Help wanted: a female caregiver to the rescue: The female nurses of exclusive duty in Greece: a remote research with a feminist approach

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The female nurses of exclusive duty in Greece:

a remote research with a feminist approach

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Abstract

The inefficiencies of the Greek healthcare system, the trafficking networks and the fact that the majority of the nurses of exclusive duty are women and immigrants, challenge the validation of their skills, position and contribution to the society. Drawing on three months of remote ethnographic research with Greek and immigrant nurses of exclusive duty, this study examines their practical and emotional challenges, and their perceptions of their caregiving role adding the connection with the gender stereotypes on care and the social inequalities. The resulting thesis comprises a written text and an ethnographic film. The text offers a reflection on methodological issues and critically explores how my conceptual framework connects with my research findings, while the ethnographic film focuses upon the subjective experiences and the emotions of three nurses of exclusive duty and juxtaposes theirs with my own experiences as a granddaughter of grandparents that were taken care of by a 'stranger'. My key research finding is that the precarity of this profession, the stereotype of women as 'natural' caregivers, the inequalities because of ethnicity and socio-economical status and the consequent crossing of the personal/professional boundaries impact their physical and mental health since they supplement the challenges of this job. The nurses constantly try to negotiate their position and prove their value to the society while working without governmental provision and support. Thus, I argue that their gender, ethical positions, ethnicity and socio-economical status affect the perceptions of their caregiving role and identity.

Keywords: visual ethnography, remote ethnography, nurses of exclusive duty, caregiving, healthcare system, Greece, immigrant women, emotional labour, gender discourse, intersectionality

Contents

I. Introduction

Which connotations does the notion of care have for people? People usually think of the care receivers and their needs. They think of medicine, people unable to move, high fever, wheelchairs, and the IV drip in the hospitals' corridors. Sometimes those ideas are enhanced with romanticised images of doctors, nurses, and family caregivers running after the patients' needs with nothing but love and empathy. But what does it actually mean to give care? According to Madeleine Leininger (1991) referring to nursing, caring is important for survival, healing and dealing with illness and death. In order to deal with those challenges the nurses have to be physically and mentally strong. This requires listening to their own needs and receiving support, something that can possibly have benefits not only to their well-being but also that of their patients (Akgun-Citak et al., 2020). The Covid-19 pandemic brought many challenges to the well-being of the medical staff worldwide. With the doctors and the nurses playing a crucial role in supporting the patients emotionally and physically. However, in the case of Greece the importance of the nurses often remains invisible and undervalued (Stefou, 2021).

The discussion about caregivers in Greece brings to the forefront the contribution of family caregivers. The phenomenon of family caregiving is quite common especially when the care receivers are the older members of a family. The large number of inefficiencies in the Greek healthcare system and the fact that Greece has more doctors than nurses in the public hospitals (Lazaridis, 2007) combined with the taboo in Greek society on placing a parent in a nursing home (Katrougalos and Lazaridis, 2003, as cited in Lazaridis, 2007), has led many family members - mostly women - to assume the caregiver role for those who are sick or old in the family environment (Lazaridis, 2007; Nazou, 2005). On the other hand, as Nazou (2005) underlines, the fact that in modern Greek society women want to be educated and work outside the house has contributed to the 'feminization' of immigration. According to Kambouri (2021)[1] immigrant women 'for many years cover the lack in the healthcare system' with regards to child, elderly and domestic care. Many of those women take the position that traditionally Greek women were left behind to perform in the household and assume the stereotypical female tasks as set for them by the patriarchal social structure (Maroukis, 2018). Also, as Maroukis (2018) highlights, the economic crisis of Greece (since 2009) has seriously affected the Greek familistic welfare regime and consequently the immigrant population that lives, works, and

[1] Nelli Kambouri is a researcher at the Center for Gender Studies and Equality, Panteion University, Athens. This reference is obtained by her participation in the online event: *"How essential is health and care work during Covid 19? A discussion on Gender, Care and Labour"* organized by ProGender in 01/03/21. https://www.facebook.com/events/1043889276132753/?acontext=%7B%22event_action_history%22%3A[%7B%22surface%22%3A%22page%22%7D]%7D
ProGender is coordinated by the Centre for Gender Studies,of Panteion University in partnership with the Institute for Gender Equality and Difference – University of Iceland Reykjavik, Iceland (RIKK), the Norwegian University of Science and Technology- Trodheim (NTNU), the non-profit organisation Research and Education Collective (REC) and the social cooperative enterprise STIN PRIZA.

relies on it; this usually means payment delays, denial for health insurance and more assigned tasks without pay raise. At the same time, informal labour agreements, and cheap immigrant labour with limited (or no) work rights continue to exist and have helped the Greek family on many levels, i.e., by allowing them to continue having managerial positions or their family businesses (Maroukis, 2018).

The gap in the Greek welfare state in terms of exclusive caregiving to elderly people, and people with disabilities etc. was filled by nurses of exclusive duty (apoklistikes nosokomes in Greek), 'les infirmières exclusives' (Lazaridis, 2007) or 'sole-agent nurses' (Groutsis, 2009) or 'private duty nurses' (Fouka et al., 2013). The exclusivity means that those nurses provide care to only one patient at a time. A large number of women that are recruited as nurses of exclusive duty (e.d.) come from Albania, East Africa, Russia, Bulgaria and Romania and they came to Greece with the migratory flows of the late 1980s and early 1990s (Lazaridis, 2007). A significant number of them remains undocumented and unregistered in this job. Many of them began as caregivers and housekeepers in domestic environments before moving on to 'bank exclusive nursing'[2] in search of stability (Maroukis, 2018).

During my ethnographic research, I have detected two main categories of female nurses of exclusive duty: the registered and the unregistered. The registered ones work mainly in the hospitals recruited by the hospital's nursing department (subscribed and chosen by the official list of the department). The inclusion in a public hospital's list is a prerequisite in order for those women to be considered registered. Then some of them also choose to turn to private recruitment agencies that help them to work in other hospitals, clinics and houses for supplemental income. On the other hand, the unregistered nurses are usually undocumented immigrants. Not all of them have a nursing diploma from their country of origin. Those women work either at houses or at hospitals recruited by illegal agencies or working by themselves. Both of the categories are self-employed and self-insured. It is important to mention that some of my participants confirmed that the majority of the nurses of exclusive duty in Greece are immigrants.

Families tend to choose the unregistered nurses to take care of their loved ones, because they are cheaper for their services, even though they are aware it is illegal and many of them are there through trafficking networks (Zacharis, 2019). This fact has created discontentment from the registered nurses' side and a lot of patients; with reactions on social media and as covered in the media that often hide racist motives (Lazaridis, 2007). The last two years there are also more strict inspections in the hospitals of the nurses of exclusive duty that were recruited by agencies or through informal agreements with families and not from the hospital's lists. One tragic example of this situation is the

[2] With the term 'bank' Maroukis (2018) means the hospital list to which all the nurses of exclusive duty of this hospital are registered. 'Hospital bank exclusive nurses are self-employed nurses who are called in to provide exclusive care to a single patient under a rota system managed by the hospital's nursing department administration' (Maroukis, 2018, p.2359)

case of Gaiyé Casarzian in 2019. She was an unregistered nurse of exclusive duty from Armenia, working in a hospital in Attica, who died after falling from the window of her patient's room in order to avoid the inspection. It should be underlined that this case led to a demonstration against decisions of the Ministry of Health and the director of the Nursing Service of the hospital – with regard to the unregistered nurses - because he had given the registered (legal) nurses the responsibility to verify and prosecute the unregistered nurses of exclusive duty[3].

Drawing on visual ethnographic methods and analysis, this study aims to understand the practical and emotional challenges the nurses of exclusive duty encounter -from the instability and precarity of this profession to the crossing of the private/professional boundaries- and how the gender stereotypes on care and the socio-political context impact their perception of their professional caregiving role. With my written and audiovisual research, this work contributes to current debates and ethnographic knowledge with regard to gender stereotypes and the ethnicity of those nurses working within the Greek healthcare system. I phrased my research question as follows:

How do female nurses of exclusive duty in Greece perceive their professional caregiving role and which are the emotional and practical challenges they encounter?

To be able to answer this question, this research draws on three months of remote ethnographic research with Greek and immigrant nurses of e.d. working in different locations in Greece.

My thesis project consists of a written part which is a theoretical article and an audiovisual part which is a 30-minute ethnographic film. With the written part I reflect on methodological issues, cinematic approach, stylistic choices and critically explore how my conceptual framework connects with my research findings. By including ethnographic vignettes and examples I enhance my arguments and give more clarity to my theoretical context.

The resulting ethnographic film focuses on the subjective experiences and emotions of three nurses of exclusive duty while offering an intersection between their narrations and my personal narration as a granddaughter of grandparents who were following a gendered and stereotypical division of roles in the household and were taken care of an unregistered nurse of e.d. during the final stages of their life. Although the textual form can fill some gaps and offer me the space to critically analyse the social structures, the audiovisual form communicates directly with the audience through reflections on emotions, juxtaposes the perspectives of the nurses of e.d. and mine as a relative of family members who received care of a 'stranger' and highlights the need for social visibility and change. Together they strengthen and complement each other. With both text and film, I aim at reaching a broad

[3] https://www.efsyn.gr/ellada/koinonia/203369_kinitopoiisi-sto-yp-ergasias-gia-ton-thanato-tis-nosokomas-sti-nikaia consulted at 21/05/21

audience and create a consciousness of the challenges that those nurses have to deal with. Thus, it is important to watch the film after reading the thesis to get a fuller understanding of the context and all the layers of my research topic. In the following section I will provide my methodology and show how I (re)shaped my methodological tools because of the Covid-19 pandemic. Subsequently I will provide a vignette based on the experiences and perspectives of one of my participants with which I will introduce my concepts and my intersectional feminist approach that will be treated in the latter section to form the argument.

II. Methodological reflection

Remote ethnography and Covid-19

Due to the Covid-19 restrictions I could not travel from the Netherlands to Greece for my fieldwork. After some attempts to change my topic and adjust it to the Dutch healthcare system, I realized that my motivation for a new topic was not strong enough and that a personal meaning was hiding in my first choice. Growing up as a girl in Greek society I always had the feeling that the care for the elderly or/and the male family members is an obligation of the youngest and especially females of the family. For instance, I had to visit or keep company to my grandfather even the days that I did not feel like to because there was always the threat of the future guilt. Many times, I wondered why we 'have to' care. Is care love, a sacrifice or a 'moral obligation' (Maria Puig de la Bellacasa, 2017)? Having heard my mother's stories about how difficult physically and mentally was for her to take care of sick relatives in the past, I was wondering how much the experience of a professional differs?

Thus, by taking the decision to keep the same topic, I adjusted and extended my methodological toolkit and started to explore the affordances of remote ethnography. That led me gradually to a speech and arts-based approach to my thesis project. By delving into articles, online and offline discussions and webinars, I explored how to structure my field work and acquired knowledge towards the potentials and the challenges of those new methodological choices.

Nowadays with the progress of technology the mediated ways of the virtual world may include synchronous video call interviews -through platforms such as Zoom, Skype, Viber etc.- that succeed to come very close to a physical personal interaction (Postill, 2016; Howlett, 2020). 'The ethnography is the art of the possible' (Hannerz, 2003, p. 213), since the essence of ethnography incorporates the idea of using all the provided technological means to gain knowledge and access into our participants' lives, taking into consideration all the various parameters (Postill, 2016). Some of those parameters relate to the technological accessibility of our research group or the social dynamics in the personal

environment of our research participants that we are trying to approach through a phone or a video call (Lupton, 2020; Postill, 2016; Howlett, 2020). Furthermore, this remote approach offers potentials not only by enabling the performance of research at places that we could not have access to before, but also by promoting more collaborative and engaging ways with our participants (Howlett, 2020). There are also different perspectives and layers of knowledge provided by observing the means of communication and framing each participant chooses or the different interaction and level of trust those media can bring to the forefront.

According to Postill (2016, p.7) there is not something 'inherently inferior' in terms of legitimacy to conduct your research by not being in the same place with your interlocutors. However, I could not stop wondering if my research was legitimate since I did not follow the traditional participatory and observational methods of ethnography and since I was not there, spending time with my participants. I had also in mind that this approach carries the ethical challenges of doing 'armchair' anthropology and may take away the chance to 'immerse' myself into the field (Howlett, 2020), since I was unable to observe interactions within space, and with objects and other people outside the screen frame. Throughout the entire fieldwork period I had to deal with the frustration that was caused by constantly doubting the anthropological value of my research. Eventually, during the analysis process, the depth of conversations I had with my participants made me realize that they were authentic and honest, and perhaps even more so than they could have been in the 'real' world; considering possible uncomfortable situations at the hospitals or the nurses' houses, that could prevent my participants to open up to me. Regarding the issue of authenticity of the nondigital or predigital world, Miller & Horst (2020, p. 12) argue that face-to-face interactions are as 'framed' and 'mediated' as the digital ones, and this conclusion could be the potential contribution of digital anthropology to social sciences.

Interviewing and active listening

Although in my research proposal I was expecting the semi-structured interviews to fill in the information gaps of what will not be 'visible' in my cinematic frame, for instance my participants personal trajectories, online and phone interviewing ended up becoming my main methodology. During my fieldwork, I contacted twelve people. With eight of them I had phone call interviews and with four of them video calls (two via Zoom and two via Viber). Eight of those participants were female nurses of exclusive duty and six of them accepted to be recorded. From those six participants I managed to talk more than once with only two. I should also underline that of those participants, three live in Athens, one in Thessaloniki and two in Peloponnese.

My initial intention was to find as many people as possible, touch upon all the categories of the nurses of exclusive duty in Greece (immigrants, Greek, registered and unregistered/ illegal) and get the

perspectives of managers (in recruitment agencies), male caregivers, associations and relatives. However, during the process, I realized that it was difficult to achieve my initial goals, especially when using remote communication. I did not have many contacts in Greece in this network, and it is certainly easier for somebody to ignore an email, a text message or a phone call especially if she/he has not met the other person.

I found my participants by using my personal contacts, I sent my request to friends and former colleagues in Greece and afterwards by using the snowball sampling technique (Bryman, 2012; Isari & Pourkos, 2015) I asked my participants for contact with other nurses of exclusive duty that I could talk to. Also, I sent emails to recruitment agencies and associations of nurses and I got one answer from a private recruitment agency for nurses (*Frontida*) which led me to two of my other participants. Lastly, I got inspired by the video series of Stanford Center of Global Ethnography[4]. In one of those Christine Hine was encouraging the researchers to step out of their comfort zone and approach people via web platforms. So, I searched on LinkedIn for nurses of exclusive duty and fortunately this was the way I found one of my participants (Katerina).

The flexibility of the semi-structured interview and the fact that it enabled me to start with non-threatening generic questions (Isari & Pourkos, 2015) worked well for me in order to see the interview part as a friendly conversation which gradually and slowly unfolds its ethnographic elements (Spradley, 1979). This took some time for me to learn. My first attempts with my first two participants, L. and A., failed since I referred to our talk as an 'interview' or asked them direct questions and that demotivated them and probably scared them to continue their participation. I assume that for L. the fact that she currently does a semi-illegal job (not nursing) that she is not very proud of, played an important role; she told me that she does not wish her family in her country of origin to know about it. About A. the explanation was probably her lack of time. Part of the difficulty with finding nurses that would consent in participating is probably the fact that this kind of phone interviewing brings connotations of phone surveys and makes people constantly aware of having to answer questions in a limited time. In the end however, the phone call as well as the video call interviews were unexpectedly revealing to me. They worked as a way for me to practice my active listening and observational skills by focusing on details such as the pauses in speech, reactions to interruptions in their environment, clearer indications when they wanted to hang up or continue speaking, their material culture through their video call background, the ways they preferred to talk during the phone call (taking me on a walk around their place) or in their computer etc. Since I follow an interdisciplinary approach, active listening is a term from the field of psychology. According to the dictionary of the American Psychological Association (n.d.) active listening is 'a psychotherapeutic

[4] https://iriss.stanford.edu/doing-ethnography-remotely?fbclid=IwAR2I_xsAuzPQuoxtoH6CmIKF7H0ibvV0z1lhpGOZSc7S_LbKWo5eZLESgDo

technique in which the therapist listens to a client closely, asking questions as needed, in order to fully understand the content of the message and the depth of the client's emotion'. It is a client-centred therapy developed by Carl Rogers in the early 1940s. The basic aspects of active listening are to listen not only to the content of the speech but also the feelings in it, reflect and respond to those feelings with sensitivity and empathy and pay attention to all verbal and nonverbal cues (Rogers & Farson, 1976). In the qualitative research, 'active listening aims to deepen the interviewer's understanding of the speaker's preoccupations and interests by creating empathy and making the speaker feel well listened to' (Louw et al., 2011, p. 72). Although active listening cannot be entirely 'captured' by speech, here I use two short examples of my online interview with G.:

G: *I had panic attacks; it was awful like a short death. For so many months…*

Me: *Hmmm, I can imagine that it was very hard for you.*

[…]

G: *Yes, yes, my life has totally changed. Since last year, you cannot imagine how much it has changed. It is totally different now, it* (the psychotherapy) *made me change.*

Me: *I am so glad you feel better now.*

G: *Yes, yes*

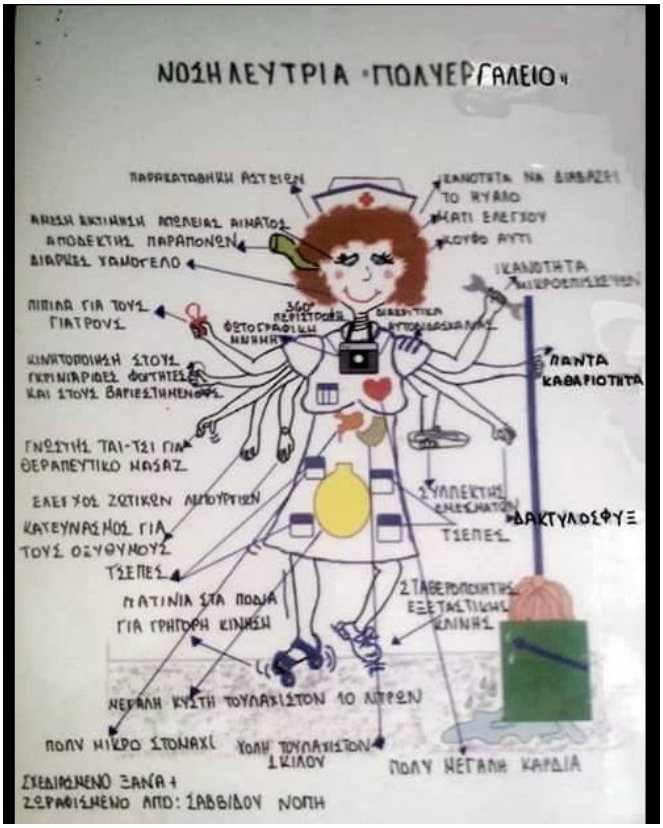
Me: *It must be really hard to have to deal with it.*

G: *Yes, because some time ago I was thinking that the important thing was to continue working. My work was the priority I could have five patients at the same period.*

Lastly, it was very important that I chose to share some personal information with the women and that they were able to check my LinkedIn page and see my face and a part of my personal space in the video call which I believe added a value of equality to the research process. Besides my willingness to answer personal questions and share my experiences, I am convinced that the fact I am a young Greek woman and of course the fact that I live in another country were factors that may have indicated that I was not 'threatening' for them to open up to. Finally, on the points that I wanted to deepen the conversation by understanding the present situation of those women, the only way that worked for me was to encourage them to share with me information about their past (in their countries), their personal trajectories and immigration stories. This 'safety' of the past (Willemse, 2014) helped this sharing process.

Online observation and discourse analysis

When I started my research, I assumed that the misunderstanding of those nurses' role and identity comes from constructed social ideas and misconceptions. Since I could not do participant observation and observe closer some societal attitudes towards those nurses, I decided to search how they are presented at social media platforms and press. I analysed the use of words that journalists use for the nurses of e.d., the Facebook posts (including photos) of public groups or pages made by nurses or nursing associations and agencies to gain insights of the way they choose to present themselves and the perspectives of other people on caregivers. The most important thing that somebody notices while searching for nurses of e.d. on the web is that the majority or all the photographs depict women and the majority of the news titles are about unregistered nurses, underlying the word 'illegal' and their ethnicity.



Drawing by Nopi Savidou

a) This is the profile photo of the Facebook page of the Union of the nurses of exclusive duty in Argos, Nafplio (Peloponnese). The title of the drawing is *Nurse as a 'Jack of all trades'*. According to the subtitles, the nurse's functions are expanded from telling jokes and calming down the angry patients to clean their vomit and hold her urine because she has no time to visit the toilet.

ΚΟΙΝΩΝΙΑ

Συνελήφθησαν 37 παράνομες αποκλειστικές νοσοκόμες

Διαμαρτυρία αποκλειστικών νοσοκόμων την Τρίτη 13 Φεβρουαρίου 2018 EUROKINISSI

b) This is the title *("37 illegal nurses of exclusive duty were arrested"*) and the photo accompanying an article[5] about 37 illegal nurses of e.d. that got arrested. The photo depicts the professional card of Greek nurses of e.d. that were used in the demonstration of the registered nurses of e.d. in Athens (February, 2018). The journalist underlines in the article that 32 of those women come from foreign countries (5 are Greek) and that their decision to work without the legal requirements results in the deprivation of income from the State and the Insurance funds without mentioning any other reason for that decision.

However, given circumstances, I decided to focus more on my participants' narratives. The analysis of my written transcriptions of the online interviews was performed by borrowing some methodological tools of discourse analysis taking into consideration the connection between social constructionism and gender identity in the use of language (Coates, 2013). My intention was not only to detect how my participants perceive their caregiving role, but also how they construct their gender identity through the comparison with men and other women in the profession. The transcriptions were particularly helpful to detect patterns, attitudes, similarities, differences etc. and observe some feelings based on my notes; I will elaborate more on the findings section. In the specific examples below I focus on the use of the pronoun '**we**' in the speech of three of my participants. I observed that they were using this pronoun even when my questions were personal. I interpret the use of '**we**' as an expression of unity, solidarity and empowerment among the nurses of exclusive duty but also as part of the structure of their gender and caregiver identity; taking into consideration that it often appears when there is a need for ethical superiority or differentiation of themselves from e.g., (male) doctors, younger nurses and nurses with no legal status.

***We** are not gods, **we** are nurses. Not doctors (laughing). The male doctors are very cold. **We** are more…more…I mean… **we** feel sorry for the patient.* (Olga)

[5] https://www.news247.gr/koinonia/synelifthisan-37-paranomes-apokleistikes-nosokomes.6622606.html consulted at 16/06/21

*Now the illegal nurses work at the hospitals without doing the corona test. If they have Covid19 they can infect the patient. I mean now that **we** are legal, **we** are safer and **we** do the test every other day.* (B.)

*But the younger nurses when they had finished the nursing school and started coming to the hospital… Eh… they were preferring them to do…not to do… because it is not a matter of studies. Since **we*** (the older nurses of exclusive duty) *had learned many things in practice, **we** were changing the serum bags, **we** were inserting catheters in order to help the regular nurses etc.* (T.)

Collaborative attempts

As I mentioned above one of the main advantages of remote ethnographic research is the encouragement for creative and collaborative ways of knowing since there is not physical presence in the field site (Howlett, 2020). Some of those ways relate to the production of audiovisual material and they may include photo/ video/ sound diaries or writings etc. I tried to encourage my participants to take photos or videos of their daily practices in or outside their work or write some descriptions of their days or express themselves with whatever medium they feel comfortable with. Although in the beginning, they were excited to do it, most of them never did; I can only assume that they did not have the time, the mood, they forgot or they were too self-conscious to share with me what they produced. I tried to explain many times what I was suggesting but again only three of my participants did it. Olga sent a picture of her mother-in-law and a short video that she was presenting herself and one of her patients, Katerina shared three of her writings and some pictures with her hobbies, cats and social media posts and Irene sent pictures of her parents-in-law house (my grandparents), that I eventually used in my film. We discussed the writings and we talked as much as possible about the pictures, however the content of those pictures was not easily and directly connected with my research topic. I consider those attempts very helpful for my participants to feel more engaged and feel that they actually contribute to the project. In the end they were also helpful to the implementation of my performative ideas for my audiovisual output. Overall, although my participants did not perform the suggested tasks and their attempts had a fragmented character, I can call this project partly collaborative since those women agreed to share their stories with me.

Incorporating poetic elements and approaching the form of an essay film

Despite the fact that my participants were not exactly filmed with a camera, I believe that the screen recording of our interviews added to the value of them sharing their experiences and also created a certain level of self-awareness in how they were presenting themselves. By watching those interviews again, I suppose that the fact they could watch themselves through their phones or computer screens during our video calls added to the aforementioned self-awareness.

The lack of actively filming with a camera in the field during the observation process does not offer enough space to reflect on the camera as a 'catalyst' for the beginning of discussions (Carta, 2015, p.4) and filming as a research method. Nevertheless, the editing process and the extra filming of my visuals were very revealing to me in terms of self-reflexivity and the anthropological value gained through aesthetics. According to Vis (2021, p.55) the approach of 'visual materials' should resemble the approach of a text; its main characteristics are intersubjectivity and context in order for the audience to enter into a 'reading' process. My main intention is to present visuals not only as connotations and interpretations but as arguments within the context of the montage. My attempts for a visually poetic and experimental ethnography meet my attempt for an essay film. Taking into consideration that self-reflexivity is the main aspect of the essay film (Corrigan, 2011), I am structuring my film with autobiographical elements through the stylistic choice of a square format camera, to give expression to my personal connotations with the narratives of the nurses, through a collage of memories of my grandparents and my experiences with them, captured in metaphoric words and images. Important part of self-reflexivity in my film is not only the inclusion of aspects of my personal story but also the use of my voice as a voice over. In the essay film the subjective voice is 'a tool to propose but not impose; to suggest but not state; to hint but not guide; to narrate while being critical of narration; to complicate, unsettle, and question' (van de Port, 2018, p.143). With the voice over I am giving parts of the interpretive context and I share my personal experience with my grandparents, their caregiving and care receiving as well as my struggles while doing this film. As Trinh T. Minh-ha argues while explaining the meaning of 'speaking nearby' my intention is not to 'objectify' (Minh–ha in Chen, 1992, p. 87) my participants and observe them from a distance but to come closer to them through my parallel story and reflections, as a woman from the same patriarchal society where they work, embracing that the 'personal is political' since 'everything can be politicized' (Minh-ha, 1989, p.2).

With my choice of the handheld Samsung handycam (with the square format) I want to: give a nostalgic sense of the time I was in Greece and my grandparents were still alive (they were receiving care by a nurse of exclusive duty); make a comment on the physical distance between me and my participants and; give a timeless character that characterizes remote ethnography as well as the experiences of those women.

My main point is to communicate something through the content and connections between the nurses stories, and my own vulnerability when relating to my grandparents, and not the technical aspects. The inspiration for the visual metaphors and their dreamy effect come from the films *News from home* (1977) and *No home movie* (2015) by Chantal Akerman (content-wise), *As I was moving ahead occasionally, I saw brief glimpses of beauty* (2000) by Jonas Mekas (form-wise), the essayistic elements basically by Chris Marker's films, especially *Sans Soleil* (1983) and Varda with her films *Uncle Yanco* (1967) and *Les glaneurs et la glaneuse* (2000). Finally, the stop motion animation inspiration and the experimentation with materials comes by *Memory objects, memory dialogues* (2013) by Grossman and Kimball.

Ethics

Throughout this ethnographic research it was always my intention to respect the sensitive information that my participants shared with me and publish only those they consented to. I protect their anonymity by not giving specific information about them and the names of those who did not want to. Thus, for some of my participants I use only the initials of changed names. I also keep their data stored on password protected external hard drives for the duration of the research. Furthermore, besides the consent and the media release forms that my participants have signed, I was informing them each time I was about to press the record button. I also explained the project as many times as needed and let them know -in written and oral form- that consent once given can be revoked. The informed consent is not just a matter of a question in the beginning of the process because in case we do not share the same background with the participants and that can possibly cause misunderstandings, but it is an issue that we should bring in all the phases of our research (Marion & Crowder, 2013) as a continuous discussion (Pink, 2013). According to Pink (2013) different contexts means different needs. The author indicates that apart from the avoidance of physical harm, ethnographers should take care of not causing anxiety to their informants by making completely clear their intentions.

Other factors that I took into serious consideration were the limited free time, the unstable work schedule and technological accessibility of my research participants. Thus, we were communicating at time and through the media that were convenient for them. For instance, Olga told me from the beginning of the research that she was not confident with the use of the smartphone or platforms such as Skype and she did not have the time to learn, this was the main reason our discussion happened via phone. T. had the same issue, but she did not have access to Internet and did not want to show her face as well.

Katerina; a vignette

Katerina, the nurse of exclusive duty from Thessaloniki was the only participant I talked with many times. The more we were discussing, the more comfortable we were feeling with each other and the more she wanted to share with me. This vignette describes our fourth and last zoom interview on the 5th of March, and we were both very excited since she wanted to read two texts she had prepared about her favourite patients. During our whole discussion like in all our other discussions, she was smiling and making jokes. Some of the topics we discussed in these two hours were about her relationship with her patients and their relatives, the relationship with her animals, how she spends her free time, the issues she has with her back and her physiotherapy sessions, the resilience of the nurses of exclusive duty compared with the regular nurses, the roles of a female caregiver and worker in general. It was obvious that she was sitting on a chair and she used her phone to talk with me. I understood it by the format of her image on my screen. I could see that she was wearing a T-shirt and she had put on some make-up. In the background I could see a colourful ironing board and a floral pillow hanging with some clothes on a cloth hanger. During our conversation I was feeling the existence of her three cats in the house because she was looking at and talking to them.

I chose to describe a part of the last minutes of the interview, because it was the most revealing part for me:

At some point I asked her why hospitals avoid sending male nurses of exclusive duty to female patients. She replied: *"At the hospitals they choose male nurses of exclusive duty for patients without consciousness or patients who have suffered a stroke. […] It is very uncomfortable when a man has to wash an older woman or a woman in general. If I was a patient myself, I would feel uncomfortable as well. For instance, at my last appointment with the physiotherapist […] I felt very uncomfortable with his movements. I do not have the proper experience… the physiotherapy I have done in the hospital was different […] I thought that I visited him only for my back and I would not have to take off my pants. It seemed weird and I wondered why and if I was overreacting."* I asked if she ever felt uncomfortable with one of her male patients and she said: *"Not with a man of my age, but with an older man I felt uncomfortable. Yes… Because he was getting handsy. And with his movements. […] I felt uncomfortable. I confronted him and I was having fights many times with men for this reason. For this inappropriate behaviour. I did not leave them but I confronted them the moment that happened. Of course, I did not leave them. […] Or if an old man does this, are you going to tell to his grandchildren and his daughter? He is an old person. It is as if you ruin his reputation […] And you do not say that. You deal with it by yourself."* When she repeated the phrase that she had to deal with it by herself there was a pause. She was all of sudden very serious and she was looking down. Although that silence was very uncomfortable for me, I believe it was a way of bonding. The strength

of this pause made me connect deeply not only with her but with my emotions too. Having experienced myself sexual harassment a few times in the past I froze. I did not know how exactly to react as a researcher or a friend or just a human being there for her. I left that pause as long as I could stand it and I asked her how she would react if she was noticing similar attitudes towards other nurses. She would speak to the patient telling him to stop.

Then, she remembered her worst case when she had to take care of a patient and stay with her at night and her two relatives decided to stay checking on her all night: *"When you hire a nurse of exclusive duty, the reason that you hire her is because you want to leave not stay with her […] That night with the two relatives was very uncomfortable. And it was very tiring because I had two people to check on me. I did not leave that case, because I have heard that other nurses of e.d. have left those kinds of cases. I stayed and it was the worst thing I have experienced in my life."* While describing that case she was very expressive, moving on her chair, moving her hands, looking up, everything was indicating how difficult it was for her. I told her that her job is so challenging and she agreed. According to her, the fact that this is a very hard job prevents Greek women from choosing it. She said:

" Only few of the nurses of e.d. I have met are Greek, most of them come from other countries etc. They chose this job out of necessity. They thought they could not do something else in Greece. It was a practical solution for the women in the past, the older women who are more than 50 years old. […] They see it as a practical solution […] I understood from the beginning that this is a physically and mentally exhausting profession. […] Most of them are immigrants […] and many of them have Greek names but they are foreigners. They have changed their names. […] Yes, there are also the ladies who stay in the patients' house to take care of the older members of the family and do some house chores. That's why there are misconceptions in Greece about this job, people tend to think that those women are nurses of e.d. […] They think that a nurse of e.d. has not finished the nursing school and comes from countries such as Georgia, Romania, Bulgaria etc. And that is true, they come from those countries. I have also met patients that do not want to hire a foreigner nurse of e.d. and they prefer only Greeks."

When she mentioned the different kinds of discrimination a female nurse of e.d. has to deal with, such as the racism and the lookism[6], I was moved by her hypothetical question:

" How should you feel if you have all those criteria in your head? Think about it. For instance, if I was an immigrant, if I was not speaking fluent Greek, if they did not want me because I was not Greek. If I had more weight. […] Isn't this attitude discriminating?"

[6] According to Merriam-Webster dictionary lookism is defined as 'prejudice or discrimination based on physical appearance and especially physical appearance believed to fall short of societal notions of beauty'.

Parts of this vignette are included in my film (00:22:17 – 00:24:28, 00:24:56 – 00:25:16).

III. Conceptual framework

Although the experiences and the perspectives that appear in the vignette presented above, belong to only one of my participants, they relate to key concepts in my discussion of their role; Care and caregiving. Secondly aspects of 'identity': gender, ethnicity and socio-economical status and finally relationship, boundaries and space.

By drawing on relevant debates in feminist anthropology and anthropology of care I discuss my concepts and comprehend the associations between those concepts and my empirical ethnographic data. My approach is not only interdisciplinary since anthropological, sociological and psychological sources are interwoven but also intersectional. The term 'intersectionality' was coined in 1989 by the civil rights advocate and scholar of critical race theory, Kimberlé Crenshaw. According to Crenshaw in her interview to Lafayette College (2015) 'intersectionality is basically that we experience life, sometimes discriminations, sometimes benefits based on a number of different identities that we have. So, the basic term came out of case that I was looking at black women who were being discriminated against not just as black people, not just as women, but as black women.' Intersectionality worked as a contribution to the fourth wave feminism as it brought to the surface the importance of all the kinds of oppression and inequality a woman has to deal with and not only because of her female identity but of all other identities as well. By perceiving intersectionality as a 'method' (Lutz, 2015) or an 'analytical tool' (Yuval-Davis, 2006) we can see the impact of the multiple 'social divisions' and their interdependent relationship within specific contexts (Yuval- Davis, 2006). Tronto (2013) highlights the importance of intersectionality by arguing that care is 'gendered' (p. 68) but at the same time gender, race/ethnicity and class are interdependent and we cannot discuss one category without referring to the others. According to Hankivsky (2014) some care theorists tend to just mention the factors of race/ethnicity and class when they examine gender issues within the care-system, without going further into the ways that those factors are interconnected and 'co-constructed' (p. 252). Although the aforementioned divisions and interconnections can be endless, in my text I chose to focus on gender and ethnicity and touch upon socioeconomical status through an intersectional feminist lens, to understand how society and the nurses themselves perceive their caregiving roles, drawing on the work of feminist care theorists such as T. Pettersen (2012) and J.Tronto (1993; 2013). Thus, my intention with this approach is to understand the specific features of their position and the experiences of the nurses of exclusive duty in Greece that are based not only on the fact that they are women -and have to deal with their patients' and Greek society's ideas of the 'natural' and sensitive caregiver – but also because they are immigrants, they are undocumented, they are unregistered, they

are poor or on the other hand they have the privilege to be Greek, registered etc. I believe this was a suitable approach for my research because I am aware of my privilege as a white, Western woman and I realize that some women are more vulnerable in society than others. This was something very clear to me while talking with my participants since all work as nurses but the various aspects of their identities affect their social experience and their perception of their caregiving role differently.

Care and caregiving

Delving into the notions of care and having deep conversations with caregivers helped me understand the different layers that are included in the caregivers' work and their physical and emotional meanings. At the same time, I acknowledge that there is not a clear definition for what 'it means to care' (Pettersen, 2012). The variety of definitions of the term 'care' can be connected with the variety of perspectives and needs. Different people have different needs, which requires different levels and roles of caregiving many times beyond physical care. So, for some cases it may be not only about caregiving practices such as feeding, cleaning, washing, lifting, organizing etc. it is also the reassurance that the caregiver is emotionally there for the care receiver.

According to Thelen (2015) care does not have a prominent position in anthropological debates and it is mainly a subject of economic and kinship studies. Thus, in order to see care practices as an important part of the social organization, Thelen (2015) suggests the conceptualization of care as a 'process with an open outcome' (p.508) by merging useful aspects of approaches on care such as Marxist, feminist approach etc. For instance, feminist scholars highlighted the emotional part of care and the role of care in identity formation (Thelen, 2015). This emotional availability in caregiving practices is derived from the stereotypical position of women in the household and society (Gray, 2010; Smith, 1992). As Gray (2010) argues 'the gender stereotype of the female carer, especially the mother figure, touches on personal and public perceptions of nursing care' (p.353) that creates not only personal but also professional expectations; the female nurses are expected to create a home and safe environment for the patient while seeing it as a part of their job. On the other hand, Henderson (2001) wonders if emotional engagement and intimacy should be automatically translated as added values to good quality caregiving whilst Gray (2010) considers the emotional labour techniques as crucial in nursing and both men and women caregivers should be encouraged to apply them.

Pettersen (2012) underlines that the equality between caregiver and care receiver should be a crucial point in the discussions about the social perspectives on care and supports the approach of *mature* care with basic features like: 'responsiveness, attentiveness, and reciprocity' (p. 374) instead of the expected -from women- *altruistic* attitude that consists of selfless actions, unconditional provision, spontaneity and compassion that can be in many cases biased and limited. According to Tronto (1993)

we should examine the care morality within a political context. While discussing the issue of self-sacrifice in the caregiving process the focus should be on the social inequalities that may lead the less powerful to sacrifice too much and not to the self-sacrifice per se (Tronto, 1993). Moreover, for Pettersen (2012) and other feminists the altruistic approach to the role of caregiver is one-sided and can easily result in gender imbalance and exploitation; issues that I will discuss further in the next sections.

Aspects of identity: Gender, ethnicity and socio-economical status

Why do women come first in our minds when we are talking about caregiving? Historically, caregiving was a part of women's roles (Revenson et.al, 2016) and it is still expected to be mainly performed by women. As Tronto (2013) critically examines, this expectation is based on ideologies relating to biological criteria and reproduction that defines what it is perceived as 'natural'. Caregiving is associated with inequality since in Western history care was considered the work of 'slaves, servants and women' (Tronto, 1993, p.21, as cited in Pettersen, 2012). These social patterns and stereotypes can be both the result and the cause of certain beliefs and attitudes about the different caregiving abilities between the two genders. Men give and receive care but in the collective unconscious, masculinity is not connected with care or at least with care of good quality (Tronto, 2013; Revenson et al., 2016). On the other side of the coin, many women perceive caregiving as an inextricable part of their role incorporating it with innate traits of being female. That makes it important for them to become 'a good caregiver' (Revenson et al., 2016, p.57) since it has become an aspect of their female and social identity.

Smith (1992) states that the gender stereotypes are especially clear within the public representations of nursing. The public translates 'alertness to the needs of the others' as the symbol of a good woman and a good nurse (Oakley, 1984, as cited in Smith, 1992). We can also add the objectification and sexualisation to those socio-political connections that Smith (1992) makes when she refers to the 'patriarchal nature of nursing's origins'. Seeing nurses as 'angels' and the emotional labour as something that women do naturally, often does not allow space for perceiving it as a professional occupation (Gray, 2010).

Furthermore, since I follow an intersectional approach, I see gender as an important aspect of the politics of care along with – in the case of the Greek healthcare system and political situation- illegal work, undocumented immigration, human and work rights, ethnicity, and class. Greece, like many countries of South Europe, is a country that accepts immigrants throughout the 20th century. After 1989 the fact that many countries changed from 'labour sources' to countries of destination coincided with the market demand of flexible work in many sections that led to a discussion about the Southern

European or Mediterranean immigration 'model' (Bettio et al., 2006, as cited in Vaiou, 2009). Women had a dominant presence in the immigration flows of 1990s to Southern Europe because of the family structural changes caused by the increased numbers of native-born women that were pursuing an education and paid jobs as well as the cutbacks in the welfare provisions (Vaiou, 2009). The immigrant women appeared mainly in domestic labour, caregiving jobs (elderly people, children etc.) and sectors of entertainment (Vaiou, 2009; Lazaridis, 2007; Maroukis, 2018). Through this 'feminization' of the immigration (Nazou, 2005; Vaiou, 2009) the immigrant women contributed to Greek women's emancipation because of the new social relations that were structured (Maroukis, 2018).

In addition to what I wrote in the introductory section as far as my research is concerned the immigrant women also covered the gaps within the Greek healthcare system (Groutsis, 2009; Lazaridis, 2007) by working as nurses of exclusive duty. Some of them mostly with undocumented presence, with or without nursing diplomas and recruited by agencies – some under trafficking conditions – which required that they started working on a very low wage compared with the registered ones that pay taxes. This situation creates certain dynamics even among the different groups of nurses that many times are connected to racist behaviours (Lazaridis, 2007; Maroukis, 2018). Those dynamics add to the existent tension about the precarity that this job position carries and the vulnerable status that self-employment and self-insurance bring since the nurses of exclusive employment are not protected by a collective work agreement as the regular nurses and doctors do. Furthermore, racist attitudes can be hidden behind the need to prevent illegality and protect one's work rights. Since 1990 the immigrants in Greece experience discrimination and social marginalization by the Greek population with the female immigrants being in the most vulnerable position (Psimmenos & Skamnakis, 2008). The social marginalization is also associated with the 'welfare marginalization' since the undocumented immigrants are deprived of their citizen and work rights; at the same time, they seek job opportunities within a system that there is division of labour and 'job positions that reproduce certain racial, gender and class stratifications and expectations' (Psimmenos & Skamnakis, 2008, p. 27).

Relationship, boundaries and space

María Puig de la Bellacasa (2017) as well as Pettersen (2012) highlights that care is 'relational per se'; adding that caring and relating both incorporate an ontological meaning. The caregiving relationship such as all professional and personal relationships include changing power dynamics that can under certain circumstances violate or extend the boundaries of the persons involved at both sides of the relationship. For instance, as I will elaborate below with examples of this research, sometimes a

professional caregiver may accept to do more tasks than those agreed such as the house chores. Based on my research, some of the reasons behind this decision are: the nurse of e.d. wants to accommodate the care receiver or this is the way she perceives the caregiving process or she is afraid to lose her job if she refuses to do so (e.g. the cases of G. and T.). The approach of *mature* care that Pettersen (2012) supports does not lack compassion but 'prevents self-sacrifice from becoming habitual' (p.380). However, in a professional environment the negotiation of boundaries have different level of difficulty and importance.

Throughout her analysis on community care, Twigg (2000) refers to the sensitive line between public and private space. She highlights the vulnerability and the feelings of discomfort that the care workers have when entering a patient's house. They have to accept that they are at the same time professionals and 'guests' (Twigg, 2000). Halford & Leonard (2003) during their research on hospital nurses explored three aspects of organizational space with a certain focus on gender issues: access, bodily movement and meaning of spaces in the hospital. The authors underline that the spatial 'structure' of hospitals has an impact on the nurses' work experience and workplace identities. The space and power are interdependent when we are talking about construction of identity, since the nurses seem to be both restricted ('passive') to create multiple identities within this limited space and 'active' the moment that they try to use the spatial organization in their favour (Halford & Leonard, 2003). Drawing on another aspect of this space issue, McGarry (2009) through her ethnographic research argues that as much as the care for elderly people focuses on caring for them in their homes, the nurses are often called to take on multiple roles that blur the boundaries of the 'traditional' female role and are difficult to be measured. Having multiple professional and private caregiving roles and provide care without conditions and boundaries can affect the caregiver's physical and mental health (Ward-Griffin et al., 2015).

Back to the intersectional approach

Having my research question as a guide I detect the main connection of my key concepts: care and caregiving, identity (gender, ethnicity and socio-economical status) and relations, boundaries and space, to the fact that they all play a vital role in how the female caregivers perceive their professional caregiving role and which practical and emotional challenges would be the cause or/and the outcome of their perspectives. In the following three sections I discuss how the nurses of exclusive duty perceive their professional caregiving role based on the expected gendered division of roles, connecting it to the challenging power dynamics in the caregiving relationships and a self-sacrifice model (IV section); how the ethnicity and socio-economical status that intersect with the gender of the nurses of e.d. affect the perception of their caregiving role combined with the notion of value,

morality and the precarity of the profession (V section) and lastly, how the emotional labour and the relation between the aforementioned morality and the professional ethics assist the crossing of private/professional boundaries and add to the challenges of this profession (VI section). By moving from how the nurses of e.d. perceive their professional caregiving role through the reflection of their gender in society and the intersection with their immigration, status experience and the precarity of this job to the consequent impact of crossing boundaries and the challenges they have to deal with I aim to indicate that there is an interdependent relation between those challenges and the reason the nurses of e.d. perceive their role as 'heavy'; with gender as the common denominator of all three sections.

Thus, using an intersectional feminist approach and focusing on how gender, ethnicity, status and relation of work/personal space are interwoven, this research explores the social and political dimensions of the topic of care by connecting those to social relations and the role of nurses as professional caregivers in Greek society.

IV. Gender and the perception of caregiving by female nurses of exclusive duty

[…] Women are more sensitive, women have resilience. We have male nurses that… what can I say? They come for work but the female nurses -who collaborate with them- do most of the work. […] He will do computer work, but the female nurse will do the caregiving […] There is a sensitivity maybe because they are women, I do not know. (Olga)

There are only a few male nurses of exclusive duty. I would say that this is something normal because the men do not have as much patience as the women that would take care e.g. of a patient with dementia. Maybe the men rely on their practical experience […] but mostly the girls have studied as nurses. I would say that 99% of the women that work as nurses of exclusive duty have finished the nursing school. Not the men […] The men that work as nurses of exclusive duty can be construction workers or plumbers that they could not find work and they work as nurses out of necessity […] I am talking about the foreigners not the Greeks, the Greek male nurses have finished the nursing school. (Philippos)

Do you know which the motivation of male nurses of exclusive duty is? The money, the unemployment. […] This is mainly their motivation. […] They won't tell you the emotional part of that job. They will tell: "What can I do? Since the situation in Greece is not that good?" The woman gives certain importance to her feelings. (Katerina)

The examples of Olga, Philippos and Katerina indicate that sensitivity, patience and resilience are perceived as innate traits of women in general and of female caregivers in particular. This is the perception of most of my participants. Male nurses of exclusive duty are described by my participants as focused on payment and not on the emotional aspect of the job, because they are considered too 'tough' (Tronto, 2013), impatient or their motivation is only that of necessity.

In the analysis of feminist scholars, care is very important for the formation of gender dissimilarities and social inequalities (Thelen, 2015). Tronto (2013) argues that the model of the man as the 'breadwinner' who aims to earn money in the public sphere and the woman as the 'caregiver' of the family who stays inside is still prevalent in the collective unconscious. During my interview with Olga, a point that captured my attention was her frustration while talking about male nurses of e.d. and saying that they only do computer and paper work. As she claims in the film (00:21:04 – 00:21:09), while talking about the collaboration between a male and a female nurse of e.d., "*the female nurse will assign him to write the reports"*. That information in combination with the fact that most of my female research participants describe themselves as 'more sensitive by nature' made me question how those women contribute to the perpetuation of the stereotypical divisions of the caregiving roles and their heavy responsibilities.

According to Yuval-Davis (2006, p.199) 'What is common to all these discourses of naturalization is that they tend to homogenize social categories and to treat all who belong to a particular social category as sharing equally the particular natural attributes (positive or negative) specific to it.' The author describes that the naturalization and the consequent categorization leads to a road of exclusion and inclusion that gives pressure to the individual subject to fit in a social group. In the case of the nurses of exclusive duty, they are all women and they 'are' or 'must be' sensitive.

For my research participants the motivation to make such differentiation between male and female caregivers is associated with how they identify with the quality of the caregiving services and the reason, they decide to continue providing those services:

I love the work I do; I like it. Let's say… I was born for this job. I like a lot to take care of a patient. (B.)

I felt deeply connected with this work since I was a child…I mean I was loving the elderly; I was feeling compassion for them… I did it because of love, of course also for the wage because I needed money to survive… (T.)

If you try to do this job out of necessity, you will never do it right. Never. You will try all the time to do it quickly and leave. […] Eh… the most important thing is to do what you love, if you do what you

love you will always enjoy your work and you will never feel pressure. […] I had this feeling inside me since I was a child. As I told you I enjoy a lot when a person feels happy, I mean… when he is happy, he feels fine. (G.)

An interesting point is that although sensitivity and compassion were defined by my participants as gender-based traits, often they have referred to their inclination to even care for people who are not their patients calling it as a humane action, hence as something natural that humans do because of their human instinct. As Olga says in the film (00:10:11 – 00:10:35):

And you see that person suffering, how can you not give him a glass of water? […] It is the human instinct. You cannot just walk next to him and pretend that you did not see him.

Thus, I am wondering: is it the human instinct that makes those women respond to the needs of other people immediately even if they are not their patients, or the naturalization of caregiving derived from the way those professional caregivers were raised as women? Or a combination of both?

According to Pettersen (2012) the 'unconditional' aspect of the *altruistic* care model can have a double meaning. On the one side the care may be perceived as something that is given without the caregiver expecting a reward and on the other side it may mean that the caregiver provides her services to anyone without discriminating. Discrimination is also one of the topics in the discussions with my participants. For instance, Katerina said that she could never understood the people that were refusing to take care of certain patients such as patients with HIV while Olga said that she is not concerned about the gender of her patient; for her *"they are all patients"*. Interestingly enough, both of them explained their position by claiming that they treat people the way they expect to be treated. At this point, I should underline that Philippos told me that male nurses of e.d. are not allowed to take care of a female patient, while Katerina explained -as I have written in her vignette- that they take care only of women who are unconscious and *"it would be uncomfortable otherwise"*. On the other hand, Olga told me that *"Greek women are shy and do not want a male nurse to change their diapers"*.

As I mentioned in the conceptual framework section, women are 'socialized into caretaking roles' (Revenson et al., 2016, p. 52). In many cases women may not want to receive any help because that would put into risk their traditional role (Abraido-Lanza & Revenson, 2006, as cited in Revenson et al., 2016). For instance, Nona does not like to receive help and she feels proud of achieving everything by herself, T. shares the same pride and self-confidence.

No. Never. For every case I had, I had never called somebody to help me. […] Since I believe in myself, I know very well to find a way to do my work. Never. Of course, we always have the option to call a man to help us, but I never do that. Because I do not need to because I always know how to do things… I never need that! (Nona)

Based on the *mature* care model, care means that the responsibilities must be shared between the caregivers, the care receivers or/and the people related to them, because it is not only a matter of morality but also a matter of justice with socio-political dimensions (Pettersen, 2012). Olga was accusing her male colleagues of not helping or not knowing how to help their female colleagues in the caregiving processes whilst she was praising her own resilience. My interpretation is that the role that Revenson et al. (2016) criticizes, leads to a self-sacrifice model (Pettersen, 2012); it is like a road that passes through the need for my participants to prove individually and socially that they are worthy, that they are useful, and able to be equal with the regular nurses or become one of them -which means equal work rights, more days off, more allowances- as this is the case for Olga:

They (the government) should hire more nursing staff and we (nurses of e.d.) should go to work legally. By legally I mean to work as regular nurses. Not nurses of e.d. Because now we are obliged to do that work. (Olga)

In the discussion about the difference between regular and the nurses of e.d.- that I will elaborate in the next sections- I have to add the different changing power dynamics in the professional relationships since the nurses of e.d. spend more time with the patients and get paid from them and not from the hospital. Also, it is not only the patients who need care and at the same time are the nurse's employer, but also the nurse who has to take care of the patient's needs and has in many cases the power to decide what is good or not for the patient. Thus, she is responsible for the patient's well-being. The oppressed can easily be the oppressor (Lutz, 2015) if we think the power politics of caregiving through the notion of oppression as described in the method of intersectionality. Not only the feminists but also the scholars of disability studies talked about the complex emotions that form the relationship between the caregiver and the care receiver and that the 'intimacy might also be an instrument of power' for the care receivers (Kay, 2013, as cited in Thelen, 2015, p. 503).

In many cases the nurses of e.d. have difficulty to negotiate their position because they depend on their salary and the patient is also their employer. But there are also cases that the nurse might be more 'powerful'. For instance, the caregiver may have specific beliefs about what is good for the patient and acts based on those beliefs violating at the same time the 'autonomy' of the care receiver while believing or communicating that she works from the *altruistic* approach (Pettersen, 2012). That can lead to caregiving that does not fulfil the care receiver's needs and can be translated as manipulative behaviour from both sides.

Lastly, almost all my participants have multiple caregiving roles including the care of family members (Olga, B.) and pets (T., Katerina). Katerina has three cats and also takes care of the stray cats of her neighborhood, she described her actions as a 'habit' that is created because of her profession. The caregiving process that follows those women home seems to decrease their already limited free time.

While their stress levels and the physical and mental fatigue are increased compared to the nurses that do not give care outside the hospital (Scott et al., 2006, as cited in Ward-Griffin et al., 2015).

V. Aspects of identity, skills and society

Gray (2010) writes that the perception of caregiving as a natural action by women is associated with the 'devaluation' of the emotional labour in terms of economy, culture and gender. Throughout the interviews the way that almost all my participants presented themselves explicitly or implicitly resembled an answer to a hypothetical question about their identity. It was like there were not answering only to me but to society and the healthcare system that ignores and underestimates their abilities. I detect a relation between the 'devaluation' and the 'deskilling' through migration as Lazaridis (2007) refers to it. The immigrant women who came to Greece from Southern Europe during 1990s and had different kind of occupations and qualifications often worked first in domestic labour before becoming nurses of e.d., (Maroukis, 2018; Lazaridis, 2007). Lazaridis (2007) argues that they automatically underestimated those traditional feminine and low skilled or unskilled jobs and as a result they undervalued their own abilities, since jobs that are worthy can be considered less worthy by the society. Those job positions with low requirements and low expectations contribute to racial and social marginalization (Psimmenos & Skamnakis, 2008). According to my participants, especially Katerina, although the registered nurses of exclusive duty have a nursing diploma and some of the unregistered nurses have a diploma in their countries of origin there are still misconceptions about their role:

This profession is not popular in Greece. Most of the people do not know what a nurse of exclusive duty does. They believe that they do not have a nursing diploma, that they are not nurses, they do not know what we are exactly. (Katerina)

We are nurses of exclusive duty eh…they call us assistants…we are patients assistants. […] That is written on out professional IDs. […] We help a lot the hospital. The nurses of e.d. play a very important role for the hospital. […] The payment of the state employees does not benefit the state. If the hospitals hire us, we will be state employees. […] Now we must help the state, because… we work and we have self-insurance. (Olga)

Also, as Katerina and Philippos highlighted *"most of the people ask for Greek nurses of exclusive duty"* but Greek women doing this job are only a few. According to Katerina they do not choose this job because it is too *"hard"* for them confirming in a way, the resilience of the women still working in this profession.

My female participants as well as the owner and the nurses' manager of the agency *Frontida* argue that the healthcare system in Greece has many inefficiencies and it is very complicated. The nurses of e.d. as the 'bosses of themselves' must deal with the precarity of this job by trying to take every available job position and working as many hours as possible without feeling secure for the future. Although they work in the hospital, they are not considered state (hospital) employees.

L. and T. expressed their frustration regarding the attitude of the hospitals towards them. They claimed that many times they were treated unfairly because they were considered the most vulnerable, the 'weakest', the nurses who are not state employees and so they do not deserve the same respect. As L. told me *"Those who clean people's faeces are worse than those who give them food"*(meaning the lunch ladies). Furthermore, Nona claims in the film (00:17:32 – 00:17:40) sometimes she has to buy gloves and other required nursing equipment because the public hospitals cannot provide; they cannot also provide masks and other required equipment to the entire nursing staff for protection from Covid-19 (Stefou, 2021).

Those discussions with my participants and the realisation of their dissatisfaction working in this system made me think that the prejudices are not only the result of misinformation and the complex structure of the Greek healthcare system. They are also an attitude towards the most 'vulnerable' (women, immigrant women, Greek women, registered, unregistered etc.) but beneficial part of the society; those who do the *"hard"* work and cover the inefficiencies of the state that do not hire more regular nurses.

The comparison seems to play a crucial role in the self-validation of the female nurses of e.d.. Morality and legal status, including all the tax and bureaucratic responsibilities to the Greek state, work as criteria for the nurses of e.d. to be compared with the unregistered ones. Nevertheless, there was a conflict of opinions concerning illegality. Some nurses were passionately against it because they pay taxes and the unregistered nurses do not and also, they consider that the care illegal nurses give is inadequate and, in some cases, can cause harm:

I believe that this wrong. I do not say that because I am just supporting the quality of my work. My opinion is based on what I have seen. The things I have seen…personally I would not hire a person that feels disgusted when touching a patient. That person comes to work only for the money. She does not know…how can I say it? Me, I care for each of my patients, I feel compassion. I want my patients to feel well. I do my best for them to feel well. They (who work illegally) do not care at all. They come only to sit next to the patient, take 50 euros and leave. 50 euros is not an inconsiderable amount of money. […] A woman from Bulgaria gave a sedative to her patient. He could not sleep. […] She gave him the pill. They were bringing pills from Bulgaria and he… had respiratory issues. He slept and he could not wake up. He had a very low blood pressure. We had to intubate him. She did her work and then what did she do? She left and we could not find her. (Olga)

Others have personal experience of working with no legal status:

I have finished the nursing school and I was working as a nurse in Georgia. I like that work a lot, to take care of people…yes. Eh…but when I came to Greece, I did not start working as a nurse. I was working at a bakery, 5 years there. The result was… my hands were hurting and that was not the job I wanted to do and I decided to start (working as a nurse). I was going to the hospitals and searching for clients, by myself. I mean I was entering the hospital and I was asking people if they need a nurse of exclusive duty and I was working. […] People accepted that because the registered nurses of exclusive duty are expensive, you know because they have services receipt. Eh… but people do not have money. So, they were ok with me working for 12 hours and taking 50 euros. Because…with services receipt, it is very expensive, if you work for 12 hours, the patient has to pay 125 euros. […] They were chasing us (the illegal nurses). We pretended that we were relatives or family friends of the patient. (B.)

And others understand and accept the fact that those women want to make ends meet or/and that the patient and the patient's family has the right to choose the caregiver he/she wants.:

They are also right. The women who want to work, they cannot find work, how are they supposed to live? I do not complain about them because they want to make ends meet. (Nona)

They say: "She is an illegal nurse of exclusive duty; she wants to steal our work!" No that is not the case, the patient has the right to choose the person that he wants to stay next to him. (Katerina)

Morality and (moral) obligation are also the criteria for the comparison between the nurses of e.d. and the regular nurses. Two of my participants made complaints about the rude attitude of the regular nurses at the hospitals towards them. I should underline that there is an official hierarchy in which the regular nurses are considered superior and if anything occurs the nurses of exclusive duty must report to them. Since, the nurses of exclusive duty are responsible only for their patient, all my participants show that they understand that the lack of nursing staff gives extra pressure to the few nurses of each hospital department. So, if the regular nurses need them, they always offer help. However, two of my participants, Katerina and T. mentioned that if they need help with their patients and call a regular nurse most of the times, they will not receive help and their answer will come with a passive-aggressive response. Katerina explained that in their response include the fact that the nurses of exclusive duty earn more money than them. In this part of the first minutes of our very first online interview with Katerina, she does not only refer to the hostile attitude of some regular nurses but also to the solidarity among the nurses of exclusive duty. She also touches upon the health issue with hernia that all my participants suffer of:

There was always a conflict in the Greek hospitals between regular nurses and the nurses of exclusive duty. It happened to me as well. They insulted me, they did not help me to turn some patients, that is

why I have a serious injury to my back, a herniated disc, because I had to lift patients of double or triple size than me. […] They rarely help you; they say: "No, you will do that by yourself, you get paid for that". However, they ask for our help. […] We (the nurses of exclusive duty) always offer help. […] We usually help each other. There is solidarity between us. (Katerina)

I found particularly interesting that the reason that the regular nurses criticize the nurses of e.d. is the same with the reason the registered nurses of e.d. criticize the unregistered ones. That makes me think that marginalization is not only because of the ethnicity and illegality but because those women earn more money even though they are in an 'inferior' and vulnerable social position by not being permanent staff of the public hospital. Katerina highlighted that this was the case many years ago, now they do not earn so much money, but the regular nurses still believe that. Lastly, it is rather questionable if this precarity, the circle of marginalization that those women experience and the 'conflict' between regular-exclusive, registered-unregistered, natives-immigrants, skilled-unskilled etc. are supported by the healthcare system. However, it is certain that they add to the practical and emotional challenges that the female nurses of e.d. have to handle including the crossing of the private/professional boundaries following the relational aspect of this profession.

VI. Responsibility, relationships, boundaries and challenges

Thus, if motivation and empathy were the criteria to compare themselves with men, their experience and conscientiousness were the criteria to compare themselves with the younger nurses by idealizing the older women in the profession:

I remember when I first went to work at a hospital. I was around 35 or 37 years old…. I met the old ladies there. They were 65, 67, 72 years old. One lady was 77 years old. Miss Maria. I have to inform you… you will probably think that it is impossible and that I am trying to brag because I am also old. No. My dear, I was so impressed by that attitude because I was 37 years old then and younger than them. My dear, they were awake all night long next to their patients, they were taking care of them. With so much conscientiousness. (T.)

The need of the constant presence if anything occurs for instance during the night shift leads to a certain weight of responsibility for the nurses of exclusive duty. For all my participants this was one of the main reasons to define this job as exhausting physically and emotionally. As I already mentioned above, Tronto (1993) and Pettersen (2012) claim that care morality has political roots. In particular, Tronto (1993) argues that during the twentieth century the notion of the more 'moral women' -than men- was used by many women's advocates for political reasons that had to do with equality and how their voice could be heard in public. However, the author claims that there are only

assumptions about what 'morality' means and the source of it; for instance, if a woman is more moral because she is a female, or a (potential) mother or because in the past she was inside and not at the marketplace as the men were (Tronto, 1993). The aforementioned 'past' in terms of age or/and experience is brought in the forefront -especially- by the narratives of T. (as we saw above) and Olga who are the oldest of my participants; it is one of their criteria to recognize who does her job better and with more dedication. Is the women's morality and the need to be, and prove that they are, 'good caregivers' that makes my participants perceive their job as 'heavy'? Or is the nature of the job in an inefficient healthcare system that brings them last in the hierarchy nursing scale of the hospital and their fear to remain in a profession that is characterized by precarity?

Although there are associations of (registered) nurses of exclusive duty in different places in Greece that organize some collective actions, my participants did not mention or denied that they are members of such an association. Some of them choose to raise their voice in an individual level for what they believe is right or wrong, to their manager, to a regular nurse to patients' relatives or talk to the nursing service of the hospital if they find out that a nurse works illegally such as Olga does. I am still wondering if this attitude has a relation with the reference to their pride, resilience and self-confidence mentioned in the previous sections about how the nurses of e.d. perceive and experience their professional caregiving role.

Going back to the alertness and the availability, I should underline that they play a significant role in the establishment of a relationship between nurses and the patients, challenging many times the personal/ professional boundaries. All my participants argue that this labour is mainly emotional and for some of them it is inevitable to become attached to the patients.

It is important to take also into consideration that the patient is a person in need and her/ his health condition depend to a certain extent on hers/ his actions. However, in many cases this cannot be easily discernible and even if it can be justified, the physical and mental impact on the nurses is not decreased.

During my fieldwork I recognized four kinds of challenges the nurses of e.d. must deal with, regarding their relationship with the patients.

i) Physical abuse because of the hospitalization delirium[7] (a very common condition to the elderly patients) or other medical issues such as dementia.

Many patients when they are hospitalized, they develop delirium, because also of the side-effects of the medicine, especially the elderly… It has happened to me, to us, the nurses of e.d. to get beaten up by patients. […] Sometimes even the sedatives cannot calm them down. Once, I was chasing a patient

[7] Delirium is 'is an acute confusional state that is extremely common among hospitalized elders and is strongly associated with poor short-term and long-term outcomes.' (Marcantonio, 2017, p. 1457)

in the corridor and he was pushing me away. As you can see, this is a very hard situation. […] Sometimes in the hospitals they have to tie the patients up because they want to protect them not to leave or jump out of the window. (Olga)

I had visited a patient at his house, he had dementia. All night long… he was chasing me with his cane. If he had beaten me up, I would be dead. (B.)

ii) Sexual harassment

I was going to check his oxygen and he was getting handsy… with his movements. I felt uncomfortable. I confronted him and I was having fights many times with men for this reason. […] ***I did not leave*** *them, but I confronted them the moment that happened.* (Katerina)

iii) Changing the initial agreement without previous notice and developing manipulative behaviour towards the nurses of e.d.

He is a very bad person; I can feel it. […] He manipulates me and the money that I receive does not worth this behaviour. He is so dependent on me. Eh… I have told him so many times that I will stop working, more than 15-20 times, I say to him: "Find another woman, I am leaving you, it is over". He says to me: "Do it if you dare, I will report you; that you work illegally". He knows that I cannot live without the money he gives me… He wakes me up at 12am, 1am, winter, summer, whenever he wants and I go. (T.)

iv) The combination of the roles of psychologist, friend and entertainer that a nurse of e.d. usually takes. Nevertheless, for some nurses of e.d. this can be a normal part of their caregiving process:

It is great, to help people, to calm them down, to give them a hope. […] That is why with my patients many times I talk to them, I try to make them happy […] I saw that it was helpful, when the patients were happy, they were psychologically better, when I made them smile. […] When it was sunny, the hospital had a balcony and the patient could walk a bit, I was taking two chairs and we were sitting together at the sun. […] I also enjoy taking them for a walk in the hospital. […] The older nurses had told me that this is my role to sit and listen to the patients, like a psychologist and not discussing my problems with them. […] You ***have to*** *listen to their problems.* (Katerina)

As far as the relatives of the patients are concerned, although most of participants claimed that at most of the cases the relatives were very helpful and appreciated their job there were many who mentioned that many times have been in distress because either they try to inspect their work or try to assign them with house chores that were not in the initial agreement and they will not include extra payment. An indicative example is the case of G.:

G.: Most of the times, if the grandmother sleeps, they will assign you other house chores.

Me: Hmmm. Do you do other chores as well?

G.: Eh, look… I was doing in the past, because I was younger and you know I loved that job, I mean really from the bottom of my heart. […] But after a while it affected me mentally and I had to do psychotherapy for 6 months, I was depressed. It was very hard… (G.)

The narrative of G. is different than the narrative of T. who is also 37 years older than her:

Now if it is for you to sweep, to broom, it is part of my personality, I do not have problem to do so. […] Look the agreement was to stay (at that patient's home) till 1pm. I have stayed till 2 or 2.30 pm without asking an increase to my payment. (T.)

Although the aforementioned challenges have many differences, they have some similar reactions, emotional impact and coping mechanisms from the nurses' side. The nurses of e.d. are affected physically and emotionally and they usually cope with their feelings by themselves through a continuous negotiation of their professional and social position. Only G. told me that she visited a psychotherapist when she felt she could not handle by herself. While Katerina told me, the fact that nurses of e.d. do not take sedatives, as most of the regular nurses do, is perceived as a proof of resilience. Drawing on discourse analysis method, I interpret that repetition of words **'have to'** or '**must**' and **'leave'** – as appeared in Katerina's words- while talking about their tasks as nurses as an ethical impasse for them, challenging the boundaries between the sense of personal morality -as a woman- and the professional ethics.

VII. Conclusion

This remote visual ethnographic research on the female nurses of exclusive duty in Greece shows that they perceive their professional caregiving role as heavy and as part of their female and social identity. The precarity of this profession, the stereotype of women as 'natural' caregivers, the inequalities because of ethnicity and socio-economical status and the consequent crossing of the personal/professional boundaries have a negative effect on the health of the nurses of exclusive duty. Although they feel proud of their resilience and morality and enjoy contributing to the well-being of their patients, they have to deal with back pain, stress, exhaustion and other practical and emotional issues such as the marginalization and the constant negotiation of their position.

The inability to travel in Greece due to the Covid-19 pandemic resulted to a remote ethnographic research. The methodological toolkit was consisted of online interviewing and observation, active listening, discourse analysis, collaborative attempts including footage by my participants and the self-reflective approach of the creative editing and the voice-over narration.

Caregiving is still considered by society as woman's work by following natural criteria. This inequality adds to the objectification and sexualisation of the public representations of the nurses in the patriarchal society. The validation of the nurses of exclusive duty is constructed through the comparison with the male nurses of e.d., the younger nurses of e.d., the regular nurses and the unregistered nurses of e.d. with no legal status. Sensitivity, patience and resilience are perceived as innate traits of a woman, while men are considered more tough and do this job mainly because of money. This work shows that female nurses do this job mainly because of love without conditions and discriminations. Regarding the younger nurses of e.d. the field of differentiation is the experience and the conscientiousness and is associated with the idealization of older nurses and the past. There is a certain connection between the reasons the registered nurses of e.d. differentiate themselves from the regular nurses and the unregistered nurses of e.d. working at hospitals; it is a matter of morality. Although in the hospitals the regular nurses do not seem to help the nurses of e.d., the opposite often happens. Most of the registered nurses of e.d. mistrust nurses of e.d. with no legal status and accuse them of providing bad caregiving services with possible harmful impact to the patients. Since this validation relates to the construction of the nurses' female and social identity, it is clear that its roots are social. The nurses of exclusive duty feel the need to prove to society that are better, hence good caregivers.

Relationships are the core of the caregiving and what makes this labour being called emotional. The nurses of exclusive duty describe their work as extremely hard not only because of the physical aspect but mainly because of the emotional challenges. From physical abuse to stress and multiple caregiving roles, the nurses of e.d. trying to find and operate within the boundaries of the ethics of care.

The nurses of exclusive duty play a crucial role in the complicated Greek healthcare system. They are beneficial to the system by filling the gap created by inefficiencies accumulated over the years. At the same time, gender and class-based inequalities, racism, prejudice, unemployment, and the lack of governmental provision put those women into a vicious circle of marginalization and perpetuate their social invisibility. By using a feminist and intersectional lens and expressing solidarity this research gives space to the stories of those women and aims at their visibility. However, further research could investigate more aspects of the role of the nurses of e.d. in the healthcare system and go deeper to the reasons that trafficking networks continue existing. But before that, those women, Greek and immigrants, need space to share their stories and experiences without being afraid to show not only the positive but also the negative side of the job, without being afraid to have voice in this system that they live and work and that constantly rejects them.

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IX. Appendix

The research participants

Participants	Short profile	Means of communication	Recorded interview(s)
L.	Around 60 years old. She comes from Kazakhstan and has lived in Greece for 30 years. She was working as a doctor in her country, now she is a retired (registered) nurse of exclusive duty and occasionally visits patients at homes. She is divorced and has a son. She gave me the phone numbers of A. and Olga.	Phone/ Viber messages	No
A.	Around 60 years old. She comes from Albania and has lived in Greece for 22 years. She is a registered nurse of e.d. in a hospital. She is married and has a son.	Phone	No
Olga	56 years old. She comes from the Former Soviet Union (Tashkent). She came to Greece in 1988. She is a registered nurse of e.d. and has worked in two hospitals in Athens. She is married and has three children and two grandchildren.	Viber (phone call)	Yes
F.	He is the owner of the nursing agency *Frontida* in Athens. He comes from Greece. We communicated after my email to the agency. He told me that it is better to talk with the manager of the nurses Philippos for more information.	Phone	No
Philippos	The manager of the nurses in the nursing agency *Frontida*. He comes from Greece. He gave me the phone numbers of three nurses working in the agency. Only two of them could participate (Nona and B.)	Phone/ Viber messages	Yes
T.	I found her number from a friend of mine in Greece. T. is 67 years old. She lives in Peloponnese and she comes from Greece. She is a registered nurse of e.d. Currently she is waiting to get retired and she is visiting patients at their homes. She lives alone with her pets. She gave me the number of G.	Phone	Yes
G.	30 years old. She is a friend of T. She comes from Bulgaria and lives in Peloponnese for seven years. She is not a registered nurse and she works at patients' houses.	Viber (video call)	Yes
Vaggelis	Around 40 years old. A friend of mine gave me his number. He comes from Greece and lives in Athens. He is not a nurse. He is educated in traditional thai massage and he works as a caregiver of elderly people.	Zoom (video call)	Yes

B.	She comes from Georgia and lives in Athens. She is a registered nurse of e.d. and she is recruited by the agency *Frontida*. Her first years in Greece she was working as unregistered. She continues her nursing studies in Greece. She is divorced with two children in Georgia and she takes care of her children and parents by sending them money. She lives alone with her dog.	Phone	Yes
Nona	She comes from Georgia and she lives in Athens. In Georgia she was working as a doctor, now she is a registered nurse of e.d. and she is recruited by the agency *Frontida*. She lives with her husband.	Viber (video call)	Yes
Katerina	Around 40 years old. I contacted her via LinkedIn. She comes from Greece and she lives in Thessaloniki. She is a registered nurse of e.d. and has worked for many years as a regular nurse. She lives with her three cats.	Zoom	Yes
Irene	61 years old. She is my mother. She is a relative (daughter and daughter-in-law) of patients that needed exclusive care. She knows and has experience with nurses of e.d. and has taken care of her family as well.	Phone	Yes