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"COVIDwear" and Health Care Workers. How Has the New Materiality of Clothing Affected Care Practices?

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Abstract

The pandemic fundamentally changed the material culture of clothing for care workers. If most of them wore already some sort of uniform, be it for hygienic reasons, be it to make their status visible, Covid19 profoundly transformed the clothing codes, beyond the mask. These new "protections" thoroughly changed the caring experiences in several aspects. As they enclose the body more intimately, working conditions became more laborious. The sensory landscapes of care (vision, hearing, touch, taste, smell) were fundamentally altered. Working rhythms had to be adopted as putting on the garments took longer. If care clothing had been characterised by a slow de-standardisation since the 1970s, the pandemic made a uniformed and medicalised uniform again mandatory.

Keywords: Material Culture, COVID-19, Care Workers, Pandemic, Mask

1 Introduction

Face masks have become iconic if multifaceted objects of the COVID-19 pandemic, a sign of conflicting views among scientific communities, public health failures, community solidarity, global trade and ecological calamity.[1] This object of care suddenly turned into an everyday object, hotly debated and making newspaper headlines. The pandemic also fundamentally changed the material culture of clothing for health care workers. While most already wore some sort of uniform, whether for hygienic reasons or as a visible sign of their status, COVID-19 profoundly transformed the codes governing clothing, beyond the mere question of masks.[2]

In medical and nursing history, the focus of interest has so far generally been on the hard things of material culture such as instruments and architecture,[3] rather than on "ordinary" clothing.[4] While some culturally inspired studies have demonstrated how clothing has materialised gender, class or race,[5] few have addressed how care practices have been conditioned by the materiality of garments. In recent years, some scholars such as Christina Buse and Julia Twigg have called for dress and care studies to be considered in conjunction with each other.[6] In this contribution, I will approach COVID dress from a twofold perspective.

The first aspect I will consider is how clothing can be seen as a boundary object[7]: both the mask and also other COVID-related garments are objects through which boundaries are negotiated in the health care sector, in particular through access to (clothing) resources which were initially very rare, but also between health care workers and the rest of the population. Over the past decades, research in science and technology studies in particular has shown that certain objects can cross

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1 Strasser/Schlich 2020.

2 Research on this article was supported by COVID-19 fast-track grant [no. 14704989] from the Luxembourg National Research Fund (FNR).

3 Sandelowski 2000; Atzl and Artner 2019.

4 Labrum 2012.

5 Bates 2012.

6 Buse/Twigg 2018.

7 Lamont/Molnár 2002.

boundaries between different disciplines, thereby establishing bridges between otherwise separate fields. This was how Star and Griesener originally coined the concept of boundary objects.[8] Objects can however also reaffirm boundaries: I would therefore like to maintain the term but stressing the duality of material entities, going beyond but also re-establishing boundaries.

Secondly, the paper will address the question of how these new garments were changing the sensory and emotional landscapes of health care workers. While there has been growing interest in these questions over the past twenty years, research is often hindered by the transience of the traces kept.[9] The COVID pandemic, like other moments of crisis, can shine new light on phenomena that are rarely expressed in "normal" times: "quiet practices" (or tacit practices)[10] became "noisy" to a certain extent, as everyday ways of doing that are rarely expressed were now explicitly thematised.

The paper is based on 52 interviews with 12 health care workers in Luxembourg carried out in April 2020 focusing on the first weeks of the pandemic when the topic of Covid wear was particularly visible in the testimonies. During this month, Luxembourg shifted from a strict lockdown to a progressive easing of lockdown measures. The first COVID-19 case in Luxembourg was confirmed in late February 2020 and the first fatality on 13 March. In mid-March, Luxembourg imposed a first lockdown: schools and most non-food shops and restaurants were closed, and people were instructed to stay at home. From the end of April 2020 on, these measures were gradually eased: building sites opened on 20 April, primary schools on 4 May and non-food shops on 11 May. During this first wave, excess mortality in Luxembourg compared to that of previous years was relatively limited.[11]

The 52 interviews are part of a larger corpus of interviews carried out between April 2020 and August 2021 by historians at the Centre for Contemporary and Digital History (C^{2}DH) at the University of Luxembourg among them the author of this article. For the moment, the interviews are stored in the C^{2}DH: it is planned to move them over to the Centre National d'Audiovisuel (CNA). A total of around 330 interviews and 136 hours of testimonials were recorded. The interviewees were selected following the snowball effect. Interviews were open-ended and not specifically related to the topic addressed in this article. Multiple short interviews – referred to as "audiovisual diary entries" – were conducted with around twenty health care workers on a regular basis, first twice a week, then once a week, then once a month.[12] "Health care workers" were defined in a broad sense: as well as nurses and physicians, the sample also included social workers, a funeral director and a cleaner.

Mixing reconstructive and narrative analysis, the transcribed interviews were used to reconstitute how the pandemic affected the social world of the care workers but also to carve out the meanings these persons gave to this experience.[13] As can be seen from the box below, the corpus is problematic on at least two levels: it includes the same number of men (6) as women (6) and almost exclusively workers of Luxembourgish nationality. However, the health care sector in Luxembourg is largely feminised – as in most European countries – and also largely driven by a non-Luxembourgish population, some of whom live in Luxembourg and some of whom cross the border every day to

8 Star/Griesemer 1989; Nolte 2021.
9 Corbin 1990; Péaud/Mehl 2019.
10 Pink/Morgan/Dainty 2014, p. 438.
11 For the chronology: "COVID-19-Pandemie zu Lëtzebuerg" 2021. For the excess mortality: Peltier/Klein 2021.
12 Majerus 2021.
13 Thompson/Bornat 2017, pp. 365–376.

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work in the country: 58% of healthcare professionals working in Luxembourg are foreigners; 80% of healthcare professionals are women.[14]

Biographies of interviewees used in this article[15]

Victor Perreira – Luxembourgish male social worker working in a care home for the elderly – interviewed by François Klein – one interview used for this article;*

Mike Conrath – Luxembourgish male nurse working in Schrassig prison – interviewed by Victoria Mouton – six interviews used for this article;

Melina Evangelakakis – Luxembourgish female nurse in a general hospital in Ettelbruck – interviewed by François Klein – three interviews used for this article;

Laurent Lamesch – Luxembourgish male undertaker in Luxembourg City – interviewed by Inna Ganschow – six interviews used for this article;

Maria Benvindo – Luxembourgish female nursing auxiliary – interviewed by Elisabeth Guerard – one interview used for this article;*

Carmen Majerus – Luxembourgish female nursing auxiliary – interviewed by Marco Gabellini – three interviews used for this article;

Yves Morby – Luxembourgish male director of CIPA (care home for the elderly) in Berbourg (Luxembourg) – interviewed by Benoît Majerus – three interviews used for this article;

Vera Neuberg – Luxembourgish female nurse working in a mobile blood testing team – interviewed by Marco Gabellini – three interviews used for this article;

Pierre Bofferding – Luxembourgish male general practitioner – interviewed by Vera Fritz – four interviews used for this article;*

Marc Peiffer – Luxembourgish male gynaecologist – interviewed by Manon Pinatel – two interviews used for this article;

Cécile Anciaux – Belgian female nursing assistant at Colpach rehabilitation centre for COVID patients, living in Belgium – interviewed by Estelle Bunout – five interviews used for this article;*

Géraldine Polfer – Luxembourgish female mental health professional working at the psychiatric hospital in Ettelbruck – interviewed by Victoria Mouton – three interviews used for this article.*

2 Boundary Objects

In the early weeks of the pandemic in March 2020, protective clothing became a hard-to-get item. In all Western countries, the lack of face masks turned into one of the first “scandals” of the pandemic and was widely publicised.[16] Obtaining these items in the different care systems became a real challenge. In many institutions, “COVIDwear” was stored in specific places and was not freely at the disposal of health care workers. In a home for the elderly, a changing room that was no longer

[14] Lair-Hillion 2019.
[15] The interviewees choose if they wanted their identity to be anonymised or not; names with an asterisk have been anonymised.
[16] Jacobs/Richtel/Baker 2020.

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in use was turned into a room specifically dedicated to storing these clothes and was referred to as "Fort Knox" by the director (Yves Morby – 19 May 2020) as only he had access to it. The room was still in use in July 2021, despite everybody agreeing on the fact that there was no longer any risk of shortages. This precaution was undoubtedly due to the experience of the first few weeks of the pandemic when obtaining masks, hand sanitisers, gowns and aprons became difficult as the usual suppliers were no longer able to deliver (Yves Morby – 10 April 2020).

In the preceding decades, the rationalisation of space – a larger space previously used as a storeroom no longer existed in this care home for the elderly – and the "just-in-time" approach that was introduced as part of the "new public management" policies[17] had significantly reduced the amount of protective wear that was kept in storage, making the care home more vulnerable in time of crisis. At the Colpach rehabilitation centre, masks were also rationed in the early weeks and distributed in limited numbers day by day in a sealed envelope with indications of when they should be changed (Cécile Anciaux – 2 April 2020). The state of abundance that had characterised Western societies since the end of World War Two became a state of scarcity again.

In March and April 2020, having access to this rare object and being able to wear it became a distinctive sign, an object that indicated who was a health care worker and who was not. The testimony of Mike Conrath, a nurse who worked in the prison in Luxembourg, illustrates this boundary role:

> there came the moment when we got the order from the hospital that when we went to see a patient, a prisoner, we had to put on gloves and also a mask as a precaution. We were distributing medicines in a ward, we had gloves and masks, and wardens were standing next to us to open and close the doors, they were physically even closer to the prisoners and they had no masks. (1 April 2020).

Three weeks later, masks were accessible for everyone – nurses, guards and prisoners – but the prisoners did not have medical masks; instead they had cloth masks sewn by female prisoners (22 April 2020).

The chronology of mask distribution also reveals hierarchies within the health care sector, hierarchies that reproduced inequalities – between men and women, between Luxembourgish and non-Luxembourgish health care workers – that existed before the crisis. For example, gynaecologists were supplied with masks before midwives (Marc Peiffer – 14 April 2020). Similarly, the staff of care homes, institutions that primarily house elderly people with severe dependence, did not have masks, unlike the general practitioners who visited them (Pierre Bofferding – 11 April 2020). The care assistants in the mobile team, who are at the bottom of the hierarchy of care professions – Anne-Marie Arborio refers to them as the "invisibles"[18] – did not immediately have access to masks, which caused some concern among elderly people who depended on these home care services (Maria Benvindo – 15 April 2020).

For some carers, wearing masks was nothing new. Melina Evangelakakis, who worked as a nurse anaesthetist, when asked when she first heard about COVID-19, says that it was when she saw a leaflet that made wearing a mask compulsory. At the same time, because of her speciality, it was something she was used to and therefore did not constitute "a significant change" (18 April 2020).

[17] Belorgey 2016.
[18] Arborio 2012.

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For others, the change was more radical. Laurent Lamesch, who as an undertaker normally worked in "a shirt, tie and suit" and who was used to only wearing gloves when handling the dead, now had to put on a full protective suit when he went into the nursing home:

> As of this week, we have the protective suits and someone stood next to us and checked that we put them on, that we put everything on professionally [...]. So yes, that someone was standing next to us and checked everything. (7 April 2020).

As a professional who worked on the margins of care and has no specific training in this field, his ability to correctly put on the "COVIDwear" was explicitly and specifically checked, a procedure that Laurent Lamesch did not formally contest but that he did explain in detail during the interview. Very often the new gear required specific training, as many health care workers had never learned to put on such clothes. Physiotherapists or occupational therapists who had had less medical training than nurses – "who had never seen basic care" as one nurse put it (Cécile Anciaux – 2 April 2020) – needed to be given accelerated training.

While masks were worn by people in specific roles within the field of care, the separation between health care workers and patients was even clearer: in the early days of the pandemic, only the former wore masks. In the first few weeks, some health care workers claimed a certain exclusivity, feeling that this object should be reserved for them, as this nurse explained:

> As someone who works in the medical field and who knows that masks are in short supply, I just want to tell them [non-medical professionals wearing masks]: "well, it's not cool and it's pointless". (Cécile Anciaux – 2 April 2021).

Three weeks later when face masks were already mandatory for some activities among the general population, this narrative remained: non-health care workers were criticised because they wore masks when it was not considered necessary (driving in a car, walking alone in a park, etc.); there was a view that "masks would be more useful in certain clinics where there is a shortage" – especially as these people often failed to wear their masks correctly, thereby creating a "false feeling of security" (Carmen Majerus – 23 April 2021). These positions were perhaps also linked to the fact that the wearing of face masks by the general public was initially quite controversial, with varying recommendations in European countries.[19] Even later – when masks came into more general use – they remained small but powerful markers of social distinction: at the neuro-psychiatric hospital in Ettelbruck, nurses wore surgical masks while patients wore cloth masks (Géraldine Polfer – 25 April 2021).

At the same time, some health care workers also wore their masks outside the workplace, because they were convinced that they were a threat to their environment:

> People often look at you strangely when you go shopping with a mask on, but I don't wear a mask to protect myself; I wear a mask because I don't know if I'm accidentally going to infect someone else if I sneeze outside or in the queue at Cactus [Luxembourgish supermarket] (Carmen Majerus – 7 April 2020).

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[19] Thießen 2021, pp. 75–80.

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This fear also explained the preventive measures regarding workwear. Before the pandemic, Vera Neuberg sometimes kept her white coat on when she left work and only changed once she arrived home, but that was no longer possible:

> In addition, we no longer wear our overall at home and drive to work; we also no longer come home with our coats and wash them at home. They are now numbered at work [...] we go there in normal clothes, we dress and undress there. The overalls are collected by work and are washed there. You don’t go home with the overalls and all the other clothes that you wear when you go from one patient to another – at home where the family is, the children – all that stays at work. (Vera Neuberg – 10 April 2020).

While before COVID, there may have been a certain overlap in clothing between the private and work spheres, the two were very clearly separated during these first weeks of the pandemic. People whose job was intrinsically defined as helping others started considering themselves as potential dangers. For health care professionals working in COVID units, the cumbersome clothing arrangements constituted a radical break with the outside world:

> When you have finally finished getting dressed and feel ready to leave the changing room, you still have to quickly send a text message to your family: “That’s it, for the next ten hours I’ll be out of circulation and you won’t be able to get hold of me”. (Melina Evangelakakis – 18 April 2020).

The mask led to a pronounced effect of strangeness between carers and those being cared for, especially in relationships where contact was regular and frequent, such as in home care. Maria Benvindo testified to the fear she initially inspired in her patients: “when we arrived we had a mask [...] it was a bit, um, scary for them but they are used to it now.” (15 April 2020). Some activities shared by health care workers and those being cared for become impossible because of masks. For example, in a ward for mentally disabled people in the neuro-psychiatric hospital in Ettelbruck, it was no longer possible for staff and patients to eat breakfast together because staff were obliged to keep their masks on. (Géraldine Polfer – 15 April 2020). Wearing masks also became a problem when meeting new patients:

> And then there were people for example [...] people for a blood test whom I only went to once and never saw again, at least not regularly; when I rang their doorbell, I tried to take off the mask, and introduce myself from a distance, from a very long way away really: “I’ve come for a blood test. Now I’ll come in and put my mask on. OK, no problem.” Sometimes they put a mask on themselves and so I would go in wearing a mask and sometimes also gloves. (Vera Neuberg – 20 April 2020).

The depersonalisation introduced by the mask was perceived as a significant hindrance to quality care that was partly based on (facial) recognition.

This was even more embarrassing for care workers who changed their appearance significantly. For undertaker Laurent Lamesch, the relationship he had with relatives of the deceased was disrupted by the new gear. The black suit and very sober style was his “uniform” as an undertaker, and the protective clothing created a significant barrier with the living, who felt “insecure” when they saw him appear like this (7 April 2020). The gaze of others transformed the undertaker from a benevolent person into someone who was potentially dangerous.

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When the first lockdown began to be lifted in late April and early May 2020, the mask lost its distinctive character as the wearing of masks became compulsory for everyone and was thus widespread among the population.

3 Sensory landscapes

Another reason that “COVIDwear” was such a key marker was because dress is a central element in the sensory experience of care. The pandemic called existing balances into question.

3.1 Seeing and Hearing

Two of the senses regularly mentioned in the interviews as having been impacted was seeing and hearing. Masks posed a twofold communication problem: not only were words less understandable, but facial expressions also became difficult to decipher. This was one of the reasons why general practitioner Pierre Bofferding, who was a member of a palliative team, thought it was better for elderly people to stay in their care homes to die rather than being transferred to hospitals:

> And then one says “OK, we will provide palliative care. When they die, they are better off being with us than at the hospital.” Like now in an intensive care unit with oxygen or even if they are masked and they do not understand anything. There [in the nursing home] they are better cared for by the staff who know them and who specialise in providing care. And care in a nursing home is better than in a hospital. A hospital is a place to heal people, not to care for them. (11 April 2020).

Distancing requirements were particularly problematic for two specific groups: the mentally disabled and the elderly with dementia. As Géraldine Polfer testified, efforts to maintain distance with the mentally disabled were doomed to failure:

> No, so I do not think that we are getting out of the way now, that is also almost impossible just because of our residents and so on, who are always getting closer to one another and who have no fear of touch or contact. So they are always relatively close to us (Géraldine Polfer – 11 April 2020).

Two weeks later the same care worker reported that the residents were complaining because the mask prevented them from “breathing, talking and smoking” (Géraldine Polfer – 25 April 2020). Mandatory protective clothing was experienced as a major moment of disempowerment. Victor Perreira, who worked in a care home for the elderly, emphasised that

> People with a form of dementia focus a lot on the facial expressions and non-verbal communication of the care worker, the staff. And hiding the mouth means depriving them of a very significant advantage. [...] There is always such a constant form of stress on the part of residents. That is something that one notices. We noticed that the flight tendency increased slightly in the group, because they feel uncomfortable. (23 April 2021).

Within the teams, the protective clothing was changing the “atmosphere”. Care worker Benvindo talked about a real “shock” during first week:

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> It’s true that it was […] it was a bit difficult and the first week when I went back to work it was a bit of a special atmosphere. Arriving at work, going to the office, finding gloves, washing your hands, masks, disinfecting everything, it was […] yes. The first day it was a bit of a shock that, um, you’re going to separate the computers, we were two metres apart, um, it was […] it was very difficult the first week between us. (15 April 2020).

It was not only the atmosphere between colleagues that changed; the atmosphere on the wards changed too. The absence of patient traffic, the wearing of masks, etc. dampened spirits: “The only thing everyone says is that it’s strangely quiet.” (Carmen Majerus – 2 April 2020). This testimony is in contrast to some media coverage that focused on the bustle in intensive care and the ambulance sirens that became ambient noise in some cities.

3.2 Time

“COVIDwear” also changed the temporal experience of care: this is the topic that was most often addressed by health care workers in the interviews. In the previous twenty to thirty years, care professions had been subjected to increasingly standardised time management with the introduction of measurement systems, notably the PRN method (*projet de recherche en nursing* – nursing research project) in Luxembourg.[20] This clocked time was thrown into complete disarray by the new clothing requirements that affected all care professions, and especially those whose profession was characterised by basic hygiene measures – e.g. hand washing – but previously did not involve specific requirements in terms of clothing.

The most striking example was the undertaker. Normally he wore a suit with a tie, the only additional hygiene measure being plastic gloves to handle the dead body. While the use of additional protective clothing was not unknown, especially for HIV-related deaths or other infectious diseases such as hepatitis, it remained a very rare practice. With the COVID-19 pandemic, the exception became the new normality, which changed the perception of time:

> because it also takes a lot of time; you don’t put on the protective clothing in two minutes, you have to dress your colleague, the colleague has to dress you and, as I said, if there are also more checks, which always last only a few minutes, but a few minutes a day at each check, then you lose a lot of time because we only work part-time, which means, as I said, there are always two colleagues at home, and the whole schedule always slips back. (Laurent Lamesch – 7 April 2020).

Even for jobs with more specific clothing requirements, considerable additional time was needed and a learning process was involved. Given the contagious nature of the virus, even putting on a mask became something to be (re)learned, as explained by a general practitioner, who would double-check that he was putting his mask on properly by watching videos online (Pierre Bofferding – 13 April 2020).

Given the complexity of the clothing and the “decontamination” arrangements, some institutions introduced longer working days in protective clothing. In the Colpach rehabilitation institution for COVID-19 patients, working days were extended by one hour.

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[20] Torresani/Liefgen 2010.

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3.3 Bodily Marks

While putting on masks quickly became routine, putting on/taking off extra clothes proved to be more complicated. For some health care workers, it was as if they were putting on a "second skin" (Melina Evangelakakis – 18 April 2020) and this second skin made the seriousness of the situation truly palpable. For a nurse working in a COVID unit, it was even a question of three skins:

> so I wore my normal nursing clothes [...] and then I had my suit, my Tyvek suit [...] and then you have to know that when I worked directly with a patient, I had to put on protective glasses, and then I put on a gown over my Tyvek suit (Melina Evangelakakis – 18 April 2020).

This particular "second skin" remained a sign of separation, contrary to other repeatedly worn clothing where the notion of "second skin" is considered as a sign of comfort.[21]

Because of the time it took to put on full protection, people working in protective clothing often only undressed at the end of their shift, which posed major problems for taking in fluids – this was particularly complicated for carers with several layers of clothing who would sweat a lot (Melina Evangelakakis – 18 April 2020) – and eating, as well as for going to the toilet. The lack of water sometimes caused headaches (Melina Evangelakakis – 18 April 2020). Care objects for patients were therefore sometimes transformed into objects for carers, such as the possibility of inserting a catheter to avoid going to the toilet for staff who had to stay dressed in maximum protective clothing for several hours (Pierre Bofferding – 13 April 2020). For the past twenty years, material studies have emphasised the importance of paying particular attention to the different stages of an object – thought object, constructed object, used object – and the fact that, especially for this last stage, imagined practices do not always necessarily correspond to actual practices.[22]

While bodily touch was rare – at a time when regulations were in place to limit it as much as possible – the skin of carers was nevertheless severely put to the test, particularly their hands. Of course, all the interviewees emphasised that basic hygiene measures were part of their daily practice – "I have my hand sanitiser in my hands, but I have had it for years" (Cécile Anciaux – 2 April 2020) – but COVID changed this, in terms of both the frequency of hand washing, for example, but also the products used, which are considered more harmful to the hands, as Vera Neuberg testified:

> So with the hand sanitiser, I would say that I have always worked in a clean and hygienic way, as was also the case without COVID, but we naturally wash our hands even more, it has just become even more important, beyond what was normal at the hygienic level. After that, there are quite a few problems. You realise that the hands are broken, all rough, it really changes the skin, it's quite aggressive. (15 April 2021).

During the pandemic, the so-called "safe hands" embodied in the use of hand sanitiser, water and gloves became "damaged hands" which made touching painful or even impossible.[23]

The hands were not the only part of the body that was affected. Although the mask was an everyday object for some carers, it was not worn systematically and not for such long periods. The first masks

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21 Woodward 2007, pp. 153–54.
22 Ankele/Majerus 2020.
23 Pink/Morgan/Dainty 2014.

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delivered in large quantities to nursing staff did not always seem to have been very suitable and needed to be adapted:

> So I think about our poor ears, we have to wear masks all the time; at the moment they are worn with elastic bands which are put behind the ears and which hurt terribly; in fact if you wear them for two or three days in a row, it bleeds behind the ears. So I began to look for a solution myself because the masks that you attach to your head were sold out at that time, or at least no longer in stock. And then I found a man on Facebook who was making intermediate parts with a 3D printer. I sent this to my brother, and my brother now prints these parts for me, so we have a supply for the whole rehabilitation centre. This is really the object that is crucially important to me at the moment because it relieves my ears. (Carmen Majerus – 2 April 2020).

The masks did not only leave "traces for hours afterwards", marking the body well beyond working hours; they also produced a feeling of unease: "It marks you strongly, and you feel [...] it's oppressive, you understand, to be locked up underneath, well I find the mask a problem." (Cécile Anciaux – 6 April 2020).

These different changes led several interviewers to report significant fatigue. For Cécile Anciaux, wearing the mask permanently required a considerable amount of recovery time:

> I only worked two shifts last week, but it took me two days afterwards to, uh... physically recover because the mask and all that is tiring and then we are working nine hours when we usually only work eight. (10 April 2020).

In some institutions, due to the cumbersome nature of the garment and the physical consequences, health care workers would work shifts, spending 3–4 days at a COVID station and 3–4 days at a non-COVID station "where you 'just' have to put on a surgical mask" (Melina Evangelakakis – 18 April 2020).

This distancing through clothing also changed the way in which contact was established with those being cared for. The latter suffered from greater isolation and monotony; they were prevented from leaving their rooms but also from seeing their families. This lack of contact was all the more acute as Easter, a traditional family holiday in Luxembourg, fell on 13 April 2020, in the middle of the lockdown period. The pandemic made family members in care institutions all the more visible – in a negative way, through their forced absence. This was particularly noticeable at times of death when the family could not be present, with a few exceptions such as in nursing homes. However, family members were obliged to wear masks and gloves and could not touch the dying person directly. (Yves Morby – 14 April 2020). The demand for care practices went beyond normal "professional" care: health care workers had to fulfill a role (chatting, signs of affection, etc.) most often provided by relatives – but even they were limited. For example, tactile contact, skin on skin, that is often considered as an essential part of everyday care[24] became nearly impossible (Cécile Anciaux – 15 April 2020).

"COVIDwear" was a frequently discussed subject in the first weeks of the interviews, although the topic was not explicitly addressed by the interviewers, but little by little the issue disappeared: what

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[24] Savage 1995.

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was rare had become a mass object, what was exceptional had become an everyday object, what was difficult to put on had become routine.

4 Conclusion

In the first few weeks of the pandemic, the mask turned into a distinctive element. Just as the nurse's uniform had become a defining element of nursing in the early 20th century,[25] masks emerged as the symbol of the health care professional. Protective clothing was not only seen as a way of achieving "infection control" but also as a way of identifying oneself as a health care worker ("the ones with the masks") and expressing professional expertise in a non-verbal way ("putting on a mask correctly"). The moral economies that dictated access to these rare objects were widely accepted, even if they strongly reproduced the social and symbolic inequalities that governed the world of remunerated care. At the same time, they were seen as making relationships between patient and practitioner and among health care workers more difficult by sensorially, physically and emotionally changing their working environments.

These new "protections" thoroughly changed the care experience in several ways. As they enclosed the body more intimately, working conditions became more laborious. The impossibility of going to the toilet and/or drinking water, for example, gave rise to new experiences of the body. In addition, verbal and non-verbal communication between co-workers but also with patients turned into a difficult exercise. Ways of caring that were previously taken for granted, such as touching patients, were considered problematic. The sensory landscapes of care (vision, hearing, touch, taste, smell) were fundamentally altered. Working rhythms had to be adopted as putting on the garments took longer. Care clothing had been characterised by a slow destandardisation since the 1970s,[26] but the pandemic reinstated the need for a medical "uniform".

Clothing regulations once again became very strict. Like the nurse's uniform in the early 20th century, "COVIDwear" brought with it an inherent notion of "formatting" of the body[27]: the mask, for example, existed as a highly standardised object and was not necessarily adapted and adaptable to bodily diversity, meaning that tinkering was required by health care workers. Although none of the people interviewed questioned the (medical) necessity for masks and other protective clothing, they all stressed the strong disadvantages for their bodies, particularly through the marks that these objects left on the body and the discomfort (breathing, sweating, etc.) that they caused. Several of the health care workers also emphasised that protective clothing led to a strong decline in non-medical care because non-verbal communication became more difficult.

It remains to be seen whether, as with the Black Death of the 14th century or the Spanish flu, which are considered as pivotal moments in the dress codes of care,[28] the COVID-19 pandemic will also be considered as a turning point. One of the remarkable aspects is a certain standardisation, especially the use of masks for health care workers: while there were differentiated temporalities of access to

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[25] Bates 2010.
[26] West et al. 2016.
[27] Bates 2010.
[28] O'Donnell et al. 2020.

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masks which served as a magnifying glass for hierarchical differences, there was also a rapid standardisation that created a certain unity between roles that at first sight appeared very distant, such as the general practitioner in a hospital, the mental health professional in a psychiatric hospital and the employee of a funeral parlour.

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