



UvA-DARE (Digital Academic Repository)

“My Color Doesn’t Lie”: Race, Gender, and Nativism among Nurses in the Netherlands

Cottingham, M.D.; Andringa, Lana

DOI

[10.1177/2333393620972958](https://doi.org/10.1177/2333393620972958)

Publication date

2020

Published in

Global Qualitative Nursing Research

[Link to publication](#)

Citation for published version (APA):

Cottingham, M. D., & Andringa, L. (2020). “My Color Doesn’t Lie”: Race, Gender, and Nativism among Nurses in the Netherlands. *Global Qualitative Nursing Research*, 7, 1 - 11. <https://doi.org/10.1177/2333393620972958>


General rights

It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations

If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: <https://uba.uva.nl/en/contact>, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.

“My Color Doesn’t Lie”: Race, Gender, and Nativism among Nurses in the Netherlands

Global Qualitative Nursing Research
Volume 7: 1–11
© The Author(s) 2020
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/2333393620972958
journals.sagepub.com/home/gqn


Marci D. Cottingham¹  and Lana Andringa¹

Abstract

Nursing in white-majority populations tends to be associated with white women. Yet as Western Europe and North America undergo demographic shifts, such associations are challenged as people of different racial and national backgrounds take on positions in nursing and other professional roles in healthcare. This article explores the work experiences of nurses from diverse backgrounds as they confront intersecting forms of sexism, racism, and nativism in the Netherlands. We use the conceptual framework of “appropriate labor” to help explain these experiences in connection with the wider climate of Dutch native homogeneity and race and racism denial. These findings have implications for work policies that might better support minority nurses in contexts of increasing superdiversity while also challenging wider cultural norms in the Netherlands that continue to associate nursing with whiteness and deny the presence of racism.

Keywords

race, racism, nativism, sexism, the Netherlands, nursing, appropriate labor

Received March 2, 2020; revised October 14, 2020; accepted October 15, 2020

Globally, the nursing profession remains an occupation marked as feminine, with women making up the majority of nurses throughout Western and non-Western countries (Centraal Bureau voor de Statistiek, 2016; Institute of Medicine, 2011; World Health Organization, 2020). Nursing is one form of care work that is predominantly performed by white women in North America and Western Europe. In the Netherlands, where non-Western migrants make up 13 percent of the population (Centraal Bureau voor de Statistiek, 2019), less than 7 percent of nursing graduates have a non-Western background (Centraal Bureau voor de Statistiek, 2015). Racial and ethnic minorities make up roughly 17 percent of U.S. registered nurses (Institute of Medicine, 2011), while they make up around 27 percent of the total population (Humes et al., 2011). In Canada, “visible and linguistic minorities” remain “under-represented in managerial positions and over-represented in lower ranking position” in healthcare occupations (Premji & Etowa, 2014, p. 1). A legacy of associating nursing with white, middle-class women continues in North America and Europe (Glenn, 1992; Premji & Etowa, 2014; Puzan, 2003; van Riemsdijk, 2010; Wooten & Branch, 2012).

Nursing scholars argue that experiences of discrimination and racism are key barriers to successful recruitment and retention of diverse nurses and can hinder the provision of culturally competent care (Tuttas, 2015). While racial categories

are widely recognized by scholars as a social construct without biological foundation, the social ramifications of phenotypical differences (namely, skin color) remain relevant for shaping social interactions, including interactions that result in differential treatment (Golash-Boza, 2016). Whiteness is generally normalized in the Netherlands (Dyer, 2002) and the Dutch emphasis on tolerance and progressive values often masks continuing forms of overt and subtle racism (Wekker, 2016). This study aims to examine the experiences of female nurses of color in the Netherlands. We ask, how do Dutch female nurses of color experience their work? What role might sexism, racism, and nativism play in their daily experiences as nurses?

Background

Nursing scholars have examined the underrepresentation and experiences of racial/ethnic, or “visible minorities,” in Europe and North America (Berdes & Eckert, 2001; Ham, 2020; Institute of Medicine, 2011; Jefferies et al., 2019;

¹University of Amsterdam, Amsterdam, the Netherlands

Corresponding Author:

Marci D. Cottingham, Department of Sociology, University of Amsterdam, Nieuwe Achtergracht 166, Amsterdam 1055AR, the Netherlands.
Email: cottingham@uva.nl



Premji & Etowa, 2014; Tuttas, 2015). Ulrich et al. (2007) found that nurses of color in the U.S. reported more stress and were three times more likely to say they wanted to leave the profession than white nurses. Black nurses in the U.S. experience both overt forms of racism such as receiving derogatory racial slurs from patients, as well as more subtle forms of racism, including patient non-compliance and questioning of authority (Cottingham et al., 2018). Ham (2020), looking specifically at the Netherlands, notes that first-generation immigrants from East Africa experience refusal and noncompliance from elders in the nursing home where they work. In focusing on the dynamics between first-generation immigrants and native nurses, Ham's findings clarify how immigrant's caring practices are adapted to expectations in a Dutch context. But further research is needed on the ways in which gender, race, and shifting European identities (van Riemsdijk, 2010) intersect to shape the experiences of nurses of color, including both immigrants and those born in the Netherlands.

Race and racism in Dutch society are seen as distinctly American phenomena (Wekker, 2016) and can be characterized as an absent presence in the Netherlands and Europe (M'charek et al., 2014). White Dutch see their country as color blind: everybody is equal and there is no racism (Wekker, 2016). White skin is seen as the norm, linked to Dutch colonial history (Mepschen, 2017; Wekker, 2016), though racial demarcations and racism are becoming reluctantly recognized as Black Lives Matter protests sweep the world and the Netherlands.¹ The Dutch government has historically distinguished between "allochtoon" and "autochtoon," with "allochtoon" ("foreigner") status being ascribed even to native-born individuals whose parents (or one parent) were not born in the Netherlands. Any racial classification system has been viewed with general discomfort—likely the result of its link to Nazi ideology and its use in the horrors of the Holocaust (M'charek et al., 2014). This has led to an absence of demographic data on the racial composition of occupations like nursing. Despite limited data on race, scholars argue that nativism is tacitly associated with whiteness and is contrasted with those classified as having a migrant background (Mepschen, 2017).

Racism and nativism are conceptually distinct phenomena, though they can be enacted in ways that lead to similar forms of discrimination and feelings of exclusion. Racism is the belief that "socially significant differences between human groups or communities – differences in visible physical characteristics – are innate and unchangeable. [. . .], accompanied by the notion that 'we' are superior to 'them'" (Duyvendak, 2012, p. 75). Nativism rests on an opposition to a minority on the ground of them being foreign or un-Dutch (ibid.). As a result, processes of othering—rendering groups as outsiders—in the Netherlands can translate into feeling that 'they' [people of color] are the 'other' or not really Dutch. A racial/ethnic hierarchy can overlap with nativist sentiments that disdain non-native, foreigners who fail to

assimilate (Weiner, 2014). Duyvendak (2011) argues that Dutch nativism is reinforced by the homogenization of shared values, particularly among autochthonous Dutch citizens. According to Duyvendak, the majority population has rapidly become more culturally homogenous since the 1970s. In many other countries, such as the United States, the majority opinion is divided on a variety of issues, but the Dutch majority population generally supports progressive values. Yet acceptance of progressive values has not resulted in acceptance of diversity. According to Dutch natives, allochtonen's "resistance" to speak proper Dutch, what the Dutch see as *the* example of integration, represents a refusal to homogenize. Racism might be less visible in the Netherlands compared to other countries, but even in tacitly progressive contexts (Hilaro et al., 2018), racism can intersect with nativism in how certain groups (native white women, for example) come to be seen as more "appropriate" to particular forms of work such as nursing.

(In)appropriate Labor

In order to explain the linking of certain groups with particular occupations, Wooten and Branch (2012) develop the term "appropriate labor" (p. 295) to emphasize the social and historical context that shapes how certain social groups come to be defined as more suitable for a particular type of work as compared to others. While building on the work of Acker (1990) and gendered organization theory, Wooten and Branch argue that the ideal worker is not, in all cases, a disembodied, white man. Rather, the construction of an ideal worker is fluid, shifting, and dependent on the type of work under consideration. The link between "laborer" and "labor" depends upon justification for why a group is "appropriate" to a certain type of work and therefore represented in one occupation versus another.

Over time, the connection between occupations and a group of "appropriate" laborers becomes pervasive and even taken for granted. But this does not mean that appropriate labor remains fixed or unchallenged: "The process of defining appropriateness mirrors a form of institutional work [. . .] by evaluating categories of laborers so as to demonstrate who is 'right' and who is 'wrong' for a particular occupation" (Wooten & Branch, 2012, p. 296). The efforts of nursing pioneer Florence Nightingale to professionalize nursing, and her subsequent glorification over other non-white nursing pioneers (Harmer, 2010), co-constituted nursing as a profession that fit with the Victorian ideal of white, middle-class womanhood. White women continue to be idealized as the most "appropriate" workers to carry out skilled nursing duties in North America and Western Europe (Glenn, 1992; Premji & Etowa, 2014; van Riemsdijk, 2010; Wooten & Branch, 2012).

Organizational scholars studying gender emphasize that organizations are inherently gendered, not gender neutral (Acker, 1990; Martin, 2004, 2006). Women spend most of

their days in work organizations that are almost always dominated by men. “The structure of the labor market, relations in the workplace, the control of the work process, and the underlying wage relation are always affected by symbols of gender, processes of gender identity, and material inequalities between women and men” (Acker, 1990, pp. 145–146). Women are devalued on the labor market because they are assumed to be unable to conform to the demands of the abstract job. More recently, Acker (2009) argues that gender intersects with organizational class, as managers are almost always men, and lower-level white-collar workers are almost always women. So “images of appropriate gendered and racialized bodies influence perceptions and hiring,” with white people preferred and women deemed “only appropriate for some jobs” (Acker, 2006, p. 449).

Under theorized in Acker’s (1990) original research on gendered organizations was explicit consideration of the role of race and native status in relation to the gendered organizational structure. Yet, it is important to realize that “as white women ignore their built-in privilege of whiteness and define woman in terms of their own experience alone, then women of color become ‘other’, the outsider whose experience and tradition is too ‘alien’ to comprehend” (Lorde, 1984, p. 117). Just as women are treated as “other” or deviant in comparison to the male standard, racial and ethnic minorities are often also seen as an “other” in comparison to the white norm. Merging these categories, women of color are uniquely positioned to reveal the gendered and racially distinct assumptions within an occupation like nursing.

While feminist scholarship has recognized the gendered nature of workplaces (Acker, 1990), it is also important to explore how race and native status intersect with gender in the workplace (Bhatt, 2013). It is rarely the case that one characteristic is salient while the other is unimportant. Both race and gender coalesce to shape the image of the appropriate worker (Wooten & Branch, 2012), as has been previously examined in the experiences of minority workers in U.S. (Wingfield, 2007). Women of color generally face a double jeopardy when it comes to discrimination on the labor market because of their gender and the color of their skin (Berdahl & Moore, 2006; Deitch et al., 2011). In the context of the Netherlands, nativism, in addition to racism and sexism, can be at play in the experiences of female nurses of color.

Methods

To investigate how Dutch female nurses of color experience their work and how sexism, racism, and nativism might intersect and impact those work experiences, we draw on interview data collected from 15 female nurses of color working in hospitals and care homes in the Netherlands. We asked nurses about their work experiences and how they view their job and perceive their interactions with patients and co-workers in a semi-structured interview (Bryman,

2012, p. 470). In this qualitative approach, we tried to understand the experiences of participants, in line with Weber’s notion of *verstehen* (Hennink et al., 2011, p. 10). This “emic perspective provides information on the insider’s point of view, their opinions and beliefs” (Hennink et al., 2011, p. 18).

Andringa conducted the interviews and, as a woman, could establish rapport with participants on the basis of gender. But as a white woman, she could not identify with respondents’ experiences of racism and overt racial prejudice from others in the workplace. Researching feelings of discrimination is especially difficult because some discrimination is hidden and might not feel like discrimination. We tried to solve this by focusing on instances when nurses felt as though they were treated differently compared to others. We used a semi-structured interview method which made the interview flexible and aimed to put respondents at ease by allowing them to guide the direction of the conversation. Ethical concerns are especially relevant when researching discrimination in the workplace. Interviews were primarily conducted outside of the participant’s workplace, at a place of their choosing. We have changed the names of all respondents and we present the demographics of our sample as a group rather than listing this information individually in order to protect their identities. We have also disguised the city and area of the Netherlands where participants work. All respondents were told about the aims of the research, the strategies we would use to protect their identities, and that their participation was completely voluntary. Participants provided verbal consent before interviews took place.²

Sample

The 15 respondents were recruited on the basis of their profession, gender, and race: we interviewed women who are trained as nurses and identified as non-white. We planned to only interview nurses working in a hospital setting, but due to difficulty in recruiting enough nurses, we expanded the focus to include those working in home care. Relatively more women of color work in home care than in a hospital context (Centraal Bureau voor de Statistiek, 2011). Fourteen interviews were conducted in Dutch. One nurse preferred to complete the interview in English. The interviews lasted between 29 and 72 minutes, averaging 47 minutes in length.

Respondents were sampled through Andringa’s network and through a call for participants on social media. We also found some respondents through a nurse blog and used snowball sampling (Bryman, 2012, p. 424)—asking participants if they could recommend others for the project. Combining these methods, we found 15 women who wanted to share their experiences with us. Respondents ranged in age from 21 to 56 years old, with an average age of 36 years old. The majority of participants in our sample are Dutch citizens (13 of the 15), either through birth in the Netherlands (5) or through passing citizenship requirements and

acquiring a Dutch passport (8). The citizenship status of the remaining two participants did not emerge in the interview and, in order to avoid perpetuating questions of origins (discussed below as particularly frustrating to participants), we did not probe further about their citizenship status. Six of the women in our sample had a Surinamese background, two had a background from the Philippines, two from Curaçao, two from Indonesia, one from Morocco, one from Burundi, and one from Cape Verde Islands. We use pseudonyms for all nurses in the findings.

Data Analysis

The interviews were recorded and transcribed. The analysis used an abductive approach so that prior theory on intersecting forms of gender, race, and nativism were incorporated into the coding process in order to extend our understanding and theorizing of these issues (Timmermans & Tavory, 2012). We also made analytic categories based on what the respondents thought was important, so these concepts were constructed inductively from the data. This included themes surrounding why they chose nursing as a profession, what they liked about the job, and what they disliked about the job. We also categorized their responses to questions about sexism and racism using this inductive approach. Following this approach, we then looked at areas of overlap in discussions of sexism, racism, and nativism and generally looked at how participant responses fit or did not fit with a thesis of inappropriate labor—that is, to what extent do nurses of color experience themselves as treated as outsiders in the profession? After analyzing the data, we selected and translated key responses from Dutch to English. As a native Dutch speaker, Andringa verified all translations. We include the Dutch original quotes in footnotes for the reader to consult.

Findings

This study asks, how do sexism, racism, and nativism shape the experiences of nurses of color? We first try to provide a holistic view of their experiences by beginning with the positive features of their work—why did these women go into nursing? What are the sources of satisfaction with their job? We then move to their negative experiences on the job—experiences of sexism, racism, nativism, and their intersection. When a quote is used, we refer to the respondents with their pseudonym and the country where they or their parents were born.

Job Satisfaction

On the whole, participants in our study emphasized the joy and passion they have for caregiving, despite the stress and low pay. Some respondents noted that nursing makes them feel grateful about their own life because they are healthy. For example, Rosa (Cape Verde Islands) notes that her work

as a nurse causes her to appreciate being able to move and feed herself independently. It makes her worry less about the insignificant things in life and feel gratitude.³ Helping patients was the biggest source of job satisfaction cited by nurses in the sample. As Marit (Suriname) notes, “I just love nursing. It’s in me, in my nature. I’ve always loved it. Always helped people. It’s my calling.”⁴ And Vera (Indonesia) similarly notes, “I enjoy taking care of people, to be there for them and to support them. That is satisfying.”⁵

Respondents also noted that they are largely happy with their current place of work. Some of the respondents changed their work place because of dissatisfaction, but are now happy with their current environment. For example, Hannah notes that her first place of work was difficult and she chose to move to a different hospital:

“The atmosphere was also not nice. There you felt like an outsider if you were a person of color. And I was looking for something different and expecting my oldest daughter. I gave birth at [current hospital] and a colleague worked there and she said, ‘it is such a nice team and you must come here.’ It was completely different. That is why I chose to apply for a job at [current hospital].”⁶ (Hannah, Morocco)

In this example, we can see Hannah hint at the unique experiences of nurses of color. One of the reasons for dissatisfaction on the job were experiences of overt and subtle racism. Before we turn to these experiences directly, we first look at our participants’ responses to questions about sexism and its overlap with racism in their work experiences.

Intersections of Sexism and Racism in Nursing

The majority of respondents (11 of 15) did not highlight gender-based differential treatment in the workplace. Some respondents told us that they have been discriminated against based on gender, but it was not the intention of the person who acted discriminatory, and in this way, they downplayed the events and seemed to accept them as part of the job. For example, Fleur from the Philippines does not feel sexually harassed on the job but notes how she has been called a “fucking whore or slut” by family members of a patient. Being called a “whore” or a “slut” certainly constitutes a form of sexism. Fleur and other nurses seem to become so accustomed to experiencing this type of treatment that it becomes normalized.

As in other jobs where women are the majority, gender dynamics can play out in unexpected ways, with men in the profession riding an invisible “glass escalator” (Williams, 1992) when it comes to receiving promotion, higher pay, and credibility and authority from patients (Cottingham et al., 2018). We can see this sentiment reflected in the responses of nurses in our sample:

“When you are a man, people listen to you, also patients. A lot of patients ask me if I am sure, but men are immediately

believed. Because they are in charge or something? Sometimes that is a pity, because I think: I know that as well!”⁷ (Nadine, Indonesia).

Hesther from the Philippines also experienced this:

“Men get easily accepted by patients. They don’t believe you that easily for being a good nurse when you are a woman, especially not when you are an allochtoon”⁸ (Hesther, the Philippines).

These reflections from Nadine and Hester echo other research on nurses of color in which they find that their authority and competence are more easily questioned in the profession (Cottingham et al., 2018). As Hester’s quote suggests, this questioning is linked not simply to gender but also to being allochtoon—a non-native.

Other respondents downplayed the relevance of gender to their work experiences and when asked specifically if gender influenced their work, they said no. But they would simultaneously relay stories of racialized sexual harassment. For example, Kathinka (Curaçao), working in a hospital, recalls a particularly memorable patient who told her, “I want to have chocolate custard because I think it is just as tasty as you.”⁹ In another example, a patient informed Esther (Curaçao) that she has “a nice pair of brown tits.”¹⁰ Esther goes on to say that “He [the same patient] was sexually unrestrained. He also masturbated often in his bed, but those things don’t shock me, it is part of your job.” Here we see gender and racial discrimination overlapping, but the sexual nature of patients’ remarks are downplayed by nurses as simply “part of the job.”

Some nurses in our sample experience the healthcare workforce as segregated along both gender and racial lines, with women of color occupying lower paying and lower status jobs compared to white men (Berdahl & Moore, 2006). While the position of a skilled nurse is associated with white, native Dutch women, higher positions in the hospital hierarchy appear closed off to participants based on both their gender and race. Maaike (Suriname) conveyed this line of thinking:

“If you want a job and you want to work in a top position? Then it is harder if you are a woman and of color. Why? Because at the top, everybody is male and white here”¹¹ (Maaike, Suriname).

Similarly, Samira (Suriname) summarizes this sentiment: “The higher you go in the hierarchy, the more male and whiter it becomes.”¹² Gender and race co-constitute the ideal worker at different rungs of the hierarchy, with white workers seen as preferred, and men seen as more appropriate than women for jobs higher in the hierarchy of healthcare work.

Experiences with Racism in Nursing

When we asked participants to tell us their experiences with discrimination, they immediately opened up about how they

are treated differently from their white colleagues. Based on these responses, participants seem to see discrimination first and foremost as *racial* discrimination—based on the color of their skin. These experiences center on the everyday discrimination that occurs in the workplace: the more subtle, pervasive discriminatory acts that women of color experience on an almost daily basis (Deitch et al., 2011). Shannon (Suriname) told us that everyday discriminatory acts are very present, that she was even warned by her tutor in her first week of her first internship that she might receive some negative comments on her skin color from patients.¹³ Samira (Suriname) notes that,

“Where I work now, I think clients are quite racist. As I said, I work in neighborhoods in small villages and they don’t really see Black people except on TV when they are being tracked [by the police].”¹⁴

Some experiences with discrimination from patients were downplayed as mostly harmless and something that they learn to tolerate. Samira (Suriname), for example, says she tends to laugh it off when patients use racial slurs.¹⁵ But Kathinka (Curaçao) highlighted the fact that she was the only person of color in her 4 years of nurse education and that she finds it challenging and tiring to have to continuously tell both patients and colleagues not to use racial slurs.¹⁶

Some experiences are so extreme that they stay with participants long after the original events. Marit (Suriname) relayed a number of particularly memorable interactions with patients:

“[. . .] He [the patient] ordered me to brush his shoes and said: ‘that is what you do in Suriname right?’ Excuse me?! Another time in home care, a woman asked me when I entered: ‘what are you doing here?’ I was surprised, maybe I was at the wrong house. But then she said: ‘they know that I don’t want foreigners and especially not Negros.’ I wanted to run away. Another time with a man, I was holding his wheelchair. And wow, he started cleaning it afterwards! Just because I held it!”¹⁷ (Marit, Suriname).

In these examples from Marit, we see both “foreignness” and race in combination. “Negros” are seen, according to Marit’s hostile patient, as a subcategory of foreigners that are signaled out as particularly undesirable or unfit for the job of nursing. The appropriateness of white women for the profession of nursing is reaffirmed in these encounters.

While patients are sometimes forgiven for their discriminatory acts, racist comments can also come from colleagues. Marielle describes an encounter with a colleague during the Christmas holidays:

“It was December, so Saint Nicholas period. The department was decorated; we do that with every season. Someone from the department was walking by and he saw me and then he said: you decorated it beautiful, ‘de Sint’ can be proud of having you as

helper [referring to Black Pete]. That was abnormal. I am really relaxed you know, just celebrate your stupid tradition but don't bother me with it"¹⁸ (Marielle, Suriname).

As the Saint Nicholas story goes, every year Saint Nicholas comes to the Netherlands along with his entourage of black-faced companions known as “Zwarte Piet,” or Black Pete. This tradition is reminiscent of slavery when multiple enslaved Africans served a white master enslaver (Weiner, 2014). Many white Dutch claim that this is an important tradition, and that it has nothing to do with racism. But Marielle, a young woman of color, experiences this differently. Black Pete (Zwarte Piet) is a tradition that remains despite an emphasis on Dutch multiculturalism and the tradition's link to colonial imagery (Coenders & Chauvin, 2017).

Even nurses with specialized training noted that their skin color seemed to impact how others viewed their expertise. Despite their specialized training, patients and new colleagues might doubt their knowledge and abilities. As Shannon (Suriname) notes,

“Patients think that I am low educated, that I am a nourishment assistant or something.”¹⁹

And Marit (Suriname) succinctly encapsulates the inappropriate labor thesis:

“Family members of patients (visitors) treat me condescendingly. They really look at my name card, to check if I am really a nurse [. . .] They would prefer to ask a white nurse rather than me” (Marit, Suriname).²⁰

In another example, Marit notes that a colleague giving a course for nurses reminded Marit multiple times that the course was for nurses:

“We often go to workshops for the job [. . .] And now, 3 times already—and it really bothers me—the woman from the workshop emphasizes that it's a workshop for NURSES. Yes, I know, the first time I didn't acknowledge it in that way. I said: ‘Yes, I know, I AM a nurse!’”²¹

In these reflections, nurses of color find that their “appropriateness” for the job of nursing appears to be continually questioned by patients and colleagues.

Intersections of Nativism and Racism in Nursing

Race in the Netherlands is generally seen as a “U.S.” issue, and as such, “race” and racism are assumed to be absent (Weiner, 2014). Conflict between native and non-native groups can entail nativism—with minorities seen as not Dutch or not Dutch enough. Nurses in our sample confront different treatment based on their supposed “origin,” but their reflections highlight that this form of nativism for the most part occurs in combination with assumptions based on

their skin color. We see examples of both racism (related to physical characteristics such as skin color) as well as nativism (related to one's status as non-Dutch) and their intersection in the examples that nurses shared with us.

One example of nativism is the ongoing questioning of “origin” that nurses of color encounter. People of color are more likely to be asked where they are “originally” from (Nzume, 2017). In a society in which white skin is the norm, this can lead nurses of color to feel like an outsider. As Marielle describes it:

“Yes I am a foreigner. I have a Dutch passport, but I was born in Suriname. My color doesn't lie, you know. Because of my color, people see me as a foreigner. I always felt different, ever since I moved here”²² (Marielle, Suriname).

Similar to Hannah's reflection above about feeling like an outsider because of the color of her skin, Marielle highlights the relevance of race—skin color as a salient marker for treating groups as outsiders, regardless of citizenship status or language abilities.

Similarly, Kathinka highlights the issue of origin:

“Patients always ask me where I am from, and assume that I am from Suriname. But you know, I was born in the Netherlands, so I am Dutch. And the second thing is, my family is from Curaçao, not Suriname! I am having this conversation all the time”²³ (Kathinka, Curaçao).

Merel (Burundi) also notes that the main way in which her skin color influences her work experiences is because it seems to prompt endless questions about her origin:

Interviewer: “And do you think your skin color influences your work experiences?”

Merel: “Skin color? Only that I notice that patients frequently ask me: ‘Where are you from? How long have you lived here?’ These questions come up regularly”²⁴ (Merel, Burundi).

Kathinka experienced frustration with the question of “origin” and Merel later noted that it bothered her to have to answer such invasive, private questions. Merel's reflection explicitly notes the link between these questions and her skin color. Compounded over time, we can imagine how being confronted with this type of questioning would create dissonance in identifying as a nurse and one's sense of belonging in the profession.

A second way in which nativism and racism intersect in the experiences of nurses of color was the issue of language and its overlap with racial markers. Fleur, a migrant nurse from the Philippines, preferred to conduct the interview in English. Here she highlights how both nativism and racism can overlap in her interactions with patients:

Interviewer: “Do you think that your gender influences your work and how you experience your work?”

Fleur: “No. My gender as a woman does not really make any difference, but my skin colour does. Because it has to do something with the language. People notice that I am not fluent in Dutch. And because I have a different [skin] color, then they think you are dumb [. . .] The disadvantage is that your color is less. They see you as less. Because you don’t speak the language very well, then they think you are not intelligent enough. Then they see whites as superior.” (Fleur, Philippines).²⁵

Here we see another example of how racism and nativism interconnect. Fleur was general in her use of “they”—which could refer to patients or colleagues throughout the interview. She finds that her racial classification (“because I have a different color”) leads others to assume that she lacks intelligence. Combined with her Dutch language skills, she believes other people treat her as “less.” While debates in the Netherlands about the relevance of race (versus ethnicity and native status) are ongoing, in this quotation from Fleur we see that in her own framing, both language and skin color are salient characteristics that appear to be used simultaneously to determine the appropriate fit between herself and the occupational role of nurse.

Discussion

We drew on interviews with 15 female nurses of color from the Netherlands to better understand how sexism, racism, and nativism might shape their work experiences. Their experiences suggest a friction between the presumed “appropriate” white, native Dutch nurse and the “inappropriateness” of their status as a person of color. As minorities within a dominant white society, the nurses in our sample experienced their race as the most salient feature of their interactions with others. While sexual harassment was present in their accounts, these could be simultaneously racialized. The examples from Kathinka and Esther, for example, echo prior findings from research on African-American female workers who encounter “gendered racism” on the job, particularly when it comes to being overly sexualized by white clients and colleagues (Wingfield, 2007). Because of participants’ minority status as non-white in a white-dominated occupation (while being female in a female-dominated occupation), race and native status appear to be more salient to them than their gender or experiences of sexism.

Dutch society has historically denied the presence of racism and even racial classifications (Essed & Trienekens, 2008), as can be seen in the continued controversy over Black Pete (Coenders & Chauvin, 2017). This might be changing, with the Prime Minister now acknowledging systemic racism in the Netherlands following world-wide Black Lives Matter protests in the summer of 2020.²⁶ In the experiences of female nurses of color, including those born in and outside of the Netherlands, we see that racial features (namely skin color) and signs of native status (language

ability) are used to mark them as distinct from white Dutch natives. The experience of Kathinka, born in the Netherlands and with perfect fluency in Dutch, shows how race remains salient in her interactions with patients. While racism and race itself are often denied in the Netherlands in order to emphasize a multicultural and tolerant society (Wekker, 2016), the experiences of nurses in our sample problematize the Dutch claim to progressive tolerance. The Netherlands has not fully developed into a truly pluralist, highly diverse society that treats everyone equally (Arab, 2014).

Several nurses noted that they felt that patients and patient’s families saw them as occupying a status “lower” than that of nurse and Fleur felt that white people (her colleagues in particular) see themselves as superior to her because of her skin color and language ability. Here, both nativism and racism are clearly at play. Nurses of color, regardless of language ability and nation of birth, are asked about their origin and seen as an outsider who is non-Dutch (nativism) but can also simultaneously be treated as less than whites and seen as better suited to a lower-skilled healthcare job like nutritional assistant (racism). While there are distinct features of the Dutch context, the experience of having one’s credentials explicitly questioned echoes the experiences of racial minority nurses in other countries like the U.S. (Cottingham et al., 2018), United Kingdom (Tuttas, 2015), and Australia (Mapedzahama et al., 2012). Similar to Shannon and Marit from this study, Tamara (an African-American nurse) relays how family members of patients continuously assume that she is there to help with bathing and toileting rather than being there as the nurse manager that she really is (Cottingham et al., 2018, p. 151).

Research on race in Europe and the Netherlands has been faulted for framing racial and ethnic minorities themselves as problems, emphasizing their need to assimilate and integrate into the dominant culture (Essed & Nimako, 2006, p. 284). While the current study does focus on female nurses who are minorities, the goal here is to highlight their experiences and the general failure of the broader Dutch culture to relinquish assumptions related to gender, race, and native status, particularly when it comes to collective definitions of appropriate labor. Only when these assumptions are challenged will the strong lines between who is and is not appropriate for certain forms of skilled work loosen and the toll that such assumptions exact from minorities be minimized (Evans, 2013; Evans & Moore, 2015).

One strength of the interview method we used in this study is that many of the interviews took place away from participants’ work context, potentially helping participants open up more fully and reveal negative experiences that they might not want to reveal in the presence of coworkers and patients. But a limitation of this approach is that we cannot observe interactions directly as they unfold. Future research should incorporate other methods, including shadowing and observation or by soliciting audio diaries from nurses (Cottingham & Erickson, 2020; Theodosius, 2008) in order

to better capture the interactions and emotional reflections of healthcare workers in situ. For example, we also found that white colleagues will sometimes try to warn colleagues of color about a racist patient or family member. More research on how these dynamics of warning play out—and the implication that racism is an individual problem to solve—should receive further examination.

The nurses in our sample were reminded of their unique position within a profession that is marked as white. Yet, it is likely that home and hospital care will be increasingly performed by a diverse group of workers of various races and nations of origin in Europe and North America. Indeed, superdiversity in carework is a growing trend given unavoidable demographic shifts in Western Europe (Bradby et al., 2017; Phillimore, 2015). Such a trend will create new challenges for dominant and homogenous native populations as they confront workers who look different than they might expect (Anstey & Wright, 2014). Understanding the experiences of diverse workers is crucial to improving their working conditions, including the creation of policies that might protect them from sexism, racism, and nativism experienced on the job, from both patients and colleagues. Such changes are needed if the level of representation of nurses of color in North America and Europe are to match their representation in the populations they serve.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Revision of this manuscript was aided by a Fellowship at the Hanse-Wissenschaftskolleg Institute for Advanced Study, Delmenhorst, Germany and by funding for research leave provided by an Aspasia grant from Sarah Bracke's Vici project, funded by the Dutch Research Council (NWO).

ORCID iD

Marci D. Cottingham  <https://orcid.org/0000-0003-3519-4100>

Notes

1. <https://www.bbc.com/news/world-europe-53261944> (accessed August 20, 2020)
2. Data were collected as part of Andringa's master thesis project. The research design was approved by the two supervisors of the project, in line with university protocol.
3. Dutch original: "Ik vind het een heel dankbaar beroep, het is echt heel dankbaar. Je ziet zoveel leed, daarom ben je echt heel dankbaar voor de kleine dingen. Dat klinkt heel stom en eigenlijk moet iedereen dat al zijn. Maar omdat je dit van dichtbij meemaakt en soms de meest lullige ziektebeelden die dan heel veel impact op je dagelijks leven hebben. Als je niet binnen het ziekenhuis werkt, heb ik het idee dat je dat helemaal niet doorhebt. Ik merk ook, maar misschien heb alleen ik dat, ik maak me veel minder druk om de stomme kleine dingen. Die zijn het zo niet waard. Ik ben al blij dat ik gewoon kan zien of gewoon kan lopen of zelf kan eten. Er zijn kinderen die letterlijk niet kunnen eten maar wel geconfronteerd worden met allerlei lekkere dingen overal."
4. Dutch original: "Ik hou gewoon van het verplegen. Het zit in mij, aard van het beestje. Ik heb er altijd van gehouden, ik heb mensen altijd geholpen. Ik voelde mij geroepen."
5. Dutch original: "Ik vind het leuk om voor mensen te zorgen, om voor ze klaar te staan en ze te steunen. Dat geeft me voldoening."
6. Dutch original: "De sfeer was ook niet leuk. Daar voelde je je wel als buitenstander als je een kleurtje hebt. En ik was dus aan het kijken voor iets ander en toevallig was ik toen zwanger van mijn oudste dochter en ik ben toen bevallen in het [redacted] ziekenhuis en een collega werkte daar en zij zei: het is zo'n leuk team en je moet hier komen. Heel anders gewoon. Vandaar dat ik besloten heb om tijdens mijn verlof te gaan solliciteren bij het."
7. Dutch original: "Er wordt als man meer naar je geluisterd, ook door patiënten. In plaats van heel veel vragen stellen, en of ik het wel zeker wist. Mannen worden meteen geloofd. Omdat mannen de baas zijn of zo? Ik vind dat soms wel een beetje jammer, van: ik weet het ook hoor!"
8. Dutch original: "Ik vind zelf dat mannen, zij worden makkelijk geaccepteerd door patiënten. Tegenover vrouwen zijn ze een beetje terughoudend, vooral als je ook nog allochtoon bent."
9. Dutch original: "Hoe ging het ook alweer? Het was in de psychiatrie en die man had een narcistische persoonlijkheid. En ik zat aan tafel en ik ging toetjes uitdelen dus ik vroeg: wat voor vla wilt u? En toen zei hij: doe maar chocoladevla want ik denk dat die net zo lekker is als jij."
10. Dutch original: "Ik had een keer een jongere man en als ik bukte zei hij: goh wat heb je een leuke bruine tietten."
11. Dutch original: "Kijk, als je een baan wilt hebben en je wilt doorgroeien naar de top? Dan denk ik wel dat het vrouw zijn en het gekleurd zijn dat moeilijker maakt. Waarom? Ja wat er hier aan de top is, dat is sowieso alleen maar man en wit hier."
12. Dutch original: "Hoe hoger in de hiërarchie, hoe mannelijker en blanker het wordt."
13. Dutch original: "mijn eerste stage was in een verzorgingstehuis, particulier. En tijdens het kennismakingsgesprek ging het al lekker. Ze zeiden: ja je hebt een kleurtje, dus je kan wel nare opmerkingen krijgen. Daar werd ik echt voor gewaarschuwd. Ik dacht: okee. . . eerste jaar, geen ervaring nog met patiënten, uh cliënten dan, en dan hoor ik dit. Ik dacht: wow heftig. Ik wist echt niet wat ik moest verwachten daarna, maar het viel echt reuze mee."
14. Dutch original: "Interviewer: En heb je weleens negatieve ervaringen meegemaakt met cliënten, zoals discriminatie?" Samira: "Ja dat wel. Waar ik nu werk, ik vind dat cliënten vrij racistisch zijn. Wat ik net zei, ik werk in wijken in kleine dorpjes en ze zien niet echt donkere mensen behalve op tv bij opsporing verzocht zeg maar (lacht)."
15. Dutch original: "Ik ben weleens neger genoemd, maar dan moet ik altijd lachen. Dat vind ik grappig. Ik ben niet heel donker, ik ben echt een halfbloedje, beetje caramel. Daar kan

- jij me toch niet voor uitschelden? Dan rol ik over de grond van het lachen! Mij uitschelden is al niet leuk (lacht).”
16. Dutch original: “Maar als je opmerkingen krijgt als neger? Dat is lastiger, want ik heb niet het idee dat ik dat kan veranderen. Dan zullen ze het niet doen waar ik bij ben, maar ze blijven het wel doen. En dat vind ik echt heel lastig. Hele tijd die discussie, dat is vermoeiend. Wanneer leren mensen het nou dat het niet goed is om dat woord te gebruiken? Als je er niets van zegt, gaan ze er natuurlijk mee door.”
 17. Dutch original: “Hij zei tegen me dat ik zijn schoenen moest schoonmaken. Hij zei: dat doen jullie toch, dat schoenpoetsen, in Suriname? Pardon?! Een andere keer in de thuiszorg, ik kwam binnen en die vrouw riep: wat kom je doen?! Ik keek verbaasd, ik dacht ik ben verkeerd. Maar ze zei: ze weten dat ik geen buitenlanders wil en al helemaal geen negers. Ik wilde daar wegrennen. Een andere keer heb ik meegemaakt, ik hield de rolstoel van een meneer vast. Nou hij heeft me daarna een hoop gepoetst! Omdat ik het had vastgehouden!”
 18. Dutch original: “Het was december, dus de Sinterklaas periode. De afdeling was versierd, dat doen we altijd met elke seizoen. Iemand van de afdeling liep langs en hij zag mij en hij zei: je hebt het zeker mooi versierd, de Sint mag trots zijn met jou als knecht. Dat was niet normaal. Ik ben heel makkelijk weet je, vier gewoon je stomme traditie maar val mij er niet mee lastig.”
 19. Dutch original: “En patiënten denken weleens dat ik lager opgeleid ben terwijl ik gewoon hetzelfde heb als een andere student. Die denken dan dat ik een voedingsassistent ben ofzo, dat dus.”
 20. Dutch original: “Maar familieleden wel, de bezoekers. Zij doen vaak neerbuigend. Ze kijken echt op mijn naamkaartje of ik wel echt zuster ben. Maar niet anders dan dat. Ze zeggen het niet, maar je merkt het wel. Ze willen liever iets vragen aan mijn blanke collega’s dan aan mij.”
 21. Dutch original: “We krijgen vaak cursussen en ik kom daar, buitenshuis. En tot 3 keer toe, ik stoorde me er zo erg aan, en die vrouw legde de nadruk erop dat het een VERPLEEGKUNDIGE cursus is. Ja ik weet het, ik had het nog niet door de eerste keer. Ik zei: ik weet het, ik ben verpleegkundige hoor.”
 22. Dutch original: “Ja ik ben een buitenlander. Ik ben in Suriname geboren maar ik heb wel gewoon een Nederlands paspoort. Maar mijn kleur liegt er niet om weet je. Ik ben gewoon een buitenlander, zo word ik ook gewoon gezien. Sinds ik hier ben, heb ik me altijd anders gevoeld.”
 23. Dutch original: “Patiënten vragen me altijd waar ik vandaan kom. Ze denken altijd dat ik uit Suriname kom. Maar weet je, ik ben gewoon geboren in Nederland, dus ik zeg ze dat ik Nederlandse ben. En ten tweede, mijn familie komt uit Curaçao, niet Suriname! Ik heb zulke gesprekken altijd”.
 24. Dutch original: I: “En denkt u dat uw huidskleur invloed heeft op uw werk?”
M: “Huidskleur? Alleen dan wat ik vaak merk is dat patiënten me vaak vragen: waar kom je vandaan? Hoe lang woon je hier? Al die vragen, die komen regelmatig naar voren.”
I: “Vindt u dat vervelend?” M: “Nou ja, soms denk ik van: in hoeverre moet ik hun vragen beantwoorden? Daar heb ik wel vaak moeite mee. Soms denk ik: nu gaat het echt over mijn privé leven. Moet ik echt blijven vertellen of kan ik zeggen:

tot hier en niet verder. Daar heb ik soms wel moeite mee, om te zeggen dat ik hierover liever niet wil praten. Antwoorden geven op bepaalde vragen. Soms denk ik: hoe ver moet ik dat doen?”

25. Fleur’s interview was conducted in English.
26. <https://dutchreview.com/news/dutch/rutte-has-changed-his-opinion-on-zwarte-piet-agrees-institutional-racism-is-present-in-the-netherlands/> (accessed August 20, 2020).

References

- Acker, J. (1990). Hierarchies, jobs, bodies: A theory of gendered organizations. *Gender & Society, 4*(2), 139–158. <https://doi.org/10.1177/089124390004002002>
- Acker, J. (2006). Introduction: The missing feminist revolution symposium. *Social Problems, 53*, 444. http://heinonlinebackup.com/hol/cgi-bin/get_pdf.cgi?handle=hein.journals/socprob53§ion=33
- Anstey, K., & Wright, L. (2014). Responding to discriminatory requests for a different healthcare provider. *Nursing Ethics, 21*(1), 86–96. <https://doi.org/10.1177/0969733013486799>
- Arab, P. T. (2014). The covenant of the allochthons: How nativist racism affects youth culture in Amsterdam. *Thamyris/Intersecting, 27*, 397–406.
- Berdahl, J. L., & Moore, C. (2006). Workplace harassment: Double Jeopardy for minority women. *Journal of Applied Psychology, 91*(2), 426–436.
- Berdes, C., & Eckert, J. M. (2001). Race relations and caregiving relationships: A qualitative examination of perspectives from residents and nurse’s aides in three nursing homes. *Research on Aging, 23*(1), 109–126. <https://doi.org/10.1177/0164027501231006>
- Bhatt, W. (2013). The little brown woman: Gender discrimination in American medicine. *Gender & Society, 27*(5), 659–680.
- Bradby, H., Green, G., Davison, C., & Krause, K. (2017). Is superdiversity a useful concept in European medical sociology? *Frontiers in Sociology, 1*. <https://doi.org/10.3389/fsoc.2016.00017>
- Bryman, A. (2012). *Social research methods* (4th ed.). Oxford University Press.
- Centraal Bureau voor de Statistiek. (2011). *Zorgopleidingen populairder dan ooit* [Healthcare Training More Popular than Ever]. <https://www.cbs.nl/nl-nl/nieuws/2011/19/zorgopleidingen-populairder-dan-ooit>
- Centraal Bureau voor de Statistiek. (2015). *Afgestudeerden HBO en MBO Verpleeging en Verzorging* [Graduates of HBO and MBO Nursing and Caregiving]. <https://www.cbs.nl/-/media/documenten-hc/afgestudeerdenhboenmboverplegingenverzorging200506201415.xls>
- Centraal Bureau voor de Statistiek. (2016). *Weinig mannen kiezen voor een zorgopleiding* [Few Men Choose Healthcare Training]. <https://www.cbs.nl/nl-nl/nieuws/2016/11/weinig-mannen-kiezen-voor-een-zorgopleiding>
- Centraal Bureau voor de Statistiek. (2019). *Population; key figures*. <https://opendata.cbs.nl/statline/#/CBS/nl/dataset/37296ned/table?ts=1553642820503>
- Coenders, Y., & Chauvin, S. (2017). Race and the pitfalls of emotional democracy: Primary schools and the critique of Black Pete in the Netherlands. *Antipode, 49*(5), 1244–1262. <https://doi.org/10.1111/anti.12328>

- Cottingham, M. D., & Erickson, R. J. (2020). Capturing emotion with audio diaries. *Qualitative Research*, 20(5), 549–564. <https://doi.org/10.1177/1468794119885037>
- Cottingham, M. D., Johnson, A. H., & Erickson, R. J. (2018). “I can never be too comfortable”: Race, gender, and emotion at the hospital bedside. *Qualitative Health Research*, 28(1), 145–158.
- Deitch, E. A., Barsky, A., Butz, R. M., Chan, S., Brief, A. P., & Bradley, J. C. (2011). Subtle yet significant: The existence and impact of everyday racial discrimination in the workplace. *Human Relations*, 56(11), 1299–1324.
- Duyvendak, J. W. (2011). *The politics of home, belonging and nostalgia in Western Europe and the United States*. Palgrave Macmillan.
- Duyvendak, J. W. (2012). Holland as a home. Racism and/or nativism? *Krisis, Journal for Contemporary Philosophy*, 2, 75–77.
- Dyer, R. (2002). *The matter of whiteness*. In P. S. Rottenberg (Ed.), *White privilege: Essential readings on the other side of racism* (1st ed., pp. 9–14). Worth Publishers.
- Essed, P., & Nimako, K. (2006). Designs and (co)incidents: Cultures of scholarship and public policy on immigrants/minorities in the Netherlands. *International Journal of Comparative Sociology*, 47(3–4), 281–312. <https://doi.org/10.1177/0020715206065784>
- Essed, P., & Trienekens, S. (2008). ‘Who wants to feel white?’ Race, Dutch culture and contested identities. *Ethnic and Racial Studies*, 31(1), 52–72. <https://doi.org/10.1080/01419870701538885>
- Evans, L. (2013). *Cabin pressure: African American pilots, flight attendants, and emotional labor*. Rowman & Littlefield.
- Evans, L., & Moore, W. L. (2015). Impossible burdens: White institutions, emotional labor, and micro-resistance. *Social Problems*, 62(3), 439–454. <https://doi.org/10.1093/socpro/spv009>
- Glenn, E. N. (1992). From servitude to service work: Historical continuities in the racial division of paid reproductive labor. *Signs: Journal of Women in Culture and Society*, 18(1), 1–43.
- Golash-Boza, T. (2016). A critical and comprehensive sociological theory of race and racism. *Sociology of Race and Ethnicity*, 2(2), 129–141. <https://doi.org/10.1177/2332649216632242>
- Ham, A. (2020). First generation immigrant and native nurses enacting good care in a nursing home. *Nursing Ethics*. Advance online publication. <https://doi.org/10.1177/0969733020921487>
- Harmer, B. M. (2010). *Silenced in history: A historical study of Mary Seacole* (Doctoral Dissertation). University of Nebraska.
- Hennink, M., Hutter, I., & Bailey, A. (2011). *Qualitative research methods*. SAGE.
- Hilario, C. T., Browne, A. J., & McFadden, A. (2018). The influence of democratic racism in nursing inquiry. *Nursing Inquiry*, 25(1), e12213. <https://doi.org/10.1111/nin.12213>
- Humes, K. R., Jones, N. A., & Ramirez, R. R. (2011). *Overview of race and hispanic origin: 2010*. U.S. Census Bureau. <https://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>
- Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. National Academy of Sciences.
- Jefferies, K., Tamlyn, D., Aston, M., & Tomblin Murphy, G. (2019). Promoting visible minority diversity in Canadian nursing. *Canadian Journal of Nursing Research*, 51(1), 3–5. <https://doi.org/10.1177/0844562118795812>
- Lorde, A. (1984). Age, race, class, and sex: Women redefining difference. In *Sister outsider: Essays and speeches* (pp. 114–123). Crossing Press.
- Mapedzahama, V., Rudge, T., West, S., & Perron, A. (2012). Black nurse in white space? Rethinking the in/visibility of race within the Australian nursing workplace. *Nursing Inquiry*, 19(2), 153–164. <https://doi.org/10.1111/j.1440-1800.2011.00556.x>
- Martin, P. Y. (2004). Gender as social institution. *Social Forces*, 82(4), 1249–1273. <http://sf.oxfordjournals.org/content/82/4/1249.short>
- Martin, P. Y. (2006). Practising gender at work: Further thoughts on reflexivity. *Gender, Work & Organization*, 13(3), 254–276. <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0432.2006.00307.x/full>
- M’charek, A., Schramm, K., & Skinner, D. (2014). Technologies of belonging: The absent presence of race in Europe. *Science, Technology, & Human Values*, 39(4), 459–467. <https://doi.org/10.1177/0162243914531149>
- Mepschen, P. (2017). A discourse of displacement: Superdiversity, urban citizenship, and the politics of autochthony in Amsterdam. *Ethnic and Racial Studies*, 42, 71–88. <https://doi.org/10.1080/01419870.2017.1406967>
- Nzume, A. (2017). *Hallo Witte Mensen [Hello white people]*. Amsterdam University Press.
- Phillimore, J. (2015). Delivering maternity services in an era of superdiversity: The challenges of novelty and newness. *Ethnic and Racial Studies*, 38(4), 568–582. <https://doi.org/10.1080/01419870.2015.980288>
- Premji, S., & Etowa, J. B. (2014). Workforce utilization of visible and linguistic minorities in Canadian nursing. *Journal of Nursing Management*, 22(1), 80–88. <https://doi.org/10.1111/j.1365-2834.2012.01442.x>
- Puzan, E. (2003). The unbearable whiteness of being (in nursing). *Nursing Inquiry*, 10(3), 193–200. <https://doi.org/10.1046/j.1440-1800.2003.00180.x>
- Theodosius, C. (2008). *Emotional labour in health care: The unmanaged heart of nursing*. Routledge.
- Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory*, 30(3), 167–186. <https://doi.org/10.1177/0735275112457914>
- Tuttas, C. A. (2015). Perceived racial and ethnic prejudice and discrimination experiences of minority migrant nurses: A literature review. *Journal of Transcultural Nursing*, 26(5), 514–520. <https://doi.org/10.1177/1043659614526757>
- Ulrich, C., O’Donnell, P., Taylor, C., Farrar, A., Danis, M., & Grady, C. (2007). Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. *Social Science & Medicine*, 65(8), 1708–1719.
- van Riemsdijk, M. (2010). Variegated privileges of whiteness: Lived experiences of Polish nurses in Norway. *Social & Cultural Geography*, 11(2), 117–137. <https://doi.org/10.1080/14649360903514376>

- Weiner, M. F. (2014). The ideologically colonized metropole: Dutch racism and racist denial. *Sociology Compass*, 8(6), 731–744. <https://doi.org/10.1111/soc4.12163>
- Wekker, G. (2016). *White innocence*. University of North Carolina Press.
- Williams, C. L. (1992). The glass escalator: Hidden advantages for men in the “female” professions. *Social Problems*, 39(3), 253–267.
- Wingfield, A. H. (2007). The modern mammy and the angry Black man: African American professionals’ experiences with gendered racism in the workplace. *Race, Gender & Class*, 14(1/2), 196–212.
- Wooten, M. E., & Branch, E. H. (2012). Defining appropriate labor: Race, gender, and idealization of black women in domestic service. *Race, Gender & Class*, 19, 292–308. <http://www.jstor.org/stable/43497500>
- World Health Organization. (2020). *Nursing and midwifery: Key facts*. <https://www.who.int/news-room/fact-sheets/detail/nursing-and-midwifery>

Author Biographies

Marci D. Cottingham, PhD is assistant professor of sociology at the University of Amsterdam, Amsterdam, the Netherlands.

Lana Andringa, Msc is an independent scholar based in Amsterdam, the Netherlands.