCC complaints mechanisms may also be available to you.

Who can answer my questions about this study and my rights as a participant?
For questions about this research, you may contact Dr. Andrea Freidus at afreidus@uncc.edu or 813-892-4457.

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Office of Research Compliance at 704-687-1871 or uncc-irb@uncc.edu.

Consent to Participate

By verbally saying 'yes', you are agreeing to be in this study. Make sure you understand what the study is about before you agree. Feel free to ask me any additional questions you may have. You will receive a copy of this document for your records. If you have any questions about the study after you verbally agree, you can contact the study team using the information provided above.

Do you verbally agree to take part in this study?

_____
Participant's Name (PRINT)

_____
Participant's Answer Date

_____
Name and Signature of person obtaining consent Date

Consent to be audio recorded

To assist with accurate recording of participant responses, interviews may be audio recorded [*explain if names will not be used during recording*].
Participants have the right to refuse to allow such recording without penalty. Do you consent to being audio recorded?

Participant's Answer: Yes/No (circle one)

Consent to be video recorded

To assist with accurate recording of participant responses, interviews may be audio recorded [*names will not be used during recording*].
Participants have the right to refuse to allow such recording without penalty. Do you consent to being video recorded?

Participant's Answer: Yes/No (circle one)

_____

Name and Signature of person obtaining consent Date