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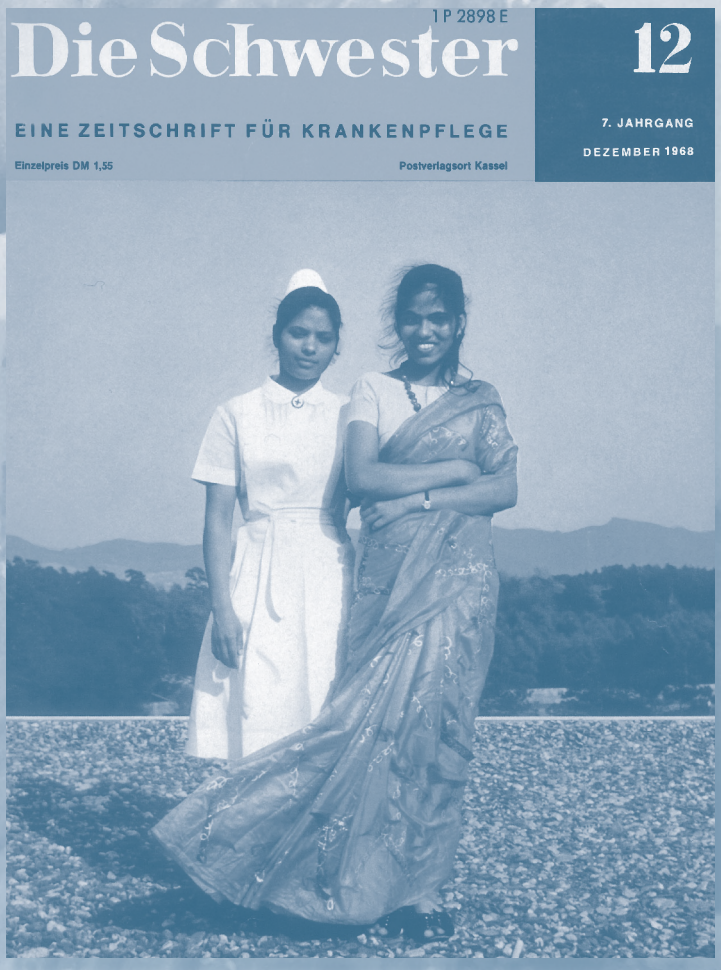

NURSING AND MIGRATION

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EDITORIAL – NURSING AND MIGRATION

Susanne Kreutzer and Karen Nolte

1 INTRODUCTION

The shortage of nursing staff is one of the constants in European healthcare systems. As early as the 1950s, European countries were recruiting qualified nurses and trainees for the nursing profession from abroad in order to avert a crisis in their own healthcare systems. Since then, demographic change and advances in healthcare have exacerbated the shortage of nursing staff. A considerable number of people working in nursing today are migrants. Without them, it would not be possible to maintain adequate provision of nursing care, either in a domestic or inpatient setting. While some aspects of the history of migration in nursing seem to be specific to the era of post-war globalisation, the internationalisation of nursing is a much older phenomenon and dates back to before the modern professionalisation of nursing.

This seventh issue of the *European Journal for Nursing History and Ethics* 2025 is dedicated to the topic of 'Nursing and Migration' and has been edited for the first time by a group of guest editors: Fruzsina Müller, David Freis and Pierre Pfütsch begin their introduction by presenting the current state of research on this topic and providing an overview of the concept and of individual contributions to the issue. The explicit aim is to establish a fruitful exchange between historical and ethical perspectives. We would like to thank Fruzsina Müller, David Freis and Pierre Pfütsch for their excellent collaboration.

The open section of this issue includes both an article with a historical focus and one that is primarily ethical. Elisabeth Hall et al. examine the transformation of paediatric nursing in the Faroe Islands between the 1960s and 1980s on the basis of an oral history project conducted with nurses. The focus is on the specific conditions of caring for sick children in a small-scale, remote European country. Jonathan L. Behrens et al. take up the concept of self-efficacy and develop a specific understanding of ethical self-efficacy, which they discuss in terms of its significance for nursing (ethics) education.

In the Lost and Found section, Mia Vrijens presents a find from the collection of the Museum for Nursing in the Netherlands that originated in the context of the 1953 flood disaster, but does not – as is usually the case – focus on the flood disaster itself, but rather on the reconstruction of the infrastructure for district nursing. The funds for this reconstruction effort were collected through a radio campaign in Switzerland, making it an example of European cooperation and solidarity.

NURSING AND MIGRATION. HISTORICAL AND ETHICAL PERSPECTIVES ON EUROPE FROM THE 1950S TO THE PRESENT

Fruzsina Müller, David Freis and Pierre Pfütsch

1 INTRODUCTION

Without migration, care and nursing in institutional and private settings would not be possible in Europe in their present form. In Germany, for example, migrants made up 17.8 per cent of the workforce in nursing and geriatric care in 2024 and have accounted for the entirety of the expansion of the nursing professions since 2022.[1] The presence of migrants in the nursing professions is the result of broader demographic developments in most European countries, which for many decades have been steadily transforming into immigration societies (without, of course, ever having been purely non-migrant societies), but their presence is also the result of specific measures to counter the persistent staff shortages in nursing that seem to be one of the constants in present-day European health systems. The historical link between migration and care thus points to a strong interconnection between different social, economic and cultural processes. While migration serves as a relief system for demographically ageing societies, it simultaneously exacerbates structural inequalities within the European care sector. This complex interdependence calls for an integrated perspective that combines historical, sociological and ethical analysis – not only to understand the current care crises, but also to trace the long-term evolution of social integration and solidarity across Europe.

Against the backdrop of an ageing society and the ongoing staffing crisis, governmental agencies and non-governmental actors in different European countries have been trying to recruit nurses from abroad. In 2025, various programmes were created to convince people from Mexico, the Philippines, Albania and Brazil to move to (Western) Europe and work in the nursing professions. However, recruitment programmes for foreign professionals are not a recent invention.

A look at earlier recruitment waves shows that the internationalisation of nursing has deep historical roots. To stay with the German example, qualified nurses and trainees have been recruited from abroad in both West and East Germany since the late 1950s. Migrants in the nursing professions have long represented a significant proportion of those employed in the German healthcare system and continue to shape it to this day. As early as the 1950s, other European states also found it necessary to look abroad to recruit qualified nurses and apprentices for the caring professions in order to mitigate a staffing crisis in their own health care systems. Since then, the nursing shortages have only been amplified by demographic changes and advances in health care. Today, partly through state-driven recruitment programmes, most countries in the Global North employ a substantial number of migrant nurses, transforming the profile of nursing in Europe, North America and Australia. Regular and

[1] Sachverständigenrat für Integration und Migration 2020; Mediendienst Integration 2025.

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irregular migration into formal and informal labour markets have played as much of a role as the increasing care dependency on migrants in ageing societies.

Despite this long-standing significance, the role of migration in the nursing professions has received surprisingly limited attention in historical research. For the most part, nursing historians and historians of medicine have left the professional and personal trajectories of migrant nurses unexplored. The same is also true for contemporary history and the history of migration. This gap in the research becomes even more conspicuous when it is contrasted with the history of other forms of migrant labour in more industrial (and hence, more masculine) settings, such as the *Gastarbeiter*, who arrived in Western Germany from the 1950s to the 1970s and are now an integral part of mainstream historical narratives.[2]

Only recently have historical studies begun highlighting the complex forms of marginalisation experienced by migrant nurses. Intersectional overlaps of class, migration and gender and the social construction of nursing as a profession long considered to be ancillary to medicine, made it easy for migrant nurses to be overlooked by their nursing contemporaries and by later historians. Nevertheless, the gaps and desiderata are conspicuous, both because migration history[3] and nursing history[4] have become established and productive fields of historical inquiry in recent decades, and because the topic is evidently relevant to current and future debates about the related topics of population health care needs, workforce planning and nursing policy for training and recruitment.

Gender plays a central role in these migration patterns, yet it has long been marginalised in historical research. As Mirjana Morokvaśic was already arguing back in the 1980s, the autonomous migration of women was largely ignored.[5] Although the autonomous migration of women has been included in German-language social science research since the 1990s,[6] this area has remained a niche that has been ignored by the majority of migration researchers.

While, in the 1980s, the focus was still on making migrant women visible, the spotlight is now increasingly turning to other factors that contribute to discrimination and exclusion.[7] Migration history is thus linked to intersectional theories, as ethnologist Urmila Goel has emphasised.[8] These intersectional exclusions were further reinforced by racialised images of 'ideal' migrant workers. The recruitment and popularity of Asian women can be explained by the prevalence of racist stereotypes in German society: Asian women were considered hard-working, gentle, resilient and therefore particularly well suited to the nursing profession.[9]

In the field of nursing ethics, topics such as the possibilities and challenges of trancultural relations in nursing have been the subject of productive discussions since the 2010s, as have the ethics of the recruitment of nurses from abroad and the potential negative impacts on the health infrastructure of the migrants' countries of origin.[10]

2 Notable exceptions include Mattes 2005 and more recently Cäsar 2024.
3 Möhring 2018.
4 Pfütsch 2025.
5 Morokvaśic 1984.
6 Hebenstreit 1988; Mattes 1999; Westphal 1996.
7 Lutz/Amelina 2021.
8 Goel 2014.
9 Goeke/Tekin 2025.
10 Bonacker/Geiger 2021.

2 HISTORICAL PATTERNS OF CARE MIGRATION IN EUROPE

The internationalisation of professional nursing has a long history – one that is surprisingly absent from the current public and political discourse surrounding the nursing crisis.[11] To better understand today's challenges, it is necessary to examine how nursing has historically depended on various forms of cross-border mobility – shaped by religion, colonial legacies, geopolitical shifts and labour shortages. This section offers selected national examples that illustrate how migrant nurses have long played a central role in European health care systems.

The history of nursing in Germany can, for example, be concisely retold as a genuinely international history that still shapes the sector today. Christian sisterhoods were pioneers of transnational female labour migration in the nineteenth century.[12] Since the creation of these communities, nurses have travelled to war and crisis zones or have been sent to distant regions – particularly, but not exclusively, to colonised territories, sometimes on missionary assignments.[13] Throughout the nineteenth century and even up to the beginning of the Second World War, the German Reich with its denominational sisterhoods was widely considered to be one of the 'cradles' of – and an important exporter of – professional nursing, even as British and American models of professionalisation were gaining traction internationally.[14]

In the 1950s, however, the number of nursing students plummeted in both West and East Germany: religiously and altruistically motivated nursing fell into crisis, not least due to social transformation processes such as modernisation and secularisation. This is when international recruitment programmes first emerged, both at the institutional level and later in national politics, as a response to the growing workforce shortage.[15]

In the Federal Republic of Germany (FRG), religious organisations were among the first actors to recruit qualified and trainee nursing staff from abroad in the postwar decades, aiming to counteract severe labour shortages in hospitals and other care facilities. Later, state actors became involved. Individual countries such as South Korea offered qualified nursing staff to the FRG because they hoped to gain economic advantages from exporting labour.[16]

As a result of intensive political, economic and religious networks – including those formed by missionaries and medical professionals – most foreign nurses in the FRG came from South Korea (by the early 1970s, there were about 5,000 of them). At the same time, approximately 3,000 Filipino and 1,500 Indian nurses were working there.

The German Democratic Republic (GDR) followed a different model, concluding agreements with African and South American countries to train and educate medical personnel, but to a much lesser extent than in West Germany. The state of research on these migrant groups is still limited and incomplete, with research tending to focus on the recruitment and experiences of migrant nurses in West Germany.[17] When it comes to migrant nurse recruitment in East (and West) Germany, only the work of Young-sun Hong can be listed: she provides an outstanding examination of this issue in the global historical context of humanitarian aid during the Cold War.[18]

[11] Kreutzer 2022.
[12] Czolkoß-Hettwer 2022; Hüwelmeier 2014; Kreutzer 2019.
[13] Büttner 2006; Kaminsky 2010.
[14] Kreutzer/Nolte 2016.
[15] Kaminsky 2012; Kreutzer 2014.
[16] Hong 2015, p. 260.
[17] Kreutzer 2022; Friedrich 2020; Goel 2014; Winkler 2014, pp. 361–365.
[18] Hong 2015, esp. pp. 250–286.

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Germany was not alone in this development. Other European countries also began recruiting foreign nursing staff in the postwar decades, shaped by their own demographic, political and colonial histories. From the 1960s onwards, France for example, took in many migrants, mainly from former colonies such as Algeria, and from Southern Europe. This labour migration was essential to meet the demand for workers, including in the care sector. Many migrants worked in informal and precarious employment, often in domestic care. In the 1980s and 1990s, migration policy regulations were tightened, especially under Conservative governments, leading to more restrictive conditions for migrants and making integration more difficult. Nevertheless, migrants – especially from Africa – remained important players in the French care sector, both in the formal and informal economy.[19]

The dual development of restrictive policies and continued immigration had a strong impact on care migration in France. Since the 2000s, the importance of care migration has increased as the French government faces an ageing population and rising demand for care. Migrant women, often from African countries or former colonies, take on many care tasks, especially in home care. The recognition of care qualifications remains complex, and many migrant care workers labour under precarious conditions.

The historical dynamics of care migration in France reflect both long-standing colonial ties and the shifting role of migrant labour in modern welfare states. The Netherlands is also considered a typical migration society. As in France and Germany, recruitment of nursing staff began in the 1960s – often from former colonies. The Dutch authorities assumed that workers from Suriname, the Netherlands Antilles and Indonesia could be easily integrated into the domestic labour market.[20]

Recent scholarship has begun to widen the historical lens on care migration, drawing not only on national labour histories but also on transnational movements and global dynamics, for example the work on the United States' 'imports' of Filipino and Indian nurses since the late nineteenth century[21] and on the role of international organisations in the immigration of Greek nurses to Canada, Australia and New Zealand.[22]

In addition to these historical examples, a rich and growing body of sociological and anthropological literature offers analytical frameworks to explore the dynamics of migrant care. Sabine Hess's 2005 study of Slovakian au pairs in Germany[23] was fundamental in this regard.

Likewise, recent research on Eastern European care workers in divided Cold War Europe has highlighted the interplay between labour migration and ideological boundaries.[24] The concept of 'global care chains' is also highly relevant for the history and ethics of nursing by migrants, as it refers to the ethical dimension of uncompensated recruitment of medical personnel from poorer and needy countries. Arlie Russell Hochschild uses the term 'global care chains' to describe the worldwide shift of care work from poorer to richer countries, often by female migrant workers who leave their own families behind to fill the care gap in wealthier households. This creates and reinforces complex, cross-border networks and often exacerbates social inequalities.[25]

These broader conceptual discussions align with an emerging consensus in migration history: migration is not an exception but a historical constant. More specifically, migration as a phenomenon is far older than the modern nation states that have attempted to regulate it, and is not a 'symptom' of globalisation.[26]

[19] Pillars of Health 2023.
[20] Jennissen/Bovens/Engbersen/Bokhorst 2022, pp. 17–41.
[21] Choy 2003; Reddy 2015.
[22] Papadopoulos/Tourgeli 2023.
[23] Hess 2005.
[24] Lutz 2018.
[25] Hochschild 2014.

3 QUESTIONS AND SUBJECTS

This diverse and interdisciplinary state of research lays the foundation for a historical and ethical exploration of migration in nursing. At the same time, it highlights the range of open questions and research potential that this field offers. The following thematic areas and questions provide a conceptual framework for the contributions in this issue.

Everyday experiences and professional identities

One key area of inquiry concerns the everyday professional lives and self-perceptions of migrant nurses. How did they imagine and conceptualise the roles of nurses and care recipients, and how did these differ between the countries of origin and the receiving countries?

How did cultural differences, relating to religious identities, assumptions about morality and gender roles, affect the practice of nursing and interpersonal relations in the workplace? How compatible was the training of nurses in the countries of origin with that of the receiving countries?

Experiences of care recipients

A second set of questions concerns the perspectives of care recipients. Migration can touch on the relationship between nurses and care recipients in different ways. For example, patients receiving nursing care from migrant nurses may have different values, expectations and prejudices that shape the nurse-patient encounter. Conversely, as care recipients themselves, migrant nurses may experience the caring encounter differently, according to whether they are nursed by non-migrant nurses or nurses of their own ethnicity.

Contexts

Understanding care migration requires attention to its broader social, political and historical contexts. Did the migration of nurses take place as part of larger migration movements, or independently? How did the migration of nurses differ from other forms of labour migration and care migration? What are the similarities and differences between European countries in terms of their migration patterns and experiences? Who were the key actors involved in shaping, facilitating or hindering the migration of nurses; for example, were they international, state or local, such as religious organisations or specific individuals?

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[26] Bade/van Eijl 2010; Berlinghoff 2018.

4 CONTRIBUTIONS

The articles in this special issue do not aim to cover the full breadth of this complex field. Instead, each individual article makes an important contribution to closing gaps in research and improving our understanding of the history of migration in nursing. All articles focus on the contemporary history of nursing and the ethical implications.

Nicola Yeates and Jane Pillinger open the issue with a global policy perspective. They trace the development of international recruitment since the Second World War, focusing on the major multilateral agreements: the International Labor Organization's (ILO's) Recommendation on Nursing Personnel (1977) and the World Health Organization's (WHO's) Global Code of Practice on the International Recruitment of Health Personnel (2010). They argue that these global agreements have consistently and deliberately tolerated the international recruitment of nursing staff. International organisations and the international community of state and non-state actors have promoted this global labour dynamic not despite two important regulatory initiatives, but because of them. Both multilateral agreements largely comply with the standards of a global ethics of care, but not with regard to a critical ethics of care, according to the authors' argument.

Claire Chatterton examines the migration of psychiatric nurses in the United Kingdom. When the National Health Service (NHS) was introduced in the UK in 1948, the shortage of nurses in all specialist areas was so severe that it threatened its ability to function. Although the situation in general nursing later improved, it remained a problem in psychiatric nursing at the time, where there continued to be significant difficulties in both recruitment and retention. For a long time, the Republic of Ireland was the main source of nursing staff in the UK. When the Irish government began to resist recruitment, English psychiatric clinics shifted their recruitment activities first to Europe and then to the British Commonwealth. This led to nurses from all over the world working together in the UK. Chatterton traces this process and asks questions about the experiences, problems and opportunities of this multi-ethnic collaboration.

As described above, there was a significant shortage of nursing staff in West Germany in the 1960s. To remedy this problem, nursing staff were recruited primarily from South Korea, the Philippines and Kerala in Southern India. Recruitment from India was organised in particular by individual clergymen, hospital directors and former migrants. Based on archival research, Urmila Goel reconstructs how the West German authorities reacted to this recruitment. She shows that there was no unified strategy among the authorities, but rather that their views differed considerably.

Care provided by migrants who live in the households of those in need of care is an essential component of many Western European care systems. In Germany, this form of care is viewed with ambivalence and is therefore the subject of emotional debate in the public arena. In their article, Matthias Hauer and Mark Schweda focus on the role of fear in this discourse, as it points to moral assumptions about care provided by migrants. They analyse how fear was communicated in the German discourse on live-in caregivers in various newspapers between 2017 and 2023 and examine the moral assumptions underlying these fears. Fear, they conclude, functions as a moral call to action. Its public communication expresses a perceived lack of political solutions to fundamental problems in care.

Ann-Christin Wedeking focuses in her article on the current migration infrastructure. Since migration has been a constant companion of care in European societies since the 1960s, the recruitment system has also become more differentiated and professionalised in recent decades. Labour market institutions are playing an increasingly important role in the labour migration process, not only in Germany but worldwide. Although initial framework conditions and guidelines were already established in the 1970s, by organisations such as WHO and ILO, as Yeates' and Pillinger's article makes clear, the need to ensure ethically correct recruitment has only gained in importance in the international debate in recent years. Wedeking provides a systematic literature review of the discourse and the role of voluntary codes of ethics as regulatory instruments for ensuring the fair recruitment of nursing staff. It identifies three main strands of research: the development and evaluation of such codes, conceptual ambiguities concerning 'ethical recruitment', and structural and regulatory challenges relating to the role of employment agencies.

Taken together, these contributions offer new historical insights and ethical reflections that are urgently needed in light of Europe's ongoing care challenges and its reliance on transnational labour.

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THE GLOBAL REGULATION OF INTERNATIONAL NURSE RECRUITMENT AND MIGRATION. A HISTORICAL-CRITICAL INSTITUTIONAL ETHICS OF CARE ENQUIRY

Nicola Yeates and Jane Pillinger

Abstract

Since the Second World War, international nurse recruitment has become a high-level political matter in spheres of cross-border global governance. This paper traces the global politics-ethics nexus of this development through a focus on two multilateral agreements that regulate such recruitment: the International Labour Organization Nursing Personnel Recommendation (1977) and the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel (2010). Innovating a global historical-critical institutional ethics of care enquiry to frame and structure the analysis, the paper argues that these global-level agreements have been consistently intentionally permissive of the international recruitment of nurses. International organisations and the international community of state and non-state stakeholders have facilitated these global nurse labour dynamics, not despite two major regulatory initiatives but through them. We find that both multilateral agreements mostly meet the standards of a global ethic of care, but do not do so as far as a critical ethic of care is concerned. The weak global institutional framework, the lack of strong connecting mechanisms in the Global Code to national spheres of governance and law, the absence of lateral links to international legal codes in the areas of social and labour policy, and the failure to address historical (including colonial) legacies underpinning the systematic depletion of national nursing workforces in poorer countries present significant challenges in realising the level of nursing workforce sustainability necessary to achieving the health and health-related SDGs.

Keywords: care ethics; nursing workforces; international recruitment; global governance; multilateralism; world-systems.

1 INTRODUCTION

International nurse recruitment and migration have played out across richer and poorer countries in complex and diverse ways throughout modern history, but only relatively recently have they become problematised as a global ethical issue requiring concerted collective action at the level of global governance. The establishment of worldwide institutions, especially in the immediate post-WWII era[1], ushered in a global liberal economic and political order that included (amongst others) greater international integration of labour markets in health care. These macro-structural changes, combined with

[1] There was no UN system prior to 1945. Its predecessor, the League of Nations, was neither strong enough nor encompassing enough of all countries; empires had not yet collapsed and colonial powers were closed to "outside" influence as to how they and the territories they occupied were governed.

advances in travel and communication technologies, built on pre-war and longer colonial trends to herald a growing reliance on overseas-born and/or -trained health professionals generally, and nurses particularly, to fill vacancies in the expanding health care services of many countries in the Global North and richer countries of the Global South.[2]

Although there is considerable variation in the proportion of overseas-born and/or -trained nurses in national nurse workforces, as there is in the strategies deployed to recruit them, there is no doubt about the significance of the internationalisation of nursing for health care services provision, workforce planning and wider development. Health and development advocacy actors, including source country governments, have long been concerned that rich destination countries at the apex of the "global nursing care chain"[3] have been able to recruit nurses from poorer countries without significant restraint.[4] This recruitment has meant that source countries have borne the investment costs of educating and training a professional nursing workforce without benefitting from corresponding health and development returns. With the general direction of nurses (and other health professionals) moving from poor to richer countries and from richer to richest countries, the distributive outcomes of these global labour dynamics on population health have been so regressive and catastrophic for the poorest source countries as to be characterised as "fatal flows".[5] At the same time, advocacy actors have highlighted the adverse labour conditions underpinning this international process: the appalling working conditions and lack of career development and other opportunities available to nurses in source countries, the dire recruitment practices used to draw nurses and other health professionals to work overseas and the grim working conditions they endure in destination countries.[6]

This paper responds to the overall question: "To what extent does the global regulation of international recruitment and migration of nurses evidence an institutionalised critical ethics of care?" It examines the historical-ethical antecedents to international nurse recruitment and migration with specific reference to the sphere of global governance. It focuses on the intersections between ethics and politics in shaping the global regulation of international nurse recruitment and migration during the eight decades since the post-World War 2 organisations and institutions of global governance were established. Above all, the paper is concerned with the extent to which the global regulation of international nurse recruitment and migration evidences a global institutionalised critical ethics of care. By this we mean global-level norms and standards that effectively practice valuing others and respond to, and meet the health and labour needs of, others, and in a way that also addresses the wider global dynamics of domination and inequality that give rise to those needs.[7] The relatively long sweep of post-war history beneficially affords a comparative perspective on ethical-political constellations at different periods across the decades.

Our focus on how nursing workforce supply issues have been construed as a matter requiring global regulation fills a notable omission in the now voluminous academic literatures on international health worker/professional nurse migration and its outcomes. With notable exceptions[8], these literatures have paid scant attention to the transnational domains of governance, regulation, policy, financing and provision. Notably, Wright et al.'s (2008) otherwise informative historical overview of ethical debates about physician migration omits to mention any involvement of international organisations in this

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2 Yeates/Pillinger 2018, 2019; Choy 2003; Rafferty 2005; Yeates 2009.
3 Yeates 2009 a, p. 9, and chapter 4.
4 Pillinger/Yeates 2020; Gencianos et al. 2022.
5 Chen/Bouffard 2005.
6 Yeates 2009; Pillinger/Yeates 2020; Yeates/Pillinger 2019; Kingma 2006; Walani 2015.
7 Our distinction between institutional and organisational ethics of care follows that by Lanphier 2021.
8 Yeates/Pillinger 2019.

field, despite their being active participants shaping the debates over time. At the same time, the global health labour migration literature tends to aggregate health professionals into a single analytical unit. Not only do nurses represent 45% of the global health workforce and are the single largest category of health workers,[9] but specificities particular to this sizeable workforce have not been adequately considered in the scholarship on global health and labour governance.[10] Our focus on the history of global governance in relation to the nursing profession renders visible a wider range of institutions, actors and ideas shaping the policy field than country-level studies have captured.

We innovate an expansive analytical framework for this task. Drawing on Joan Tronto's pioneering work on a feminist ethics of care[11], Fiona Robinson's critical ethics of care in international relations, and the concept of domination rooted in world-systems theory[12], we introduce a globalised and historicised critical care ethics framework developed by us for the purpose of this paper, rooted in social justice and rights. Our data was gathered through extensive archival research covering the seven decades since 1946[13]. Search terms 'international migration', 'international recruitment', 'health personnel', 'health professionals', 'health workforce', 'shortage', 'brain drain', 'brain circulation', 'health care', and 'health services' were used in combination to sift significant quantities of resolutions, policy initiatives, meeting notes, and studies spanning seven decades. This was a mammoth task. For example, constructing the UNGA's activity since its earliest days entailed searching about 18,000 documents on the UN database. Ascertaining WHO's history involved systematic searches of seven decades' worth of World Health Assembly (WHA) documentation at two major volumes per year each consisting of 100–300 pages. Similar searches were undertaken for ILO over the decades, and for other international organisations and bodies. In each case, documentation was sifted to check relevance and analysed to identify instances of intervention, connections and thematic threads using manual coding techniques. The results of this research exercise were used to construct a 'timeline' of principal UN activity (decisions, resolutions, recommendations) in relation to international health worker-migration, taken by organs and bodies of the UN and by its specialised agencies.

Our systematic search for UN official documentation pertaining to its initiatives on cross-border health worker-migration was complemented by consulting the e-libraries of the Organisation for Economic Cooperation and Development (OECD), the World Bank, the International Organisation on Migration (IOM) and the Global Forum on Migration and Development. We concentrated on the official documentation emanating from the UN bodies and agencies in New York and Geneva. We did not include regional bodies of the UN or regional development banks. We limited ourselves to the discourses and commitments in official documentation, not whether they have been implemented in country-level contexts. In addition to our analysis of the primary (archival) research, we undertook secondary analysis of international health worker and migration datasets and academic research literatures.[14]

The analytical framework we have developed clearly demonstrates how the international community has collectively responded over time to the global nursing crisis, through cross-border spheres of governance and processes of global norm- and standard-setting, to govern international nurse recruitment and migration. This finding is based on routing evidence regarding how those institutionalised norms and standards fare in relation to our expanded care ethics analytical framework. We specify

9 Boniol et al. 2022.
10 Kingma called for a special global fund to support health systems strengthening and the human workforce to be set up, but this was incidental to her research, see Kingma 2006, p. 209.
11 Tronto 1993.
12 Wallerstein 1974, 2004; Chase-Dunn/Grimes 1995; Chase-Dunn/Hall 1997; Soederberg 2006.
13 Yeates/Pillinger 2019.
14 Ibid. pp. 45-46.

key moral elements to assess the adequacy of two global agreements and apply them to a global context. Our overall aim is to bring nurses into critical care ethical enquiry in a field that remains predominantly focused on contemporary and short-term history, country-level spheres of governance, informal family care and health professionals in general, and to stimulate further theoretical and empirical research into global critical care ethics.

The paper develops through four further sections. Section 2 sets out the rationale and nature of the analytical framework used here. Sections 3 and 4 trace how nurses have featured within the ongoing ethical-political construction of global-level responses to the collective ethical dilemma associated with mass international health professional recruitment and migration. It shows how the politics of global policy have shaped the global regulatory response. The discussion focuses on the two multilateral agreements: the International Labour Organization (ILO) Nursing Personnel Recommendation (1977) (hereafter R157) (Section 3) and the World Health Organization's (WHO) Global Code of Practice on the International Recruitment of Health Personnel (hereafter Global Code) (2010) (Section 4). Section 5 concludes by returning to the paper's objectives of discussing the ethics-politics nexus in an historical and global framework. It considers the implications of this enquiry for future ethics-led research and reflects on their meaning and significance for current debates about the future of global governance of international nurse recruitment.

The overall argument presented is that global-level regulations in this policy space have been consistently permissive of the international recruitment and migration of nurses. International organisations and the international community of stakeholders have facilitated these global labour dynamics, not despite two major regulatory initiatives but through them. Furthermore, we argue that although R157 and the Global Code contain many positive elements that accord with a critical feminist care ethics, they fall short of this ethics' standards. This is principally due to the agreements' failure to sufficiently address structural dynamics rooted in histories of colonialism and uneven development, together with the weak global institutional framework in which they are embedded and upon which they partly rely for implementation.

2 GLOBALISING CARE: BUILDING AN ANALYTICAL ETHICAL FRAMEWORK

In 1993, Joan Tronto launched a stinging critique of care being framed as a personal moral disposition of and/or actions by women, an activity most appropriately analysed at the level of inter-personal relations between the care-giver and -receiver.[15] Her intervention called into question the gender bias (indeed, sexism) of care essentialism, the problems of abstract reasoning and decontextualised constructions of care, and the resultant invisibilisation and de-politicisation of care. The subsequent re-focusing of research towards what socio-institutional arrangements best promote gender-equitable care has proved productive for feminist scholarship across many disciplines.[16] This scholarship

[15] Tronto 1993.
[16] See, for example, Dalla Costa/Dalla Costa 1993; Duffy 2011; Ehrenreich/Hochschild 2002; Feder 1999; Folbre 1995; Gardner 1997; Himmelweit 1999, 2000, 2007; Hooyman/Gonyea 1995; Narayan 1995; Pearson 2000; Razavi 2012; Robinson 1999; Ungerson 2007; Williams 2012; Yeates 2004.

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redrew the boundaries as to what counts as a public affairs issue and showed care to be a significant, if severely undervalued, public good. Indeed, progress in public policy as a political practice of policy-makers, by contrast, has proved glacial in pace. Thus, Tronto (amongst others) continues to call out the de-prioritisation of genuinely gender-equitable care in public policy and political-philosophical treatises on the human condition.[17]

For the purposes of this paper, we focus on feminist scholarship in international relations (IR)[18] in the form of Fiona Robinson's work on a critical ethics of care. Taking up Tronto's ethics of care, she questioned whether and how what "we" value is visible and ingrained in the sphere of international relations among states. Like Tronto, she argued that an ethics of care demands "an awareness of social relations as a starting point for ethical enquiry"[19] and an orientation towards "problematising norms and structures that underwrite and sustain exclusionary structures"[20]. For Robinson, an IR-led ethical enquiry through the lens of a critical care ethics means engaging with how:

> [...] the structures of a globalising political economy sustain exclusionary social practices and structures in the contemporary global system: how boundaries are constructed, how 'difference' is assigned, and moral and social exclusion is legitimated.[21]

Although the sphere of cross-border governance was not the major focus of Robinson's work, she considered how the language and practices of multilateralism, interdependence and partnerships in relation to poverty and humanitarianism perpetuate exclusionary structures, gendered international norms and practices, and the cultural hegemony of Western values.[22]

A focus on geo-power and -politics in all its guises is clearly relevant for any sort of global analysis, but missing from Robinson's account is a robust theorisation of domination. World-systems theory proves helpful here for its focus on how historically embedded world-level structures and relations of inequality and exploitation between core, peripheral and semi-peripheral zones of the world actively condition development, resulting, for many countries, in "maldevelopment"[23]. This paper's focus on global-level norms and regulatory interventions is, like world-systems theory and Yeates' previous work, also rooted in a theoretical tradition inspired by historical materialism. This roots our concern with configurations of organisations, actors and ideas in the material contexts from which they originate and in which they operate, and their capabilities for promoting progressive social development. The resultant materialist analytics of global nurse labour governance retains a focus on the array of social forces shaping that governance over time, including capitalist social structures in general, globalising dynamics of health care services economies, and geo-politics. This materialist analytics connects the multilateralisation of international nurse recruitment and migration governance and policy with the ongoing multilateralisation of nurse recruitment and migration,[24] together with the legacies of colonial historical dynamics that continue to play out in national and cross-border spheres of governance.[25] These legacies are normatively very relevant for a critical global historical ethics of care. Notably, some have argued that former colonising countries have special responsibilities towards formerly colonised ones, particularly concerning reparations and the ongoing impacts of colonialism.[26] Versions of this

[17] Tronto 2013, 2017, 2018, pp. 21–27. See also fn 13.
[18] Robinson 1999.
[19] Robinson 1999, p. 165.
[20] Robinson 1999, p. 132.
[21] Robinson 2006, p. 131.
[22] Robinson 1999, pp. 97, 109–110, 158.
[23] See fn 9; Yeates/Holden 2022; Amin 2011. Yeates' 2004, 2009, 2014 "global nursing care chains" research draws on world-systems theory.
[24] Yeates 2014.
[25] Yeates/Pillinger 2019.
[26] Hickel 2018; Mehta 2019; Goldstone 2024.

argument have featured in discussions of the sort of global-level interventions needed across the period examined here.[27]

The implications of these feminist analytical frameworks are twofold. First, although Tronto's focus was on family care, it is applicable to professional carers, including nurses, working in professionalised, institutionalised and highly-capitalised healthcare environments[28]. A care ethics in relation to nurses goes beyond the moral decisions individual nurses make during their professional practice (including decisions to emigrate/remain) and the micro-level nurse-patient relationship to also consider the macro-level determinants of relations between nurse workforces and population health as a whole. Second, and relatedly, the corollary of Tronto's and Robinson's insistence that the rightful focus of a care ethics-led enquiry should be on social, economic and political structures shaping who provides care and mutual support, under what material (and other) conditions, and with what effects and outcomes, is to bring the sphere of global governance squarely within the scope of enquiry. If, as Tronto has argued, an ethic of care involves the moral elements of attentiveness, compassion, nurturance, responsibility and responsiveness[29], then a critical care ethics enquiry directs our sights towards their "global" equivalents. In this vein, the classical concerns with caregivers' personal moral dispositions, decisions and responses become, in a globalised context, the quest for socio-institutional arrangements and practices that are: attentive to the health and care needs of populations and the nursing workforces caring for them; display compassion towards these populations; nurture long-term nurse workforce planning and funding in support of robust health care systems, universal health and care coverage and high-quality public services; evidence a clear responsibility to stop the depletion of collective human health resources from poorer countries and the exploitation of health labourers; and enshrine transnational obligations of all stakeholders to uphold their responsibilities in accordance with agreements, together with robust, responsive monitoring and accountability mechanisms. Because present-day workforce challenges are in part rooted in long histories of uneven development and colonialism, these transnational obligations include a clear responsibility of (former colonising) recruiting countries to compensate (former colonised) source countries for depletions.

But what would it mean for an institution or a formal agreement to demonstrate its capability to enact all these elements of a critical ethics of care? In order to answer this question, we need to move from identifying elements of a critical ethics of care to operationalising them. Figure 1 sets out a framework for this. It identifies what sorts of institutional mechanisms and actions are needed to fulfil the standards demanded by this moral approach. We deliberately eschew identifying specific criteria or exact thresholds because these are not appropriate for the paper's purpose of assessing the quality of a multilateral agreement. Indeed, such agreements are invariably restricted to setting out overall aims, principles, signatories' (and other stakeholders') responsibilities, mechanisms propelling action and monitoring overall standards. It is the presence or absence of particular elements, as operationalised in Figure 1, that enables us to draw an overall conclusion as to whether a global agreement meets the standards implied by a critical ethics of care approach. Finally, it is worth noting that the elements individually identified below are in practice closely interconnected.

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[27] As covered by Yeates/Pillinger 2019.
[28] Yeates 2004.
[29] Tronto 1993, 2013.

Figure 1: Analytical framework to operationalise a critical institutional ethics of care in relation to global treaties on international nurse recruitment and migration

MORAL ELEMENTS	OPERATIONALISED THROUGH
Attentiveness to the health care needs of populations and the nursing workforces needed to meet them	Periodic comprehensive nurse workforce planning viz size, composition, practice and deployment, in relation to population health needs
Compassion towards populations' unmet health care needs and nursing workforce needs	Feed-in of evidence to timely and well-constructed action addressed to the problem(s) identified
Nurturing long-term comprehensive nurse workforce planning in tandem with robust health care systems and universal high quality public services coverage	Addressing the root causes of nurse international recruitment and migration Nurse workforce planning and investment International solidarity and cooperation among countries, especially for poorer ones
Responsibility to stop the depletion of nursing workforces from a country	Threshold of nurse workforce at which nurse recruitment from a country is not permitted Compensate sending countries for lost investment of health and development resources (nurses) due to recruitment/migration
to stop labour exploitation of nurses, including during recruitment to work overseas	Adherence to human rights and international labour standards, including decent working conditions, fair and ethical recruitment, and fundamental labour rights of migrant workers
Responsiveness of all stakeholders to address existing shortfalls in realising any of the above elements and preventing these from recurring	Robust monitoring, learning and accountability systems underpinned by timely data and results

Note: the moral elements of care are identified by Tronto (1993, 2013); they have been adapted by the authors of this paper to the focus and context of this paper'.

Looking at these issues through the lens of a critical ethics of care raises questions about how to balance the health care needs of the population in richer countries with those of poorer countries. How is the right of the individual to migrate to be balanced against the collective right to health and development? And what responsibilities do recruiting countries have towards source countries and the nurses they recruit from them? Such questions go to the heart of the problem: How far should international recruitment and migration be regulated in the interests of global public health, welfare and social development? And what should that regulation aim to do? Cognisant of Tronto's insistence that morality and politics are closely entwined, and in keeping with our historicisation of global governance interventions and their material bases, the emphasis of our discussion is on whether global regulatory

agreements institutionalise a critical ethic of care and how they have changed over time. In keeping with our critical care ethics, we are also interested in whether global-level action in the shape of R157 and the Global Code have the capability to decisively "shift the dial" when it comes to the power and material inequalities underpinning international nurse migration and recruitment, leading to fairer distributive outcomes across the global nursing care chain.

3 THE NURSING PERSONNEL RECOMMENDATION, 1977

The first ever global agreement aimed at regulating the international recruitment and migration of nurses was negotiated and concluded through the International Labour Organization (ILO)[30] in 1977 and took the form of the Nursing Personnel Recommendation (hereafter, R157)[31]. In the ILO institutional framework, a recommendation is a distillation of labour-related norms and standards translated into positive guidance to governments, trade unions and employers (and other parties). It is not binding on governments in the sense that ILO conventions, once ratified, are. Two points of note about R157 are pertinent. First, the issues of direct concern to this paper are confined to just one article – Article XIII (there are 14 articles in all). Second, R157 needs to be read in the context of the UN's normative framework (holding that international migration is a human right and should be voluntary and freely chosen) and the ILO's body of labour norms and standards that promote dignity at work and high standards of decent work.[32]

Figure 2 maps key features of R157 onto our operationalised care ethical framework. Given that R157 is primarily an ILO labour standards instrument, most of its content concerns nurses' working conditions (education, training, career development, pay and overall working conditions). In addition, institutional governance, policy and implementation are framed in relation to overall ILO provisions, which cover our criteria of attentiveness, compassion and responsiveness. And, as far as the focus of this paper is concerned, although the inclusion of Article XIII is evidence in itself of these three criteria in a general sense, it is most direct and explicit in relation to the nurture and responsibility criteria. The Preamble refers to "shortages" of qualified nurses, many of whom "are not always utilised to best effect", as an obstacle to the development of effective health services. Article XIII's overall approach accepts, values and encourages international nurse migration, notably for its contributions to improving nurses' professional development and the standard of nursing care as part of an expansion of nursing (and other health) services. At the same time, it makes clear that international recruitment should be deployed as an exception in responding to staffing shortages. In this, it specifies very precisely the circumstances where these exceptions apply (Article XIII.67.1) (Figure 2) and stipulates the conditions under which such recruitment should take place (XIII.67.2). This international recruitment circumstances-and-conditions "red line" applies to nursing personnel involved in providing nursing care and nursing services anywhere.

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[30] The ILO is a specialised agency of the United Nations. It promotes internationally recognised labour rights, bringing together governments, employers, and workers' representatives from its 187 member states to set labour standards, develop policies and create programmes that advance "decent work" for everyone.

[31] ILO 1977. R157 was accompanied by a Nursing Convention (C149). ILO conventions are binding on ratifying parties but C149 was silent on international recruitment and migration.

[32] Universal Declaration on Human Rights, 1948, Article 13. UN General Assembly Resolution 217 A; also, see Migration for Employment Convention and Recommendation (Revised), 1949, to which R157 makes direct reference (Article XIII.67.2). R157 is one instrument in a broader body of labour norms and standards and should be read in conjunction with them (R157 Preamble).

Joan Tronto was insistent that care ethics must be understood in their political context. On this point, we remark that R157 was the apex global policy response to the anxieties about national technical personnel shortages that many source country governments had expressed in UN General Assembly (UNGA) resolutions[33] throughout the 1960s. Those resolutions highlighted the need for systematic assessments of human resources as part of a wider strategy of social and economic development planning, including urging developing countries to grow their education and training capacity to ensure they have sufficient health personnel to meet their own needs. Those calls were echoed by other UN agencies which had called for UN action to stop source countries' human health and development resources from being depleted.[34] Two reports (UN Secretary-General (UNSG), 1967, and ILO, 1967) stood out for highlighting that the most acute shortages were often to be found in the nursing and midwifery workforce's adverse working conditions,[35] in a debate otherwise largely referring to the emigration of male-dominated professionals (engineers, scientists, physicians).

These UN reports helped forge a growing consensus that such action was a global responsibility, and called for stronger global-level action to coordinate and steer national governments. UNESCO was clearest in this, insisting that "brain drain" was a global issue requiring a global response from UN and other international organisations.[36] It argued that "[i]t is obvious that the migration of specialists must be regulated",[37] but the question was how to respond. Amongst the possible responses it set out was a global labour compensatory facility, funded by recruiting countries to compensate source countries for "draining" their highly skilled labour and depleting their development resources.[38] Had such a response been instituted, it would have been the first ever global reparations fund, paid by rich (former colonising) recruiting countries for poorer (former colonised) source countries. In practice, however, UNESCO stood back from it, and came out in favour of an international declaration to raise public awareness of the catastrophic consequences of "the brain drain" and forge a political atmosphere conducive to solving the problems identified with mass international recruitment of highly skilled personnel.[39]

Although most of the impetus was driven by the ILO, UNESCO, UNSG and UNCTAD, the WHO's contributions were significant. On the one hand, it was an early participant in the debate, having referred to serious health workforce shortages in its first and third World Health Situation reports and in World Health Assembly (WHA) resolutions in the late 1950s and the 1960s.[40] These warned that worsening staffing deficiencies (including nurses) impeded the extension of health services, the elimination of disease and the improvement of public health.[41] Then, the WHO's focus was on supporting newly independent countries to address deficiencies in their health programmes, facilitating international exchanges of health personnel through its fellowships scheme, and advancing work to enhance the equivalence of medical curricula and qualifications internationally.[42] The latter two strands mostly seemed to facilitate international recruitment, but – arguably – addressed the "brain drain" problem insofar as non-recognition of overseas training required for professional development and advancement constituted a barrier to health professionals returning "home" to practise their profession. As

[33] UN resolutions play a key role in shaping global norms and making visible member states' "anxieties". They can be a prompt or precursor to further UN work on the issue at hand. With some exceptions (not relevant to this paper), they are not binding and have the status of a recommendation.
[34] ILO 1967; UNESCO 1966; UNSG 1964, 1967; UNCTAD 1971, 1975.
[35] See ILO 1967, pp. 17–18, regarding shortages of midwives, nursing staff and others in Central, North and Latin America.
[36] UNESCO 1968 a, p. 36.
[37] UNESCO 1968 a, p. 37.
[38] UNESCO 1966, p. 177.
[39] UNESCO 1966, p. 43.
[40] WHO 1959, 1967; WHA 1961. See Yeates/Pillinger 2019 for further information.
[41] WHO 1967, p. 34; 1969 b.
[42] The WHO initiative on equivalence of medical degrees (WHA 1968, 1969 a), promoted by the UN Regional Committee for Africa (AFR/RC17/R4), was primarily concerned with inadequately equipped and trained "manpower"(sic) in Africa (see WHO 1968, p. 5).

permanent non-return meant a loss of potential dividends for source countries from their investments,[43] the curricula and qualifications strand of the WHO's work programme was a practical response to mitigating the impacts of overseas migration. The WHO did not publicly engage with the growing consensus on the need for global-level action at the time; its focus was country-level action and in this regard its sight was firmly fixed on countries in the Global South. In any case, the focus of WHO work was on physicians, not nurses (as judged by its work programme during the UN's First Development Decade (1965–1975)).

It was not until the end of the 1970s, that the place of nurses within the "new" globalising dynamics of health labour markets was explicitly recognised.[44] A major report was commissioned in 1974 in response to explicit demands by source country governments at the WHA year after year that global-level action was urgently needed. It provided new data about the extent and dynamics of nurse (and other health personnel) recruitment and migration, estimating that about "5% of all the world's nurses are outside their country of origin or training."[45] The authors reported that decolonisation had accelerated the pace of nurse emigration from newly independent countries, especially those in Asia[46]. The principal direction of this emigration was from (mostly former colonised) developing countries to developed countries of Europe, North America and the Western Pacific, and to the oil-producing states. Nurses were "even more inequitably distributed around the world" than physicians:

> Of the world's 3.6 million nurses, 3.1 million (85%) are in developed countries which contain only a third of the world's population. Thus, the two-thirds of the world's population living in developing countries have only 15% of the world's nurses. Asia, alone, which has over 40% of the world's population, has only 10% of the world's nurses. This situation is aggravated by nurse migration patterns. [...] the developed countries receive 92% of the migrant nurses but supply only 60%; the developing countries, on the other hand, supply 40% of the world's migrant nurses but receive only 8% [...] At the lowest level, Africa and Oceania receive very few nurses indeed. [...] [T]he developed countries are seen to gain 0.4% per annum and to lose 0.3% per annum, with Canada and the USA gaining more than four times as many as they lose. [...] All the developing areas lose more than they gain.[47]

In a context where the focus on the medical "brain drain" debate had referred to doctors, the WHO's specific focus on nurses helped feminise the global policy field. It proved to be an important starting point for a strand of WHO activity that grew into more substantial programming over time.

For the WHO, R157 was an opportunity to demonstrate the policy applications that the Mej'ia et al. study had raised – even before the report had formally concluded. The ILO's role as the organisational "host" for a new global regulatory instrument reflected the fact that the WHO was unable to make much headway on its own, given its institutional governance structures gave de facto controlling power to the rich, formerly colonial, countries.[48] For the ILO, R157 was an opportunity to demonstrate its engagement with the working conditions of skilled labour migrants in a highly feminised branch of the health workforce. Indeed, the mid-to-late 1970s was a period of intensifying ILO activism in standard-setting in international migration and recruitment. This followed up ILO's Migrant Workers Convention and Recommendation (1975) affirming that migration policy should take account of the

[43] Two WHO resolutions (WHA 1968, 1969) established the principle that qualified doctors from developing countries who emigrate for professional development should be encouraged to return to their countries voluntarily following placement.
[44] Mej'ia et al. 1979.
[45] Mej'ia et al. 1979, p. 43. Mejia et al. op cit. (broadly comparable with physicians (6%)).
[46] Mej'ia et al. 1979, pp. 46–47.
[47] Mej'ia et al. 1979, p. 47.
[48] WHO membership is comprised exclusively of national governments, unlike the ILO which has a tripartite governance structure. Even though governments can never be outvoted by Employers' and Workers' groups, the ILO's institutional structure gives rise to a different policy dynamic than the WHO's. WHA resolutions have no binding force, simply reflecting collective concerns raised by governments. Health regulations are used only for bio-health issues, while multilateral conventions take years to negotiate.

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short-term labour needs and resources and the long-term social and economic consequences of migration for migrants and communities in source and recruiting countries, and that adverse human and wider social consequences of excessive or uncontrolled increases in international migration should be avoided.[49] The ILO regarded R157 as integral to the second phase of its action programme to promote women's working conditions and prospects at work through equal pay, and equality of opportunity and treatment in employment.[50] For both the ILO and WHO, then, R157 was an opportunity to pursue elements of their own institutional mandates and work programmes. Above all, R157 could help realise multiple goals: strengthen international standards on gender equality and labour migration; address health worker shortages and the development of health professions; promote wider UN principles on migration as a human right; and promote international development cooperation through the provision of technical assistance and international agreements.[51]

R157 was the first UN agreement to regulate international nurse and health worker recruitment. It complemented and extended the "no harm" principle of the Migrant Workers Convention (1949). And although it was confined to making "suggestions" for the practical application of the principles, R157 automatically benefitted from ILO's implementation-monitoring and reporting mechanisms. In practice, however, this has been hard to achieve, as Recommendations are not subject to ratification. In any case, the implementation of R157 has never arisen in the Conference Committee on the Application of Standards[52]. None of the General Reports by the Committee of Experts on the Application of ILO Conventions and Standards (including the only three dedicated to migrant workers) covered nursing personnel, whether migrant or not. Nor did they follow up issues to do with the implementation of R157 (or the Nursing Personnel Convention). In ILO governance of monitoring-implementation processes (under article 19), the Conference Committee may, request a report on a specific convention or general survey. However, it has never requested a report on the Nursing Personnel Instruments. Indeed, R157 does not seem to be even considered as a migration instrument: on neither occasion when the Conference Committee requested a report on ILO labour migration instruments (1999 and 2016) did it include R157. This collective failure by the ILO constituencies (governments, employers, workers) to make full use of the ILO's monitoring mechanisms has undermined the realisation of the international standards R157 set for international nurse recruitment.

4 THE WHO GLOBAL CODE OF PRACTICE ON THE INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL

Some three decades elapsed before the WHO was able to make good on demands made at successive World Health Assemblies (WHAs) by source country governments in the 1960s and 1970s to regulate international nurse recruitment. In May 2010, the 63rd WHA adopted the WHO's first, and the world's second, multilateral framework to regulate the international recruitment of health workers. Unlike the nurse recruitment and migration principles bolted on to R157, the Global Code was wholly dedicated to international recruitment; it related to all health workers, not just nurses. Figure 2 sets out the provisions of the Global Code in relation to our operationalised care ethics criteria. Like R157, the Global Code

[49] ILO 1976.
[50] ILO 1978.
[51] Both organisations made compromises to push the recommendation through. See Yeates/Pillinger 2019 for further information.
[52] This committee is a standing tripartite body of the International Labour Conference and an essential component of the ILO's labour standards supervisory system.

aims to "establish and promote voluntary principles and practices for the ethical international recruitment of health personnel" while reaffirming the basic human right of everyone to migrate internationally.[53] It also addresses health worker shortages, though in a way that gives more attention to health systems and services than R157 did. In this, it refers to the need for health system strengthening, ensuring collective rights to health and development, especially in developing countries, as well as the need to "safeguard the rights of [health] personnel" (Table 2, attentiveness). The Global Code is far more explicit and elaborate than R157 about the institutional governance and effectiveness review mechanisms which are the basis of compassion and responsiveness. The actions and mechanisms needed to be spelt out because the WHO does not have a built-in implementation and monitoring structure like the ILO. The principle that all stakeholders could submit evidence to the ongoing monitoring process was not achieved at the time of the Global Code's conclusion, but six years later when an Independent Stakeholders Reporting Instrument (ISRI) was introduced. This specified that all "natural constituencies" can submit evidence to the WHO regarding the implementation of the Global Code.[54] In doing so, it fosters participatory policy making, which is a hallmark of democratic governance. Together with regular review points built into the Global Code's implementation, it facilitates upgrading the implementation mechanism over time[55] and enables it to become more responsive. This is a fundamental principle of accountability.[56] However, this presupposes that stakeholders have sufficient capacity and resources to engage with these participation and accountability mechanisms.

The approach of the Global Code to international recruitment of health personnel is similar to that of R157 insofar as it lauds the value and benefits of working overseas as part of professional and career development, and emphasises how that learning can reap dividends for source country health care systems on the return of the nurses (and other health personnel). In this, the Global Code is far more explicit about circular and temporary migration than R157 was, perhaps reflecting the growing importance of these forms of migration (and recruitment) in the international health labour market. A key difference between the two agreements is that the Global Code eschewed R157's assumption that international recruitment should happen only under exceptional circumstances and its criteria-led approach to those circumstances. Instead, it favoured a more general statement that "Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers" (Article 5.1), and that "All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible" (Article 5.4) (Figure 2, see appendix, p.19-21).

In short, the Global Code's ethical framework assigned explicit responsibility to recruiting countries to: adequately inform migrant health workers of their rights; provide the same working conditions as are enjoyed by nationals (the equality principle); avoid active recruitment from developing countries facing critical shortages of health workers and support the development of sustainable health systems, especially in low- and middle-income countries, through the provision of technical and financial assistance aimed at supporting workforce planning commensurate with future service needs, and developing working environments conducive to retaining health workers. Of note, financial reimbursement payable to source countries to compensate their loss of investment in human capital formation resulting from health workers being recruited to work overseas was dropped in the final stage of negotiations.

[53] WHO 2010.
[54] Only governments were originally identified as having access to the implementation mechanism. Although non-state stakeholders were incorporated into the process in 2016 through ISRI, this was only in relation to monitoring. The degree of engagement among stakeholders other than governments remains limited. See WHO 2016.
[55] This was the case for OECD Multi-National Enterprises Guidelines. The efforts of the ILO and UNCTAD secretariats also helped make the implementation mechanisms effective. See Sauvant 2015.
[56] Sauvant 2015.

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It is undeniable that the Global Code was a significant intervention in the global governance of international nurse recruitment and migration. The macro-political and -economic environment in which the Global Code was negotiated was significantly different from that when the ILO's R157 Recommendation was concluded. For one thing, it was overtly hostile to binding global agreements and measures for anything other than those concerning the promotion of "free" trade. Self-regulation was the default preferred mode. The formerly expansive labour activism of the ILO had rolled back its ambitions to focus on "core" labour standards. Also, in the early 2000s, the UN's authority was diminishing in a global policy field that increasingly took its inspiration from the USA and the rich-world-dominated World Bank and International Monetary Fund, which encouraged the liberalisation and integration of international (health) labour markets (amongst other things). Although the UN had always emphasised the benefits of time-limited international exchanges of nurses and other health workers, there was now a decisive shift in favour of temporary and circular migration – just at a time when permanent rights of settlement for labour migrants were coming under attack. These changes strongly conditioned the prospects for any meaningful global-level action to curtail international nurse (and health worker) recruitment by the richer countries of the world; they help explain the continued emphasis on the responsibility of all stakeholders to adhere to the spirit and letter of the Global Code.

The Global Code had come about in a context of political resurgence and the growing advocacy power of coalitions of state and non-state actors pressing for regulation in the interests of ethical recruitment of health workers. These coalitions had developed through campaigns for unilateral voluntary codes of practice on international recruitment of health workers during the 1990s. Initiated in advanced industrialised countries (also drawing in some developing countries) and "made" outside the UN system, they were bilateral or multinational in scope and often involved "the voices of employers, recruiters, unions, and migrants themselves".[57] The experience of these ethical codes and the advocacy coalitions that pressed for them was brought to bear in scaling up national-level coalitions into a global coalition advocating for a multilateral code uniformly applicable to all WHO member countries. The Global Code was a major step-change for the WHO.[58] Prior to then, the WHO had worked with individual governments one by one to strengthen the workforce components of national health systems. And whereas R157 was limited to nurses, the Global Code extended to all health workers recruited from overseas.

The Global Code's multilateral framework codifying universal principles and standards for ethical recruitment of international health workers has undoubtedly raised awareness, stimulated dialogue, and promoted the sharing of good practice, thereby succeeding in keeping the linked issues of ethical recruitment and health workforce shortages visible on global policy agendas. But there are several reasons to doubt its ability to engender transformative change in regulating international nurse recruitment and migration.

First, it is legally unenforceable:[59] the recommendation (Article 8.2) that the Global Code be incorporated into national policies and laws to make it legally binding has been systematically ignored by most governments.[60] Second, the Global Code permits substantial programmes of active overseas health worker recruitment so long as source countries do not have a critical shortage of health workers.[61] Third, the Global Code's provisions do not apply directly to "other stakeholders", such as private

[57] PSI 2012, p. 2.
[58] Lidén 2014.
[59] Bourgeault et al. 2016.
[60] The only major example to date of a government domesticising the Global Code is South Africa.
[61] The WHO's Health Workforce Support and Safeguards List (2020) (Red List) identifies countries whose low health workforce density renders them vulnerable to not achieving the UN Sustainable Development Goal target for universal health coverage (UHC) by 2030. These are countries from which no government should actively recruit health workers.

recruitment agencies (PRAs), despite clear evidence that many PRAs' practices are unethical. Private enterprises and employers are not obliged to comply with the provisions of the Global Code, unless required by national law to do so.[62] To the extent that the Global Code has any leverage at all, it is over WHO member states, whose responsibility it is to ensure their systems attain the required standards. Fourth, the absence of a precise operational definition of "ethical recruitment" hampers coherence across other policy instruments (e.g. bilateral/regional labour agreements and trade agreements). Fifth, the Global Code asks Member States only to "[…] observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel" (Article 8.7; emphasis added). A bolder agreement could have called on governments to invest more, above and beyond the level of support they already provide, for health systems strengthening as part of the Global Code's provisions on compensation.

Sixth, the Global Code fails to make lateral linkages with other global initiatives. Provisions on the protection of recruited workers only refer to "fairness"; they give insufficient attention to equality of treatment of migrant health workers in accordance with ILO conventions on fundamental rights at work and migration. Also, there is no mechanism in the Global Code linking the international standards of ethical practice to other areas. For example, global health partnerships and global health development assistance are not required to sign up to the principles in the Global Code.[63] And the Global Code is weakened by not referring to international standards.[64] In this, the absence of "lateral" mechanisms isolates the Global Code from global conventions embedded in the UN normative framework, such as the UN Convention for the Protection of the Rights of All Migrant Workers and Members of their Families, and ILO conventions on labour migration and recruitment standards. Seventh, the absence of a clear link between the Global Code and national regulation is a further issue.[65] In this, it fails to sufficiently promote better collaboration and shared responsibility for implementation and monitoring between different government ministries (health, justice, finance, employment) in source and destination countries.[66]

Data suggests that compliance with the Global Code is very limited. Engagement with it by state and non-state actors is low, especially so in countries and regions worst affected by health workforce shortages.[67] The "mutuality of benefits" principle embedded in bilateral labour market agreements is mostly restricted to the minimum of providing education and training to recruited nurses (and other health workers).[68] In the same vein, Public Services International (PSI)[69] concluded that "progress with the Code's implementation has stalled".[70] Governments have called for more technical assistance to support them in implementing the Global Code,[71] but the ability of the WHO to provide this is severely hampered by resource constraints (even prior to the USA's withdrawal from the WHO in 2025) and its reliance on donor funding from countries which are major recruiters of nurses. This financing challenge is heightened by declining levels of official development assistance (ODA) and greater competition for what ODA funds do exist.

[62] Non-government stakeholders only participate in monitoring the implementation of the Global Code but no obligations are conferred upon them to implement it.
[63] Mackey/Liang 2013.
[64] Following the argument of Sauvant 2015.
[65] Campbell et al. 2016.
[66] Yeates/Pillinger 2013.
[67] The WHO reported that just 14 independent stakeholders contributed to monitoring the implementation of the Global Code, see WHO 2022. This had increased to 13 independent stakeholders and 38 private recruitment agencies in the subsequent (fifth) round of reporting, see WHO 2025.
[68] Yeates/Pillinger 2018.
[69] PSI is a public services global union federation spanning 154 countries, with a membership of more than 700 trade unions representing 30 million workers.
[70] Gencianos et al. 2024, pp. 14–15.
[71] Campbell et al. 2016; WHO 2015, 2025.

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In short, weak national capacity and health systems, especially in lower-income countries, have confounded the implementation of the Global Code.[72] A sign of fragility of commitment to the Global Code was seen during the Covid pandemic,[73] when OECD countries intensified international recruitment of nurses and other health workers.[74] The justification for breaching the Global Code in letter and in spirit revolved around the "essential nature" of international recruitment in responding to the Covid pandemic. Some governments targeted countries with severe health workforce shortages, including several countries in Africa on the WHO's Health Workforce Support and Safeguards List.[75] This recruitment depleted those countries' capacity to respond effectively to the pandemic,[76] and the depletion was so extensive that (for example) the government of South Africa added six categories of specialist nurses to its critical skills list.[77]

5 DISCUSSION AND CONCLUSION

For much of the 20th century, nurses have been invisible in research agendas on ethical international recruitment. Internationally mobile nurses were nevertheless the subject of the first multilateral agreement on international health worker recruitment – the ILO's R157 – as policy agendas of southern countries, the ILO and WHO coalesced. In the opening years of the twenty-first century, the focus on nurses was broadened to encompass other health professionals in the WHO's purpose-made Global Code of Practice on the International Recruitment of Health Personnel.

In what we understand to be the first systematic academic evaluation of its kind, we have innovated an expansive analytical framework to "benchmark" these multilateral agreements against operationalised elements of a critical ethics of care. A key empirical finding of our research is that both the agreements generally fare well against these elements but they do so in different ways and to different degrees. To a point, this is explained by their being negotiated and concluded in markedly different political-economic circumstances: the first during the global "post-war consensus" of embedded liberalism, at a time of expansive labour and gender equality activism through the ILO; the second during the global neo-liberal consensus that rejected social regulatory expansionism, when the human health and development costs borne by low- and middle-income countries became intolerably high. The substantive differences between the two agreements in terms of the operationalised care ethics have not been as great as their similarities, however: they both uphold the right to migrate and the rights of countries to actively recruit nurses and other health workers (almost) without restriction. However, a higher standard of responsibility in R157 applies to international recruitment compared with the Global Code. Ultimately, though, neither agreement stops individual nurses from being recruited to another country to practise their profession.

Although the two agreements fare well against the moral elements of a global ethics of care framework, the norms and institutional arrangements put in place through the two agreements struggle to meet the standards of a critical global ethics of care. Structurally, the global agreements have not launched

[72] WHO 2015, 2025.
[73] Yeates et al. 2022; Pillinger/Yeates 2020.
[74] OECD 2020, 2021; WHO 2022; Yeates et al. 2022.
[75] Yeates et al. 2022.
[76] ICN/CGFNS/Buchan 2022, p. 30; Africa News 2022.
[77] Magubane 2022.

a significant challenge to the global relations of domination and inequality that historically gave rise to the global nursing workforce 'crisis' evident today. Across this entire period, developing source countries have continuously protested against their wealth being siphoned off through international recruitment to richer countries in order to fill nursing and other health vacancies in those countries. This dynamic has persisted, intensified even, over time, creating pronounced inequalities. Thus, ten principal high-income countries have 23% of the global stock of doctors, nurses and midwives while accounting for just 9% of the world's population[78]. Low- and middle-income countries remain focused on: targeted recruitment programmes resulting in the loss of specialists who are difficult to replace; needing to undertake international recruitment themselves as nationally trained graduates emigrate abroad; and the outflow of practising nurses to other countries as social care workers.[79] These are far from new phenomena or concerns. The Global Code's discourses of "international partnerships" and "mutuality of benefits" obscure the material reality underpinning these dynamics of intense inequality.

It must be concluded that, ultimately, these agreements have done more to secure wealthy countries' continuing access to the human resources for health of less wealthy countries than they have to limit it. Neither the WHO nor the ILO, nor any other multilateral or national organisation for that matter, has the authority and power to enforce restraining conditions on international recruitment beyond the exertion of moral leverage (save, perhaps, expulsion from the WHO, in extremis). The surge in international recruitment of nurses and many other health professional occupations during the Covid pandemic points to the fragile commitment by major recruiting countries to common international norms and standards. The incursion of active recruitment to "red list" countries and the stagnation of the implementation of the Global Code are, perhaps, the most apparent indicators of an unravelling global political consensus.

As we have suggested, critical questions about the Global Code are mounting in the face of growing evidence on the limited progress made in "shifting the dial" on international recruitment. Key issues for ongoing reviews of the effectiveness of the Code include: the scope of the agreement in relation to current international recruitment levels, trends and pathways and the recruitment practices of PRAs; the value of financial and technical assistance from recruiting countries relative to source countries' loss of investment; the challenges presented by temporary and circular migration and the contributions of the health and migrant diasporas to mitigate losses and maximise benefits of international recruitment.[80] A major issue of strategic importance is whether the Global Code should be opened for renegotiation or kept "closed", albeit with concerted efforts to strengthen its implementation. The risk that hard-won gains could be lost must be set against the prospective gains of broadening and strengthening its provisions. Either way, there is significant scope for strong global and national leadership among nursing professions and trade unions amongst others, to advocate the end of structural dependence of rich (core, formerly colonising) countries on overseas-born and -trained health and nursing workforces, and the dependence of poorer (semi-peripheral, peripheral, former colonised) countries on 'producing nurses for export[81]'. Only with structural changes in the political economy of nurse labour migration and recruitment, including a clear shift in favour of the presumption that "[a]ll Member States [will] meet their health personnel needs with their own human resources for health"

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[79] Mahat/Cometti 2024.
[80] Mahat/Cometti 2024.
[81] Yeates 2009.

(Article 5.4, Global Code) and strengthened compensatory mechanisms to address the ongoing legacies of historical (including colonial) development that deplete nursing workforces in poorer countries, does it seem that the standards of institutional practice consistent with a global critical ethics of care will be fully realised.

While we support a more engaged and historically-conscious debate about what strengthened global responsibility and accountability for the nursing and wider health workforce could mean, we reject the idea of establishing a dedicated international fund for health workforce and health systems strengthening.[82] Although such a fund could coordinate the disbursement of funds according to shared (global) priorities rather than according to the preferences of individual donors, it would reinforce the charitable model of international health assistance, while leaving untouched the crippling debt burdens that divert debtor countries' resources away from health systems strengthening to keeping to debt repayment schedules. It is easy to imagine that recruiting governments, which also tend to be principal donors of health-related financial and technical assistance, would reduce their overseas aid budgets by the amounts they contribute to such a global compensation fund. More promising may be to look outside of the health-migration nexus, in the form of a radical shift in the terms of international trade and investment to better support poorer source countries unlikely to meet the SDG health targets (or their future equivalents), coupled with international debt cancellation for those countries and a relaxation of the restrictions placed on their social spending by global institutional lenders, notably the World Bank and IMF. All of these would permit the increased level of investment in the health (and nursing) workforces that are required for strong health systems worldwide.

To conclude this paper, what are the implications of our expanded, 'thickened' analytical framework for how care ethics might be taken forward? A driving premise of this paper is that there is an unexplored possibility of using a care ethics framework to assess the overall moral quality of the two multilateral agreements that govern international nurse migration. This is a quite different approach than that which has dominated the field of care ethics to date, insofar as we have focused on regulatory instruments negotiated in spheres of cross-border (global) governance rather than in spheres of domestic (country-level) governance. Our study undertook a textual analysis of the two multilateral agreements, focusing on what the agreements say. Clearly, there is scope for further empirical research in relation to the quality of multilateral agreements viz how they have been implemented and in relation to other care professionals that do not share the labour conditions and occupational characteristics of nurses. Migrant social care professionals would be one prime focus for such a study, and would likely reveal a contrasting multilateral political-ethical institutional framework despite the significant overlaps between migrant nurse and social care workforces in practice. But a critical global ethics of care framework need not be confined to regulatory agreements pertaining only to migrant care workforces, as Robinson's application of care standards to poverty and humanitarian assistance has already demonstrated. A critical care ethics enquiry that looks beyond the health and social care sector prospectively opens up a wide range of other international agreements negotiated and concluded in global and sub-global multilateral forums pertaining to other sectors (e.g. trade and investment) whose ethical qualities can be assessed using the global institutional critical ethics of care approach and evaluative framework that we introduced and used in this paper. Our framework would, we believe, stand up to

[82] Kingma 2006, p. 209; O'Brien/Gostin 2011; Mackey/Liang 2013; Ruger 2012. Van de Pas et al. proposed a global compensation fund with obligatory payments from high-income countries and private sector organisations, see Van de Pas et al. 2016.

use in sectors other than nursing and care and provide a significant building block for further research into how the sphere of global governance interacts with and shapes public policy in domestic spheres. Such applications would be significant steps towards an expansive institutionalised care ethics of global governance and public policy.

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Appendix

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MORAL ELEMENT	OPERATION-ALISATION	ILO NURSING RECOMMENDATION R157	WHO GLOBAL CODE OF PRACTICE
Attentiveness	Periodic comprehensive nurse workforce planning viz size, composition, practice and deployment, in relation to population health needs	Art II.4(1): "Member[s] should adopt and apply…a policy concerning nursing services and nursing personnel designed, within the framework of a general health programme and within the resources available for health care as a whole, to provide the quantity and quality of nursing care necessary for attaining the highest possible level of health for the population"; Art II.4.2: "The said policy should--(a) be co-ordinated with policies relating to other aspects of health care and to other workers in the field of health…; (b) include the adoption of laws or regulations concerning education and training for and the practice of the nursing profession and the adaptation of such laws or regulations to developments in the qualifications and responsibilities required of nursing personnel to meet all calls for nursing services; (c) include measures--(i) to facilitate the effective utilisation of nursing personnel in the country as a whole; (ii) to promote the fullest use of the qualifications of nursing personnel in the various establishments, areas and sectors employing them; and (d) be formulated in consultation with the employers' and workers' organisations concerned."	Article 3.6: "Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel."
Compassion	Effective responses: feed-in evidence of timely and well-constructed action addressed to the problem(s) identified	Not specifically identified, but Art XIV.70 (Methods of Application) states R157 "may be applied by national laws or regulations, collective agreements, works rules, arbitration awards or judicial decisions, or in any other manner consistent with national practice which may be appropriate, account being taken of conditions in each country."	Article 3.7: "Effective gathering of national and international data, research and sharing of information on international recruitment of health personnel are needed to achieve the objectives of this Code." Article 5.4: "Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan."
Nurture	Addressing root causes of international recruitment & migration	Preamble: "[Notes] that the present situation of nursing personnel in many countries, in which there is a shortage of qualified persons and existing staff are not always utilised to best effect, is an obstacle to the development of effective health services."	Article 3.2: "Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed."
	Nurse workforce planning and investment	All Articles, esp: Art II.4(1) (see attentiveness, above) Art XIII.62 promotes "exchanges of personnel, ideas and knowledge, and thereby improve nursing care", using multilateral or bilateral arrangements, to (a) harmonise education and training for the nursing profession without lowering standards; (b) lay down the conditions of mutual recognition of qualifications acquired abroad; (c) harmonise the requirements for authorisation to practice; (d) organise nursing personnel exchange programmes."	Article 5.4: "Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible." Article 5.5: "Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs…" Article 5.6: "Member States should consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs. Member States should adopt a multisectoral approach to addressing these issues in national health and development policies."

MORAL ELEMENT	OPERATION-ALISATION	ILO NURSING RECOMMENDATION R157	WHO GLOBAL CODE OF PRACTICE
Nurture	International solidarity and cooperation among countries, especially for poorer ones	Not specifically identified. Two articles relate to international nurses: Article XIII.68 (International Cooperation): "Nursing personnel employed or in training abroad should be given all necessary facilities when they wish to be repatriated"; Art. XIII.69: with regard to social security, members should (a) assume to foreign nursing personnel training or working in the country equality of treatment with national personnel; (b) participate in bilateral or multilateral arrangements designed to ensure the maintenance of the acquired rights or rights in course of acquisition of migrant nursing personnel, as well as the provision of benefits abroad.	Article 10.2 "International organizations, international donor agencies, financial and development institutions, and other relevant organizations are encouraged to provide their technical and financial support to assist the implementation of this Code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this Code. Such organizations and other entities should be encouraged to cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development."
Responsibility	Threshold of nurse workforce at which nurse recruitment from a country is not permitted	Article XIII.67.1: "Recruitment of foreign nursing personnel for employment should be authorised only-(a) if there is a lack of qualified personnel for the posts to be filled in the country of employment; (b) if there is no shortage of nursing personnel with the qualifications sought in the country of origin." Art XIII.67.2: "Recruitment of foreign nursing personnel should be undertaken in conformity with the relevant provisions of the Migration for Employment Convention and Recommendation (Revised), 1949."	Article 5.1: "Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers." Article 8.7: "Member States are encouraged to observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel, and assess the scope and impact of circular migration."
Responsibility	Compensate source countries for lost investment due to recruitment/ migration of nurses	Not specified	Not specified. Note, however: Article 5.2: international cooperation and coordination arrangements "should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures." (e.g. technical assistance; support for health personnel retention and for social and professional recognition of health personnel; appropriate training in source countries; health facilities twinning; access to specialized training, technology and skills transfers; support for return migration). Article 10.3: "Member States either on their own or via their engagement with national and regional organizations, donor organizations and other relevant bodies should be encouraged to provide technical assistance and financial support to developing countries or countries with economies in transition, aiming at strengthening health systems capacity, including health personnel development in those countries."

MORAL ELEMENT	OPERATION-ALISATION	ILO NURSING RECOMMENDATION R157	WHO GLOBAL CODE OF PRACTICE
Responsibility	Adherence to human rights and international labour standards, including decent working conditions, fair and ethical recruitment, and fundamental labour rights of migrant workers	All Articles, esp Arts V-X inclusive concerning workers' representation, career development, remuneration, working time and rest periods, occupational health provision, and social security	Article 3.4: "nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them." Article 3.5: "Member States, in conformity with national legislation and applicable international legal instruments to which they are a party, should promote and respect fair labour practices for all health personnel. All aspects of the employment and treatment of migrant health personnel should be without unlawful distinction of any kind." Article 4.4: "Member States should, to the extent possible, under applicable laws, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to illegal or fraudulent conduct. Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about all health personnel positions that they are offered." Article 4.5: "Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws."
Responsibility	Robust monitoring, learning and accountability systems underpinned by timely data and results	Not specifically identified (but see compassion, above.)	Article 5.6: Member States should consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs." Article 6 – Data gathering and research 6.1 Member States should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base. 6.2 Member States are encouraged to establish or strengthen and maintain, as appropriate, health personnel information systems, including health personnel migration, and its impact on health systems. Member States are encouraged to collect, analyse and translate data into effective health workforce policies and planning. 6.4 WHO, in collaboration with relevant international organizations and Member States, is encouraged to ensure, as much as possible, that comparable and reliable data are generated…for ongoing monitoring, analysis and policy formulation." Article 7.1: "Member States are encouraged to, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health personnel migration and health systems…" Article 7.3 "Member State[s] should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code…and to submit reports and other information to the WHO Secretariat". Article 8 – Implementation of the Code 8.1 "Member States are encouraged to publicize and implement the Code in collaboration with all stakeholders." 8.4: "All stakeholders…should strive to work individually and collectively to achieve the objectives of this Code. All stakeholders should observe this Code, irrespective of the capacity of others to observe the Code." 8.6 "Member States should, to the extent possible, encourage and promote good practices among recruitment agencies by only using those agencies that comply with the guiding principles of the Code."

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WORKING IN 'PERFECT HARMONY'? OVERSEAS RECRUITMENT AND MENTAL HEALTH NURSING IN ENGLAND, 1948–1968

Claire Chatterton

Abstract

In May 1964, the *Daily Express* newspaper featured a photograph of nursing staff from 34 different countries at an English mental hospital, standing in a line with their arms linked, together with the matron. According to the feature writer, these nurses lived and worked in 'perfect harmony'. This article examines the broader issues that this image raises, by analysing international recruitment to mental health nursing in England between 1948 and 1968 and the impact this had on these recruits, their patients and colleagues. It will also discuss the ethical issues that ensued.

When the National Health Service (NHS) was implemented in the UK in 1948, the shortage of nurses, across all specialities, was so severe that its viability was threatened. Although the situation was to subsequently improve in general nursing, it continued to be an issue in what was then known as mental nursing, which experienced severe and ongoing problems in both the recruitment and retention of staff. This article is drawn from a wider study which analysed the strategies that were adopted to ameliorate this situation in England between 1948 and 1968, including the recruitment of mental health nursing students from an increasing number of overseas countries, which will be the focus of this article. The Republic of Ireland had been a major source of nursing labour before 1948, but when recruitment began to be resisted by the Irish government and alarm over poor staffing levels intensified, English mental hospitals moved their recruitment activity to other European countries and to the British Commonwealth.

Keywords: Recruitment, Retention, Mental Health Nursing, Migration, NHS

1 INTRODUCTION

This article is drawn from a wider study[1] which examined recruitment and retention in mental health nursing in England[2] in the first 20 years of the National Health Service (NHS), between 1948 and 1968. This period is noteworthy for being the time when concerns over shortages in mental health nursing were at their height, to the extent that this issue was discussed on several occasions in the UK parliament.[3] As part of this study, the strategies that were adopted to ameliorate both recruitment to, and retention in, mental health nursing were examined. Four were identified: advertising campaigns, educational initiatives, changes to the skill mix and the recruitment of mental health nursing students from an increasing number of overseas countries. This article will focus on the last strategy, which was

[1] Chatterton 2007.
[2] This article primarily focusses on England as this is where archival sources were consulted. England is one of four countries that constitute the United Kingdom. The other three are Scotland, Wales and Northern Ireland.
[3] For example, Hansard 1952.

arguably the most successful of the four but which did raise a host of ethical issues. Primary archival sources were utilised to examine this, with secondary sources and oral history interviews also contributing.

It will begin by discussing mental health nursing at the onset of the NHS in 1948 and will then examine the patterns of recruitment that followed. The countries that were targeted and the numbers of those recruited, shifted and changed in the period 1948–68, and will be considered in broadly chronological order, although there were some overlaps and variations between different mental health institutions in the countries that they recruited from (no hierarchical order is implied). This recruitment from overseas was to become the source of some ethical debate. As Rajpoot et al. note, "The significant rise in the recruitment and migration of nurses from one country to another may help address the shortage of nurses but it also poses several risks because of cultural differences, language barriers, and practices"[4] and, although they are commenting on current issues, an examination of the past shows that these risks were also of relevance then. Thus, while this article takes a historical perspective, it is also timely as the international recruitment and migration of nurses and the ethical, interprofessional and interpersonal challenges that can arise, remain contested issues today. In addition, this discussion aims to address what Julian Simpson has termed one of "the silences of NHS history" by, as he extols, "writing migrants back into the history of the NHS".[5] He argues that despite the NHS' dependence on migrant labour throughout its history, with recruitment often taking place within a context related to Britain's colonial past, this has rarely been acknowledged. As a result, he states, the contribution of nurse migrants has been marginalised and sometimes ignored or denied (as has that of other NHS staff),[6] which supports the persistence of racism and discrimination today, thus raising an important ethical issue in historiography.

2 MENTAL HEALTH NURSING BEFORE THE NATIONAL HEALTH SERVICE

Nursing is not a monolithic entity and in any discussion of nursing history, it is important to recognise the diversity of the areas that nurses have worked in and the way in which nursing has developed in the four nations of the United Kingdom (England, Scotland, Wales and Northern Ireland). The UK has never had a generic model of nursing; instead, nursing has developed within a series of specialities, which were recognised and formalised (after much debate) by the 1919 Nurses' Registration Act.[7] The main part of the register was reserved for those women who were nursing physically ill adults. This was known as the general part of the register and it is from this that the term 'general nursing' derives. However, the act also established several supplementary registers, including one for male nurses and one for nurses working with those termed as mentally ill, with the 'mentally deficient' and with sick children.[8] Today in the UK, it is still possible to train, and be registered, as nurses in four fields of nursing: adult (or general), mental health, learning disability and children's nursing.[9]

When the NHS was being planned, after the Second World War, the shortage of nurses, across all specialities, was so severe that it threatened its viability.[10] Aneurin Bevan, the Minister of Health, described

4 Rajpoot et al. 2024, p. 2.
5 Simpson 2010, p. 392.
6 Weekes-Bernard 2013.
7 Baly 1985. There were three parliamentary acts – one for England and Wales, one for Scotland and one for Ireland.
8 Bendall/Raybould 1969.
9 Nursing and Midwifery Council 2024, p. 8.
10 Solano/Rafferty 2006.

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the lack of nurses as approaching "a national disaster"[11] and although the situation was to subsequently improve in general nursing, it continued to be an issue in both what was then known as mental nursing, and also mental deficiency nursing (the former now being termed mental health nursing and the latter learning disability nursing in the UK). Difficulties in recruiting staff to work with mentally ill people have been an ongoing issue throughout its history. This was commented on in many enquiries and reports, including the Lancet Commission in 1932,[12] the Athlone Report in 1945[13] and the post-war Wood Report.[14] The annual reports of many mental hospitals[15] also contain frequent references to the difficulties of attracting and retaining staff in this specialty, a discourse which continues today.[16]

The nineteenth century had seen a huge growth of institutional provision across Europe for those deemed to be mentally ill.[17] Asylums were built across England (and the United Kingdom), and these grew rapidly in size as the century progressed, necessitating the need for more men and women to be recruited to work as nursing staff there.[18] These early mental health nurses were known by a variety of titles, including keeper, attendant and, later, mental nurse,[19] and both men and women had to be recruited for this work, due to the spatial divide in asylums, which had strictly delineated male and female sides for patients, who were nursed by those of the same sex.[20] In 1948, these former asylums and the staff that worked in them, joined the new NHS. As Nolan and Hopper note, "The mental hospitals were old, badly maintained, poorly provided with amenities, geographically isolated and mostly too large to provide an appropriate caring environment for highly vulnerable adults."[21] Although the 1960s were to see the beginnings of community care, these institutions would constitute the main mental health provision throughout the period in question, 1948–68. New therapeutic approaches were highlighted in some recruitment campaigns.[22] For example, in government-created advertisements, treatments such as electro-convulsive therapy (ECT), psychosurgery, insulin and malaria therapies were described as the "new attitude towards mental illness" and nurses were pictured participating in them[23] but there was also a great deal of stigma and ignorance around the whole subject of mental illness, which impacted on patients but also staff, and there is no evidence that these adverts aided recruitment.[24] In 1945 it was noted in a British medical journal that, "the fact that mental nurses have so far not been held in the same esteem as men and women in other branches of nursing reflects on the public attitude towards mental disease and those who suffer from it."[25] The severe shortage of mental health nursing staff in this period can be broken down into two issues: difficulties in recruitment but also problems with retention (or wastage or attrition, as it was then more commonly termed). This was particularly marked in relation to student nurses, with up to 80 per cent of entrants failing to complete their training.[26] Charles Webster, the official historian of the NHS, has described mental health nursing, as "the single, most intractable nursing problem of the early NHS."[27]

In the years leading up to the Second World War and the subsequent formation of the NHS, female staff had proved the most challenging to find. Some hospitals kept records of where advertisements

[11] The Lancet 1945, pp. 412–413.
[12] The Lancet Commission on Nursing 1932.
[13] Report of Sub-Committee on Mental Nursing and the Nursing of the Mentally Defective 1945.
[14] Working Party on the Recruitment and Training of Nurses 1948.
[15] Mental hospital began to replace the term asylum from the early 20th century in the UK and was the official term in use during the period under discussion, 1948–68. Carpenter 1988, p. 107.
[16] NHS Long Term Workforce Plan 2023.
[17] Porter 2002, p. 112.
[18] Chatterton 2015, p. 86.
[19] Nolan 1993, p. 6.
[20] Chatterton 2013, p. 45.
[21] Nolan/Hopper 2003, p. 334.
[22] Chatterton 2007.
[23] The National Archives, LAB 8/1803.
[24] Chatterton 2007.
[25] The Lancet 1946, p. 5.
[26] White 1985.
[27] Webster 1988, p. 4.

were placed to recruit staff and these give an insight into the areas that were being targeted at the time. Examples of adverts used by the Warneford Hospital, Oxford, for example, can be found in the Oxfordshire Health Archives. In 1946 they advertised for student nurses, staff nurses and assistant nurses in the national press, the nursing press and the local press but also in Scotland and Ireland.[28] The West Sussex Record Office contains a cuttings book[29] of the adverts placed between 1924 and 1945 by the West Sussex County Mental Hospital at Chichester. Again in 1944, adverts for female probationer nurses were placed in the *Irish Independent*, as well as the national and nursing press. However, as Dingwall et al. point out, employers did not respond by improving pay, conditions or career opportunities in a bid to attract and retain more nurses; "instead they turned their attention to regions of high unemployment and especially to Ireland as sources of cheap labour."[30] This raises an important ethical issue about migrant labour being used to plug gaps in the labour market, rather than examining the deeper issues that may have contributed to the severe shortage of mental health nurses in England at this time. Overseas recruitment thus could be seen as providing a panacea rather than a solution.

3 RECRUITMENT FROM IRELAND

As Dingwall et al.'s comment illustrates, Ireland had become a major source of labour for all fields of nursing, including mental nursing, by the onset of the NHS. Irish people had a long history of emigration to Britain for work, particularly after the 1930s when more stringent immigration control in the United States considerably reduced the numbers going there.[31] Amongst them were many women and some men who were recruited into all areas of nursing and also midwifery.[32] As Daniels points out, "the complexities of Irish supply and British demand are even greater in the field of nursing and midwifery."[33] Some were economic migrants, their decision forced by financial necessity. Others came specifically because they wanted to nurse and came to England due to the lack of opportunities at home, where waiting lists for nurse training were long and training had to be paid for, in contrast to the free training on offer in the UK.[34] As Ryan et al. pointed out, there could be a complex interplay of different factors in decisions made by those who migrated, which was often broader than pragmatic and economic reasons and included the quest for adventure and "the lure of networks of friends and relations".[35] In addition, emigration offered the opportunity for freedom and a different way of life compared to an Irish society which could be a conservative and sometimes controlling environment, especially for women, coupled with the powerful influence of the Roman Catholic Church.[36]

However, what is not clear from current evidence is how many of these Irish recruits specifically chose mental nursing. Anecdotal evidence would suggest that some went into mental nursing through ignorance, not realising that they had been recruited to a mental, rather than a general, hospital. As one nurse told Nolan, "I thought at first I was going to do general nursing and when I discovered that it was an asylum, I thought that I would never stick it."[37] This issue also appears to have raised concerns for

[28] Oxfordshire Health Archives, Warneford Hospital.
[29] West Sussex Record Office, HCGR/SG/1.
[30] Dingwall et al. 1988, p. 134.
[31] Daniels 1993.
[32] Corduff 2021.
[33] Daniels 1993, p. 5.
[34] Corduff 2021.
[35] Ryan et al. 2025, p. 35.
[36] Ryan et al. 2025, p. 111.
[37] Nolan 1993, p. 90.

the Irish government. In a 1946 letter from the Irish Department of Industry and Commerce to the UK Liaison Officer for Labour in Dublin, they asked that in the case of Irish recruits to Runwell Mental Hospital in Essex that he made it, "clear to the candidates the nature of the work offered to them viz; in a Mental Hospital."[38] Recruitment practices that did not make it clear to candidates which type of nursing they were entering raised ethical issues relating to informed consent and truth-telling which could have directly impacted on these nursing recruits' autonomy. This could also be seen as being in conflict with another important ethical principle: that of justice, which can be described as generally fair, equitable and appropriate treatment.[39] These issues proved to be recurrent themes in the period under examination.

Some commentators have also noted that Irish recruits could face prejudice, again a theme which was to recur. For example, Nolan argues that, "There were some head attendants and matrons who were reluctant to employ Irish nurses because of a prejudice against them, but in rural hospitals where recruiting and retaining staff proved very difficult, they were welcomed."[40] In his research, Nolan found that, during the Second World War, Irish men and women came to work in the understaffed mental hospitals, taking the place of those who had been called up. One nurse interviewed by him spoke of returning from military service to find that,

> Many Irish nurses had been recruited during the War and were given Sisters' and Charge Nurses' posts [...]. Those of us who had returned found ourselves at the bottom of the pecking order and had to start all over again to build up years of experience before we got promoted.[41]

This led, he argues, to some embitterment amongst staff, particularly as his interviewee noted that his Irish colleagues had mainly come from the rural west of Ireland, had little education and had no, or only a limited, experience of mentally ill people.

This negativity could be ascribed to resentment and prejudice but the poor educational abilities of some of the Irish recruits were also highlighted elsewhere. For example, Dr Armstrong, Medical Superintendent at the Oxford County and City Mental Hospital, Littlemore, noted in his 1946–47 annual report:

> In the meantime the nurses we do manage to recruit are almost entirely young girls from Ireland with usually a primary education which ill-equips them for the struggle to pass the nursing examinations.[42]

Again, this raises an ethical issue in terms of recruiting those who may not have had the ability to pass their training course due to their poor educational background. However, this was part of a bigger picture where entry requirements to mental nursing courses were not required for candidates at that time across England. Whether there should be a minimum educational standard for entry to nurse training was contentious and indeed for much of this period there was no minimum standard applied in any fields of nursing. It was only in 1962 that this was applied in general and sick children's nursing, and four years after that in mental and mental deficiency nursing.[43]

In the post-war period, it was becoming obvious that recruitment from Ireland was waning. This decline in recruitment seems to have been for a variety of reasons. The Ministry of Labour files reveal

[38] The National Archives, LAB 8/1301.
[39] Beauchamp/Childress 2019.
[40] Nolan 1993, p. 90.
[41] Nolan 1993, p. 111.
[42] Oxfordshire Health Archives, OHA L 1 A2/24.
[43] Chatterton 2007, p. 145.

that the recruitment of Irish labour to the United Kingdom during the Second World War was the source of some debate and the Irish government was becoming concerned about increasing emigration. In an attempt to "control the outflow",[44] it was agreed in 1944 that the British Ministry of Labour and National Service could set up a Liaison Office in Dublin to facilitate Irish recruitment to a variety of jobs in the UK and prevent "the previous system of a free-for-all scramble by the interested parties."[45]

On 18 September 1944, the Liaison Office officially came into force, and a nursing recruitment section was established as part of this, much to the chagrin of some mental hospital managers in England. One matron, speaking in 1945, noted that:

> In her experience the flow of nurse recruits from Ireland almost seemed to have dried up since the Liaison Office was established and she wondered if it might not be possible to decrease the delay in sending forward recruits who had been in direct contact with a hospital in this country and were acceptable to that hospital.[46]

Changes in the application process had exacerbated the situation, with candidates being expected to attend for interview, which had implications in terms of both cost and time, leading to a considerable drop in recruitment.[47] Arguably though, this was attempting to address the ethical issue of unsuitable candidates being recruited who were then unable to meet the requirements of their training or who did not appreciate what kind of nursing work they were being recruited for, again related to ethical principles of autonomy and justice.[48]

In addition, British recruitment in Ireland per se was becoming increasingly contentious. In 1946 a British newspaper stated that, "worried by mounting emigration from Eire,[49] Mr de Valera[50] is thinking of banning all ads, offering jobs in Britain, which appear in the Government–controlled newspaper".[51] This highlights an important ethical issue in international nurse recruitment both in the past and present, where one country recruits heavily from another country, resulting in what is sometimes referred to as a 'brain drain'.[52] This is illustrated by a whole file at the Ministry of Labour and National Service, which was devoted to a dialogue that took place in August 1946, after the Clerk and Steward of Runwell Mental Hospital, Essex, wrote to the Ministry asking to be able to visit Eire with the hospital matron to recruit directly, rather than go through the Liaison Office in Dublin. "Of the present female nursing staff over 70% are from Eire, no less than 10 out of 14 Sisters and an Assistant Matron being Irish," he said, and:

> Our success with Irish nurses has led us to hope that the present shortage of staff may be remedied by the recruitment of additional candidates from Eire but experience shows that this is unlikely if the present methods and machinery are employed.[53]

The Irish Department of Industry and Commerce in Dublin, after hearing of this, was soon to respond, saying:

> The Government's policy that the emigration of Irish citizens should not be encouraged beyond facilitating those, who, of their own volition, seek assistance in obtaining employment outside the State [...] it will be appreciated that (recruitment visits to Eire) [...] cannot be agreed to.[54]

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[44] McCrae/Nolan 2016, p. 208.
[45] The National Archives, LAB 9/98.
[46] The National Archives, LAB 8/954.
[47] The National Archives, LAB 8/1468.
[48] Beauchamp/Childress 2019.
[49] Eire is sometimes used as an alternative term for Ireland. It is derived from the Irish language.
[50] Eamon de Valera was a prominent politician in the Republic of Ireland and served as the Taoiseach (Prime Minister) and later President.
[51] Newspaper cutting from the Reynold's News in The National Archives, LAB 8/1301.
[52] Pressey et al. 2023.
[53] The National Archives, LAB 8/1301.
[54] The National Archives, LAB 8/1301.

A similar request from the Recruiting Officer for the City of Birmingham's tuberculosis sanatoria met with the same response. As the Liaison Officer pointed out, "It should be understood that open recruitment and emigration, on the whole, are opposed by State and Hierarchy."[55] These exchanges between the British and Irish governments on the subject of nurse recruitment clearly caused some anxiety at the Ministry of Labour and a series of memos in the file reveal that civil servants were unsure whether the protest from the Irish Ministry of Labour and Commerce might be 'a flash in the pan' or something more serious. As one civil servant, Miss Stopford, noted:

> [This] brings to a head the question to which Employing Authorities in this country will be tolerated if they go browsing about Eire trying to persuade Eire girls to come to their hospitals. If this goes on, there may well be further difficulties put in the way of the emigration of Eire girls to this country by the Eire government.[56]

This flurry of correspondence illustrates the sensitivity of post-war nurse recruitment in Ireland (and the ethical issues that it was creating). As a result, hospitals began to look elsewhere for new recruits to nursing. In addition, the numbers coming forward to the Liaison Office continued to drop and, from November 1949, the office in Dublin moved to smaller premises and its outstations across Ireland were closed.[57]

Many of those Irish nurses recruited in this period remained in England and some were to work in the NHS for the rest of their working lives. In a series of oral history interviews, Ryan et al. discovered that, while many Irish nurses had had very positive experiences, some had difficult experiences as Irish migrants, encountering hostility and racism. As they highlight, "The legacy of anti-Irish stereotyping and prejudice, with deep roots in colonial history [...] was very much present in British society, particularly during the 1950s–70s and amplified by IRA[58] bombing campaigns across England."[59] For example, some nurses described being called 'Irish' or 'Paddy' instead of their first name, their accents being imitated, both patients and colleagues making derogatory and racist remarks and the shock of seeing signs on shops, lodgings and boarding houses saying 'No Irish'.[60] As Walter noted, Irish people have occupied an ambiguous position in British society, as much-needed workers but also by being perceived as undesirable migrants and potential terrorists.[61] Thus, some of those who came into mental health nursing as a result of recruitment campaigns then experienced hostility and racism, an issue which was also to have a major impact on recruits from other countries. This raises considerable ethical issues.

4 RECRUITMENT FROM EUROPE

Partly in response to the decline in the numbers of potential recruits from Ireland, primary sources reveal that medical superintendents and matrons started to look to the rest of Europe as a source of recruitment. Dr David Clark, a medical superintendent near Cambridge, gave an insight into this. "Before the war," he said,

[55] The National Archives, LAB 8/1301.
[56] The National Archives, LAB 8/1301.
[57] The National Archives, LAB 9/98.
[58] IRA – Irish Republican Army.
[59] Ryan et al. 2025, p. 161.
[60] Ryan et al. 2025, p. 185. Commonly these signs said in full, 'No Dogs, No Blacks, No Irish' see footnote 126.
[61] Walter 1980.
[62] Clark 1996, p. 151.

> the staff at Fulbourn Hospital were similar to those in most English mental hospitals. Many were local youths or girls, but others came from the Welsh hills and from Tyneside – driven into a secure, if unpleasant job by the shortage of work during the depression.[62]

However, after the war, the situation changed, he said:

> The search for people to work on the back wards became more desperate. Various recruiting experiments were tried at Fulbourn, as in other English mental hospitals. At Fulbourn many immigrants, particularly refugees from Eastern Europe were taken on – people who could often speak very little English. The challenge to integrate these staff and help them become more effective, as well as to enlist their altruism, was enormous.[63]

In her study of Severalls Hospital in the south of England, Diana Gittins describes a similar picture: "Nursing staff had, prior to the war, been traditionally recruited in Ireland, Wales, Scotland and the North-East[64]. After the war, these sources had, to a large extent diminished, if not dried up, and recruitment was taken into first Italy, France and Spain, and then eventually through the West Indies, Africa and China / Hong Kong."[65] Often the new recruits began as nursing assistants before later commencing their training. Elisabeth Gimblett wrote an account of how she came from France to train at Hellingly Hospital, East Sussex, in 1963:

> For a number of years Matron, Miss Bradley, had placed recruiting adverts in newspapers abroad to get nursing staff, with board and lodgings, monthly wages and the possibility of free training. This made for a cosmopolitan Hospital to say the least. Irish nurses were the first to come, then the Scottish, Welsh, Dutch, German, French, West Indians, Norwegians, Filipinos, Mauritians, Spanish, Chinese etc [...] (and not forgetting my Canadian friend!)[66]

As this reveals, recruitment in mainland Europe became widespread across English mental hospitals in the 1950s and 1960s. It was not coordinated or organised on a national scale but was usually carried out by individual hospitals, either through advertisements or recruiting visits to Europe, or both. One former mental hospital matron, in an oral history interview, remembered the severe staffing shortages she faced in the 1960s. She recalled that she received a letter from a French girl who was working as a teacher but was interested in mental nursing, whom she successfully recruited and retained. "So of course I jumped on the band wagon," she said, visiting France to recruit and then later, making several trips to Italy. Some of these were on her own initiative, some in conjunction with the Regional Hospital Board and also with "a lady from a Liverpool hospital, who was very short of staff." "These recruits then made recommendations as to where to place adverts and where to go and that [...] That was the way I got my staff," she recalled.[67]

Whittingham Hospital in Lancashire, in the north of England, also advertised for staff in European newspapers and magazines from 1951. According to a commemorative history of the hospital, this was very successful with 87 female recruits arriving in the early 1950s.[68] However, although these recruitment figures are recorded, their retention figures are not. It is, however, telling to note that in 1956, the Minister of Health toured the hospital in response to serious concerns being raised by the hospital's management committee about nursing shortages and he reported that he had seen wards in which 186 patients were under the care of only four nurses. It was noted that "Whittingham had advertised in, and

[63] Clark 1996, p. 153.
[64] North East of England.
[65] Gittins 1998, p. 55.
[66] Gimblett 2004, p. 5.
[67] Chatterton 2007, pp. 193–194. (Oral history interview, F7).
[68] Whittingham Hospital 1973, p. 36.

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recruited from, Italy, France, Denmark and Malta, as well as Northern Ireland; although this had alleviated the problem to some extent, many more were still needed."[69]

5 CONCERNS OVER RECRUITMENT FROM EUROPE

In his history of the Maudsley and Bethlem hospitals in London, Russell remarks uncritically, "A healthy feature of that period was an openness to the wider world, with students coming from Denmark and other European countries."[70] However, it can be seen from primary sources that concerns were being raised, which seem to have centred both on language difficulties and retention rates. In 1949, Miss Olive Griffith, Mental Nursing Officer for the Ministry of Health, said that "The special difficulties of training recruits from overseas are frequently mentioned on visits."[71] For example, in 1952 the topic of overseas recruitment was raised at a meeting of the National Advisory Council for the Recruitment and Distribution of Nurses and Midwives (NAC) on 25 July. As a result, it was decided to conduct an investigation into whether,

> the intake of Aliens[sic] into nursing employment and in particular alien student nurses was on the whole beneficial to this country or whether, as the majority, no doubt, do not remain here after training, hospitals who accepted them as students were limiting the future supply of trained nurses for this country.[72]

Thirty-nine mental hospitals were visited to check on the records of those 'aliens' who had been given student permits in 1948 and in 1951 and find out whether they actually started training, whether they completed training and qualified and whether they remained post qualification.[73]

An example of one of the reports created by the investigation is the one concerning Roundway mental hospital in Wiltshire, following a visit in September 1952. The matron was interviewed and stated:

> The language barrier is the great problem. Some of the French were of poor quality, physically, mentally and educationally [...] some were of doubtful moral standard e.g. two became pregnant within three months of arriving in England.[74]

The matron was also asked why she was unable to recruit suitable British student nurses or local nursing and domestic staff. The main reasons cited were the distance from town and bus routes, and competition from local industries and local barracks. A similar report on Park Prewitt Hospital pointed out, "Basingstoke has few attractions."[75]

At the October 1952 meeting of the NAC, the findings of all the hospital visits were summarised: "The engagement of aliens was fully justified by the hospitals' needs which could not be met otherwise." When retention was considered, very high wastage rates were found. Of the 94 students from overseas who had been given permits and who had started training in 1948, only four had qualified and five were still in training. Eighty-five were described as, "known wastage". In 1951, of the 131 mental nursing students commencing training, 49 were still training and 82 were "wasted" i.e. had left. The reasons given included, "not enough care was taken in recruitment", "using agencies who recruit abroad

[69] Whittingham Hospital 1973, p. 37
[70] Russell 1996, p. 168.
[71] The National Archives, DT 5/382.
[72] The National Archives, LAB 8/62.
[73] The National Archives, LAB 8/62.
[74] The National Archives, LAB 8/62.
[75] The National Archives, LAB 8/62.

was not always satisfactory", some girls come "without any intention of completing their training but taking the opportunity of coming to the country to learn the language." The survey found that wastage was found to be due to "homesickness, poor health, illness at home, marriage, failure in examinations most of which affect British as well as alien students."[76]

Overall, the survey concluded that there was no reason to believe British candidates were being rejected. Hospitals, they said, would prefer candidates from the UK but were accepting 'aliens' because the former could not be obtained in sufficient numbers. However, because wastage was so high and so few remained, they did not, they said, "add substantially to the number of trained nurses working in this country. Their main value is as stopgaps in hospitals which are short of nurses through inability to recruit sufficient at home."[77] An appendix to the report contained anonymous comments from some matrons, who had been interviewed as part of the survey. Some were very positive, with comments such as "On the whole aliens have been most satisfactory", "We would certainly have had to close wards without our foreign nurses. I would welcome any suitable European candidates", and "The Italians were excellent girls, kind to the patients and very well educated and gave good service for the limited time they were here to see London and improve their English. Without such candidates it would have been impossible to nurse the patients." However, other matrons were less complimentary and some talked of being at 'saturation point'. "The French candidates are not settling down. They out-number the English students." Language difficulties were also frequently cited, for example, "Neither speaks English well but the hospital needs students so badly they are putting up with this disadvantage." In addition, some students went home after six months (the earliest point at which their travelling expenses home were paid) and failed to return.[78] Again, this raises questions about the ethics of the recruitment practices being utilised and a mismatch between the expectations of those recruited and the reality of the work.

In an oral history interview, a French nurse reflected on their experiences at a mental hospital in the south of England, where they spoke of having many French nursing colleagues. In answer to the question, "How did that work out? Was that good?" they replied:

> Well, opinions are divided on that subject. For me, first of all, it was quite good [...] because we had sort of peer support as well. But on the whole, I don't feel it was that good for some of the patients. You know [...] one of them asked if they were in France so we felt terribly ashamed because we were not supposed to speak, at work, we were not supposed to be speaking in French. But it was quite difficult. It's so natural to speak your own language with somebody who you knew will understand exactly what you are talking about. We did speak, we were only supposed to speak in English and some of us managed to do that [...] I used to translate occasionally for Matron because she interviewed all the French nurses on arrival, within a few days of arrival.[79]

Dr David Clark, writing about Fulbourn Hospital near Cambridge, also displayed mixed feelings about their European recruitment strategy. He described how, "an engaging publicity man drafted advertisements for us in the French press" which brought in over a hundred applications. The matron, Miss Brock, and he,

> sorted them out and sent for the girls. This involved much planning as few of them spoke English. We interviewed them all, arranged English classes for them and gradually started them in

[76] The National Archives, LAB 8/62.
[77] The National Archives, LAB 8/62.
[78] The National Archives, LAB 8/62.
[79] Chatterton 2007, p. 193. (Oral history interviewee F3).

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> doing simple work on the wards. By the spring of the second year, we had about 20 French girls working in the hospital.[80]

On reflection however, he described this influx of French staff as being like a blood transfusion to the staff of the women's side, "the effect was a tonic rather than sustained." Although he found that the French recruits were

> pleasant, cheerful, reasonably educated and did well at first. It gradually became clear, however, that many had little continuing interest in nursing and most of them went home after a year having acquired a smattering of English. Only a handful persevered, became student nurses and finally qualified as psychiatric nurses.[81]

In addition, he reported that factions developed amongst the French staff which resulted in quarrels and the eventual resignation of six French student nurses, including two of those he described as the best students.

A report by the National Association of Chief Male Nurses in 1956 would seem to support Clark's experiences when they argued that,

> The introduction of foreign workers to fill nursing vacancies must at best be regarded as palliative [...] We have good reasons to believe that such measures are not in the best interests of the patient. Moreover, promotion and seniority problems are likely to arise at a later date through large-scale employment of these workers.[82]

In 1958 the Mental Nurses Standing Committee of the Staff Side of the Nurses and Midwives' Whitley Council conducted a survey of the mental and mental deficiency hospitals approved for training nursing students and the numbers of students being recruited from overseas. Replies were received from 138 chief male nurses (out of a potential 159) and 149 matrons (out of 185). In those hospitals that responded, 444 of 2,562 male students and 1,255 of 3,278 female students came from overseas.[83]

By 1965, concerns were still being raised about the employment of European nurses. The Aberdeen Evening Express reported on some of the proceedings at the annual conference of the main trade union for mental nurses, the Confederation of Health Service Employees (COHSE), which was held in Aberdeen. According to one of the speakers, "an 18 year old who could not speak English was left in sole charge of 18 patients in a South of England mental hospital" and this was, he said, only one example of the shortage of trained staff in mental hospitals, "particularly in the south [...]. In his hospital, they had Greeks, Poles, Lithuanians and Chinese who were unable to speak English."[84]

The risk to patients from being looked after by nursing staff who could not communicate with them can only be imagined, but there was also the risk to the staff themselves of being left in these unsafe working environments, thus negating the important ethical principle of non-maleficence (doing no harm) to patients or staff.[85] Shanley, a nurse tutor, highlighted the language issues of some of the overseas students he had encountered. It had, he said,

> very serious implications for the effectiveness of the psychiatric nurse whose therapeutic function and social skills is totally dependent on a proficiency in communication. Language difficulties may result in misunderstandings and distortions, both for the patient and the staff, and may eventually result in little or no effort to communicate being made.[86]

[80] Clark 1993, p. 153.
[81] Clark 1993, p. 154.
[82] National Archives, MH 55/2585.
[83] Royal College of Nursing Archives, 13/B/13/3.
[84] Aberdeen Evening Express, June 22, 1965, p. 5.
[85] Beauchamp/Childress 2019.
[86] Shanley 1980, p. 542.

In addition, this issue raises wider ethical questions as to whether mental hospitals were importing cheaper labour from overseas, instead of improving pay and working conditions for existing staff and thus aiding retention, as the trade union, COHSE, suggested.[87] However, it must also be remembered that most English mental institutions were part of the NHS, so staff pay was negotiated at a national level.

Primary sources have revealed official attitudes to the issues that arose from recruiting staff from Europe. The views of matrons and medical superintendents can be seen in the documents but what are often lost are the views of those students who came and went (and the patients they were recruited to care for). From the fragments reported, it is clear that some European recruits came to England under the impression that they would be training as general nurses or working with sick children, and the reality of nursing in a large mental hospital or mental deficiency institution was not what they had expected or wanted. For example, archival sources reveal that in 1948 four Norwegian recruits to a mental hospital left after one month, stating that they thought that they were coming to a children's hospital.[88] In an oral history interview conducted by Mitchell, he was told of how a group of women came from Germany, "under the impression that they would be training for general nursing but soon after arriving they were divided into general, mental deficiency and mental groups."[89] Research by Lee supported this when he found that a large proportion of those applying to be student nurses in the UK from overseas lacked a general knowledge of British hospitals, the main types of nursing and training available, plus the educational requirements. Just under half of those he interviewed, said they had received no information about this before they arrived in the UK.[90] Ethical principles that were compromised by these recruitment practices include truth-telling, autonomy and justice, such that McCrae and Nolan described them as being "brazenly economic with the truth".[91] Deontologists would contend that acts of deception are morally wrong in themselves, regardless of any good consequences which may ensue, such as improving mental hospital staffing.[92] Recruitment practices such as these could also then lead to a dissonance between the expectations of many overseas recruits and the "reality of working as cheap labour while a learner within a poor environment,"[93] which the antiquated, overcrowded and understaffed mental hospitals provided.

For Elisabeth Gimblett, a French recruit who stayed and spent the rest of her career as a Registered Mental Nurse (RMN) in England, mental health nursing proved a satisfying career. When she saw the advert in a local newspaper in France, "it offered adventure, escape from the mundane, mystery, something different definitely."[94] However, as the source material reveals, the reality of nursing in the large English mental hospitals in this period was a hard and arduous task and maybe, for many, the 'adventure' was not what they had expected. This also has to be seen in the wider context of broader migration and labour patterns. Many of the recruits were young women, who had traditionally been a transitory part of the nursing workforce and indeed the wider workforce.[95] It is, however, pertinent to note that, despite the high rates of wastage, some European nurses did stay and make considerable contributions to British mental health care.

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87 Carpenter 1988.
88 The National Archives, LAB 8/62.
89 Michell 2001, p. 192.
90 Lee 2019, p. 5–37.
91 McCrae/Nolan 2016, p. 218.
92 Robinson/Garratt 2008.
93 Shanley 1980, p. 541.
94 Gimblett 2004, p. 5.
95 Lewis 1984.

6 RECRUITMENT FROM THE COMMONWEALTH

Concerns over the low rate of retention amongst European nurses led mental hospitals to look elsewhere for recruits and, during the 1950s, European recruitment campaigns began increasingly to overlap with recruitment from what had been the British Empire. As McCrae and Nolan state, by the 1950s "recruitment campaigns were not supplying enough workers to run the wards, to wash the incontinent, or to watch the suicidal; indeed, the viability of some hospitals was at stake. As human wells dried up, hospital managers broadened their horizons to the colonies of the Caribbean, western and southern Africa, the Indian subcontinent and the East Indies. The composition of mental hospital staff was about to change dramatically."[96]

The post-war years were to see large-scale immigration to Britain. The year that saw the creation of the NHS, 1948, also saw the arrival of the passenger ship, the *Empire Windrush*, which brought to England several hundred migrant workers from the Caribbean. As Culley and Mayor say, this "signalled the start of a pattern of immigration that has provided many migrant workers for the NHS and other public services."[97] In addition to doctors and nurses, workers were also recruited for ancillary jobs as domestics and as maintenance and catering staff in the NHS as well as a myriad of other occupations. This large-scale migration was mainly in response to labour shortages in key sectors of the British economy[98] and was "seen by employers and the government as a way of filling the jobs which indigenous workers were unwilling to do."[99] It was also aided by the British Nationality Act of 1948, which gave special immigration status to Commonwealth citizens, encompassing the right to freely enter, work and settle with their families, which led to increasing numbers of nurse recruits from former colonies during the 1950s and 60s.[100] Beula has argued that most of the nurses and other health care staff recruited from the Caribbean came over to the UK between 1955 and 1975, although they are now commonly described as the Windrush generation.[101] In addition, as Norris Nicholson and Brown point out, some overseas recruits preceded the arrival of the Windrush.[102] It is difficult to state with accuracy how many migrant workers joined the NHS as statistics for ethnic monitoring were not kept at this time. Akinsanya estimated that by 1971 there were 15,000 overseas nurses in the NHS (9% of the total), 40% of whom were described as West Indian, 29% Asian and 27% African.[103]

Recruitment campaigns were carried out throughout the Commonwealth, with British nurse managers visiting a variety of countries in pursuit of labour.[104] Some hospitals also advertised, targeting Caribbean newspapers such as the *Barbados Beacon.*[105] For example, Foss and Trick, in their study of St. Andrew's Hospital, a private charitable psychiatric hospital in Northampton, stated: "Finding suitable nursing staff remained difficult. In 1952, it was agreed that Afro-Asian students could be engaged as nurses." In the years that followed, the medical superintendent recorded in his annual reports that many of the European staff were proving unsatisfactory, the Austrian girls tended to marry locally, and that he hoped to recruit male nurses from Nigeria, as those from Jamaica had been a success.[106] Similarly, at Saint Francis' Hospital in Sussex, Gardner found that "in 1956, despite the presence of nurses from Nigeria, Holland and France, the hospital was still 70 female nurses short [...] in 1958, the hospital tried to get girls from Scotland, the only place 'not tried yet' [...] the acute staff shortage was partially resolved by recruiting from the Commonwealth from the late 1950s onwards".[107]

[96] McCrae/Nolan 2016, p. 209.
[97] Culley/Mayor 2001, p. 213.
[98] Fryer 1984.
[99] Culley/Mayor 2001, p. 213.
[100] Culley at al. 2001.
[101] Beula 2021, p. xii.
[102] Norris Nicholson/Brown 2021.
[103] Akinsanya 1988, p. 444.
[104] Culley et al. 2001.
[105] Kramer 2006.
[106] Foss/Trick 1989, p. 261.
[107] Gardner 1999, p. 269.

As Carpenter notes, the numbers of nurses being recruited from the Commonwealth in the 1950s "increased dramatically. Enoch Powell, the then Minister for Health, while publicly denying that there was a staffing crisis, was encouraging their recruitment as a cheap and convenient way out of it."[108] But, as Carpenter points out, "this was ironic, given his sustained opposition to 'coloured' immigration."[109] Webster also comments on this anomaly. He argues that in 1961, Powell was perhaps more relaxed about immigration then he later proved to be, because in nursing it provided a plentiful supply of cheap labour, reduced wastage and undermined the shortage argument. Immigration therefore strengthened his hand in pressing for a strong line against the nurses' pay claim, which itself was a chief weapon in his wider campaign to induce colleagues to adopt a more aggressive approach to the control of public sector pay.[110] This again highlights the tension, and ethical issue, of overseas recruitment being used to fill gaps in mental health nursing, which could be seen as an underpaid and undervalued occupation in the UK. "Foreign nurses," argued McCrae and Nolan, "worked unpopular shifts [...] and in so doing, they performed a vital role eschewed by the native population."[111]

However, like their European counterparts, these recruits to nursing tended to be recruited to the services that had the lowest status. The study by Thomas and Williams was one of the earliest to examine overseas nurses in 1972, and found that they were more likely to be found in the less popular and less prestigious specialities, such as older people's and mental health nursing.[112] Carpenter concurred: "The role of the black nurse was to fill the most unpopular spaces in the labour force – the low paid, low status and low opportunity areas that were shunned by others [...] The hospitals where overseas staff were concentrated tended to be the less glamorous, dealing with more 'run of the mill' illnesses, caring for the elderly and the physically ill and mentally impaired."[113] In 1961, a survey in the Oxford region found clear disparities between the proportion of nursing students in the more prestigious teaching hospitals (where 3% were non-European) and non-teaching hospitals (perceived to be of lower status), where the percentage was much higher (21%).[114] In 1965, this issue was debated in parliament and speakers raised the question of whether this was overt discrimination. It was cited that nationally only 1–2% of students in teaching hospitals came from a non-European background.[115]

The 1950s were also to see the beginnings of large-scale immigration to Britain from the Indian subcontinent, with the arrival of workers predominantly for the textile industry, who tended to settle in the northern mill towns and in the Midlands, but, as McCrae and Nolan point out, "Perhaps the most notable foreign import into mental nursing was from a small island in the Indian ocean": Mauritius.[116] It has been estimated that in the 1960s and 1970s, around 40,000 young people came to Britain from there, and Mauritian nurses were to contribute considerably to the mental health workforce.[117] Archival sources in the Surrey History Centre reveal that in the 1960s, the large psychiatric hospitals in that area, such as Brookwood Hospital in Woking and Netherne Hospital near Coulsdon, engaged in active recruitment campaigns in Mauritius, West Africa and the West Indies.[118] Kevin Gournay and Peter Carter, both of whom trained as mental health nurses in the 1960s, remembered that their fellow "nursing staff recruits, who trained in the schools of nursing that were situated in hospital grounds, came from the local area, often as part of a family tradition" but also, "increasingly, from a number of more distant countries, notably Mauritius, Malaysia and the Caribbean islands."[119] Mental nursing students also

[108] Carpenter 1988, p. 315.
[109] Carpenter 1985, p. 44.
[110] Webster 1996, p. 173.
[111] McCrae/Nolan 2016, p. 224.
[112] Thomas/Williams 1972.
[113] Carpenter 1988, p. 315.
[114] Carpenter 1988, p. 315.
[115] Carpenter 1988, p. 315.
[116] McCrae/Nolan 2016, p. 213.
[117] McCrae/Nolan 2016, p. 214.
[118] Surrey County Council 2021.

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came to some hospitals from other countries in the Far East, such as Hong Kong, Sri Lanka and Singapore. Jimmy Loh, who came from Singapore to do his training at Fulbourn Hospital near Cambridge, recalled, "So I arrived, thinking I was most probably the only Chinese student [...] and I was pleasantly surprised. There were 24 others already there! (Laughter) So I was astounded."[120]

Although many recruits from the Commonwealth did stay, there continued to be issues with retention, and some hospitals continued to report high wastage rates. For example, a letter from the Management Committee of St. John's and Manor House Hospital, Stone, to the Ministry of Labour and National Service noted, "The majority of students recruited during recent years have come from the Continent and the Colonies, mainly the West Indies, and whilst these members of staff have proved most valuable, the percentage of wastage amongst them is most high." During 1953–55, they recorded that 70 women were recruited, (22 from the British Isles and 48 from Jamaica and the Continent) with a wastage of 30. Of the men:

> We find that nurses recruited from abroad and especially the West Indies only stay in the Hospital Service for a period long enough to become acquainted with the general employment prospects of the country, and that the hospital service is left for more remunerative employment in industry or elsewhere.[121]

Perhaps this reflected the fact that, although mental health services were beginning to change in the 1960s[122] with the advent of new treatments, a change in legislation,[123] a less custodial approach and the beginnings of a move to community care, mental health nursing continued to be perceived as, and was sometimes experienced as, an unattractive occupation.

In May 1964, the *Daily Express* newspaper featured Claybury Mental Hospital in Essex with the headline, "Togetherness ... in 34 lessons", accompanied by a photograph of mental health nursing staff from 34 different countries, standing in a line with arms linked, together with the matron, Miss Darley.[124] In the words of the newspaper's staff reporter, the nurses at the hospital lived and worked in "perfect harmony [...] an idealist's dream which the League of Nations and UNO never attained is working perfectly in a hospital tucked away in England's countryside." According to the matron, "There has never been a hint of racialism [sic] in the 16 years that nurses from the Commonwealth and foreign countries have been employed here."[125] However, the voices of the other nurses in the photograph are not heard and it is important to acknowledge that the matron would have been in a considerable position of power over her nursing staff. Her country of origin is not given in the newspaper but she appears to be white, which may also have impacted on her views. Adams found that all the mental health nurses he interviewed for his research denied that they had experienced or witnessed any racism or prejudice,[126] as did McCrae and Nolan amongst their interviewees.[127] However other researchers who have looked at the experiences of some of these overseas recruits into nursing have discovered some very negative experiences[128] and concurrent ethical issues and these will now be examined.

[119] Gournay/Carter 2021, p. 184.
[120] Adams 2009, p. 255.
[121] The National Archives, LAB 8/2467.
[122] Nolan/Hopper 2003.
[123] 1959 Mental Health Act.
[124] The countries listed were: Ireland, Russia, France, Yugoslavia, Ceylon, Barbados, Jamaica, Greece, South Africa, Trinidad, Ghana, Wales, Italy, Poland, Scotland, Mauritius, Finland, St Vincent, Portugal, Southern Rhodesia, Sierra Leone, Malaya, Canada, Spain, China, Granada, British Guiana, Germany, St Lucia, Australia, Latvia, Nigeria, America and England.
[125] Daily Express 1964, p. 9.
[126] Adams 2009, p. 255.
[127] McCrae/Nolan 2016, p. 224.
[128] For example, Beula 2021 and Shkimba/Flynn 2005.

7 EXPERIENCES OF OVERSEAS NURSES

There was initially little research on how these recruits from overseas fared in the first 20 years of the NHS.[129] For example, Culley at al. commented that "We know little about the experiences of Caribbean born nurses and midwifes some of whom have contributed their entire working lives to the NHS [...] Evidence from the early years is fragmentary, yet suggests many nurses encountered racial discrimination."[130] This fragmentary evidence has been strengthened by more recent research, such as the interviews conducted by Kramer amongst NHS staff recruited from the Caribbean between 1951 and 1965, which has also contributed to a shift in historiographical perspectives. Many of those she interviewed stated that they had encountered discrimination and racism in their careers, from some of their colleagues but also from patients and their families and the wider community. Several made reference to the notorious sign displayed in some shops and lodgings in the 1950s and 60s: "No Dogs, No Blacks, No Irish" and the impact that this had on them.[131] Flynn also found that many of her nurse interviewees had experienced racism. Some, she argued, encountered the racist stereotypes that white nurses held about black people in general. Others felt isolated through being ignored at work, or mentioned patronising comments and attitudes directed towards them.[132]

Mayor interviewed 88 "leading ethnic minority nurses" about their experiences in nursing.[133] She found significant evidence of discrimination amongst those she interviewed. One of the most frequently cited examples of discrimination was the number of black nurses who did enrolled nurse training. Enrolled nurses had been introduced in the UK, initially into general nursing in 1943 and later into mental health and mental subnormal (now known as learning disability) nursing in 1964, as a second level of entry into nursing. Students were known as pupil nurses (to differentiate them from student nurses who were training to be registered nurses). Their training was shorter and less academic and, once it was completed, their names were recorded on a roll, rather than a register, hence their title. Being an enrolled nurse was seen as being more practical and less managerial, which meant that opportunities for promotion and career progression were very limited.[134] Mayor found in her research that 18 of her interviewees had started out as pupil nurses, even though 13 of them had met the criteria for first-level entry.[135]

Similar issues were reported in other oral history interviews. For example, one interviewee remembered being measured for a green uniform at the hospital's sewing room when she started her training in 1960. She noticed that other students were being issued with purple dresses. She queried this and her Jamaican friend explained that this meant that she was a pupil nurse, not a student nurse as she had thought. She went to the matron but was told, "I had to do my pupil nurse training, otherwise they would send me back to Grenada."[136] An article in *Nursing Times* in 1965 was one of the few to highlight this and led to some debate in the letters column in the weeks that followed.[137] For one writer, senior nurses were "exploiting (them) and getting as much cheap labour as they could to run the hospitals,"[138] although others were less sympathetic.[139] Later that year, Joseph Martin, a tutor, published some research he had undertaken, about the West Indian pupil nurses in his school of nursing. He also found that many would have preferred to train as registered nurses and he discussed the great difficulties

[129] Akinsanya 1988, p. 444.
[130] Culley et al. 2000, p. 236.
[131] Kramer 2006, p. 84.
[132] Flynn 2012.
[133] Mayer in Culley et al. 2000.
[134] Dingwall et al., pp. 115–116.
[135] Culley/Mayor 2001, p. 224.
[136] Kramer 2006, p. 70.
[137] 'SRN' 1965, p. 198.
[138] Wehnerson 1965, p. 259.
[139] For example, Calbran 1965, p. 436.

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they faced.[140] Shanley argues that, though disillusioned, these nurses did not leave because they were not able to. Some felt trapped into remaining on their training courses, as the loss of student status might result in them forfeiting their right to stay in Britain.[141] After training, they found themselves with a qualification which gave them no opportunities of advancement within the NHS, and which was unlikely to be recognised in their home country or other countries. Carpenter suggests that black nurses rarely put forward their opinions in this period, as it was unsafe to do so. They lacked power and felt vulnerable. Letters to the nursing press at this time reveal that some white nurses "thought that the problems lay largely with the attitudes of overseas nurses themselves, not British racism."[142] Ethical issues related to truth-telling, justice and autonomy are clearly apparent here, with the lack of information and transparency about the type of training on offer denying overseas recruits the ability to make autonomous choices about their own lives and careers. This led to some recruits being caused harm (in contravention of the principle of non-maleficence) as their future career and wage-earning opportunities were impacted in a significant way.[143] In addition, even for those nurses who had undertaken state registered nurse training, some then reported that they had been discriminated against in their subsequent careers when they went for promotion.[144]

Another issue for some recruits could be described as 'culture shock', when, as well as facing prejudice and racism, they also had to adapt to living in a new country, and one that was very different from their own.[145] Gardner spoke of the difficulties that new recruits faced in the local town of St Francis' Hospital: Hayward Heath in Sussex. "An all white town was not an easy one to adapt to." In addition, the large mental hospitals had a culture of their own and were often geographically isolated. Shanley argued that for many overseas recruits, "Right from the start they remain in comparative isolation. [...] Their accommodation is usually in the nurses' home where they enter a type of ghetto, which discourages contact with the host culture."[146] Lee's research[147] supported this when his respondents told him that many had not been met at the airport, had been expected to start work the next day and had had no orientation course.

This again raises ethical issues about the lack of preparation experienced by many new recruits to mental health nursing, in terms of assimilating into their new country of work, which could have impacted on their ability to empathise and understand their patients. For some student nurses, McCrae and Nolan argued that "their only window to British society was the television set in the nurses' home."[148] Many experienced a dissonance between what they had expected and the reality of what they encountered.[149] As Shkimba and Flynn note, "Their expectations of Britain, buttressed by a 'narrative of the nation', which circulated in the Caribbean, led to feelings of disengagement and loneliness" amongst some nurses.[150] As Olusoga notes, the 1960s saw a heightening of an awareness of racism amongst some of the British public, with protests over the apartheid regime in South Africa and against the labour restrictions brought in by the 1962 Immigration Act, for example, as well as the passing of the Race Relations Act in 1965. However, at the same time Britain remained a country where many black nurses were to continue to encounter racism and discrimination.[151] The colonial context was also shifting as some of the Caribbean countries gained independence in the 1960s.[152]

[140] Martin 1965.
[141] Shanley 1980, p. 542.
[142] Carpenter 1988, p. 316.
[143] Beauchamp/Childress 2019.
[144] Norris Nicholson/Brown 2021; Hayward/Heenan 2025.
[145] Kramer 2006, p. 63.
[146] Shanley 1980, p. 542.
[147] Lee 1976.
[148] McCrae/Nolan 2016, p. 218.
[149] Kramer 2006; Beula 2021.
[150] Shkimba/Flynn 2005, p. 145.
[151] Olusoga 2021.
[152] Jamaica and Trinidad and Tobago in 1962, Barbados in 1966.

8 CONCLUSION

As McCrae and Nolan highlighted, "Perhaps the most neglected aspect of the history of the mental hospitals is the cultural diversity of staff and its impact on institutional life."[153] Simpson has also talked of a "collective amnesia" in NHS histories when it comes to immigration. As he points out, "The relationship between the NHS and migrants has been one of dependency – it could not have existed in the form that it took without overseas employees" and this is, without a doubt, the case in mental health care, both amongst nurses and other staff groups, such as psychiatrists.[154] This article has illustrated how the recruitment of overseas nurses into mental health nursing in England in the first 20 years of the NHS, was a pragmatic response to severe difficulties in both recruiting and retaining mental health nurses in this period. Having first turned to Scotland, Wales and Ireland, medical superintendents and matrons had to look further afield for staff, with recruitment taking place across the rest of Europe and from the British Commonwealth. The consequences of this for the overseas nurses themselves, and the patients that they worked with, remains an area that would benefit from further research, as would greater recognition of the ethical issues that international recruitment has raised in the past and continues to raise. As Pressey et al. point out, "International nurses (migrant nurses who are recruited to work in different countries) make essential contributions to global health and care workforces that are experiencing domestic nurse shortages"[155] but this can come at a cost to themselves, their patients and their country of origin.

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[153] McCrae/Nolan 2016, p. 207.
[154] Simpson 2010; Weekes-Bernard 2013.
[155] Pressey et al. 2022, p. 1.

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"IN GERMANY'S INTEREST": STATE RESPONSES TO TRANSNATIONAL NURSE RECRUITMENT

Urmila Goel

Abstract

West Germany experienced a considerable shortage of nursing staff in the 1960s. One way of countering this was to recruit nurses from abroad, mainly from South Korea, the Philippines and Kerala in Southern India. Recruitment from India was organised primarily by individual clergy, hospital directors and former migrants. Based on archival research, this article reconstructs how the West German state authorities responded to this transnational recruitment. In particular, it analyses the arguments used by the state authorities to justify why they had to respond in a particular way. It shows how they referred – either explicitly or implicitly – to the interests of West Germany, and how the definition of West Germany's interests differed between the various authorities. It illustrates how development aid entered as an argument, and the impact of the sociopolitical context.

Keywords: Nurses, Transnational Migration, India, West Germany, State, Development Aid

1 "IT WOULD BE INHUMANE"

> After the German authorities have tolerated the stay of these Indian nurses and nursing students for years, it would be inhumane to expel them from Germany at short notice, when they have a genuine contractual relationship with their hospital operator and many Indian women are also in the middle of their nursing training.[1]

In 1977, the German Caritas Association of the Archdiocese of Freiburg appealed to the Minister for Labour of the southern German state of Baden-Württemberg not to act inhumanely in the context of nurses working in West Germany who had been recruited from the southern Indian state of Kerala. Attached to the letter was a memorandum from the nurses pleading against forced termination of their residence in West Germany.

In this article I reconstruct the state actions in West Germany that led to this ethical appeal by a religious institution. Although nurse recruitment had been predominately organised by non-state actors since the early 1960s, West German state authorities were involved in various ways. Consequently, German state archives contain much correspondence between state authorities, and between state and non-state actors, concerning the recruitment of Indian nurses. In this article I am interested in reconstructing how the West German state authorities responded to this transnational recruitment,

[1] Caritasverband für die Erzdiözese Freiburg e.V. to Frau Minister Annemarie Griesinger, Ministerium für Arbeit, Gesundheit und Sozialordnung Baden-Württemberg, 04.02.1977, PA AA B85-REF 513/1262. Translated with the help of deepl.com.

the arguments they used to justify why they had to respond in this way, how they referred explicitly or implicitly to the interests of West Germany, how the definition of West Germany's interests differed between the various authorities, how development aid entered this as an argument and the impact of the sociopolitical context.

In order to better understand the framework in which the state authorities needed to respond, the article starts with a brief overview of the recruitment processes. Following this, I provide a short description of the archival sources used and my methodological approach as a cultural anthropologist. On this basis, I commence the analysis by describing how staff shortages were the major concern in the beginning, and how claims of development aid entered later. Subsequently, the article looks at attempts to restrict recruitment, and how these gained traction when West German unemployment levels rose in the early 1970s. Finally, the article turns to the attempt to terminate the right of residence of the migrated nurses in 1976/77, which prompted the Caritas Association to write to the Minister of Labour. I show how, at this stage, the West German interest was defined in very different ways, ranging from privileging non-migrant unemployed nurses to showing gratitude towards the migrants. The article ends with a brief look at how recruitment of nurses from abroad was – and continues to be – resumed whenever staff shortages reappear.

2 AN OVERVIEW OF NURSE RECRUITMENT

In the 1960s there was a massive shortage of nursing staff in West Germany.[2] A number of different measures were taken to counter this. Firstly, efforts were made to professionalise the nursing profession in order to provide better working conditions and thus attract more women into this field of work.[3] Secondly, an (unsuccessful) attempt was made to attract men to nursing.[4] Thirdly, since these measures were not sufficient to end the shortage, recruiters turned their attention to nurses from abroad. This endeavour, however, ran counter to the repressive immigration policies of West Germany at the time. Since there was a ban on non-European immigration,[5] initial attempts focused on recruiting nurses from European countries. But as the status of nurses in those countries was higher than in West Germany, this strategy was not successful.[6] Consequently, the recruiters shifted their focus to South Korea[7], the Philippines[8] and Kerala in southern India[9].

Kerala was a particularly attractive place for recruiting nurses since it was home to a large Christian community, in which many women were already working as nurses (both in secular contexts and as part of religious orders) and were already migrating, both within India and internationally.[10] The West German recruiters were able to build on this background.

One protagonist in the recruitment process, who is frequently referred to in the state archives, was a Catholic priest, Hubert Debatin. Tobias Großmann has reconstructed in detail how Debatin started recruiting sisters for a convent in southern Germany in the late 1950s, then proceeded to recruit secular nurses as well, and left West Germany to do missionary work in Southern Africa in 1971.[11] In

2 Kreutzer 2005.
3 Kreutzer 2005.
4 Schwamm 2021.
5 Schönwälder 2001, pp. 257–277.
6 Schuhladen-Krämer 2007, p. 301.
7 Chang Gusko/Han/Kolb 2014.
8 Mosuela 2020.
9 Goel 2023; Großmann 2024.
10 Kurien 2002; George 2005; Nair 2012.
11 Großmann 2024, pp. 101–279.

Großmann's reconstruction, it seems that Debatin acted outside of the German church framework, but in cooperation on the one hand with clergy in Kerala and on the other hand with West German state authorities, religious orders and hospitals.

However, Debatin was not the only recruiter. Other clergy, hospital staff and private individuals were involved. One was Pater Werner Chakkalakal from Kerala, who first became aware of the needs of religious orders when he was studying in Bonn in 1958.[12] Subsequently, he became involved in the recruitment of women from Kerala to work in West Germany.[13] A few years later, the Second Vatican Council (1962 to 1966) brought clergy from Kerala to Rome, who travelled through West Germany, staying at Catholic institutions. Consequently – like Chakkalakal – they learned of the shortage of nursing staff and subsequently became involved in transnational recruitment.[14]

Regardless of how recruitment was organised in individual cases, state authorities had to be involved in order for the (trainee) nurses to come to West Germany. The local state authorities in India had to issue a passport, the German consulate in Madras had to grant a visa, the local labour agency in West Germany had to provide a work permit, the state nursing training schools had to open their doors to the recruited trainee nurses, the state hospitals had to issue contracts to the recruited (trainee) nurses, etc. In other words, many different state authorities at municipal, state and national level, both in India and West Germany, had to respond to recruitment endeavours. Each pursued specific responsibilities, had particular competences and worked under differing political majorities.[15] In West Germany it was the task of the interdepartmental working group on the employment of foreign workers, which came under the Federal Ministry of Labour, to coordinate the responses of the state authorities.

Whereas the 1960s were a time of economic boom and full employment, in the early 1970s the economy stagnated and unemployment rose. The government responded by terminating the recruitment of foreign workers in 1973.[16] While this did not immediately impact nurse recruitment, it changed the general atmosphere in which recruitment took place and in which the recruited nurses worked. During the time of nursing staff shortages, the restrictive immigration policies that were in place were not strictly implemented. In the stagnating economy they were implemented more rigorously, in particular by local immigration authorities.

At the end of 1976, the first recruited nurses were informed that their residence permits would only be extended for a few more months and that they should prepare to return to India.[17] This caused much anxiety among the nurses from Kerala and for the hospitals that employed them. The Caritas Association, which had been taking care of the nurses from Kerala,[18] supported the nurses against these measures. It was in this context that the Caritas Association of the Archdiocese of Freiburg appealed to the Labour Minister of Baden-Württemberg.

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[12] Fr. Werner Chakkalakal to the journal Priester und Mission, Keralesische Mädchen in Deutschen Klöstern, ADCV 380.40 (540) Fasz. 01. My notes from the archive are unclear at this point. It is unclear, whether Chakkalakal's text was published in Priester und Mission or whether it was just a letter to the editors. My notes are also undated, but from the context it is likely that this text is from 1965.

[13] Fr. Werner Chakkalakal to the journal Priester und Mission, Keralesische Mädchen in Deutschen Klöstern, ADCV 380.40 (540) Fasz. 01. Cf. Documentary Film: Translated Lives, Shiny Jacob Benjamin, India/Germany, 2013.

[14] Goel 2025.

[15] A detailed analysis of these different responsibilities, competences and political frameworks goes beyond the possibilities of this article.

[16] Berlinghoff 2013.

[17] Goel 2019.

[18] Goel 2025.

3 THE SOURCES

As the focus of this article is on how the state authorities responded to transnational nurse recruitment, it is based primarily on sources from state archives. Firstly, I used sources from the Political Archive of the Federal Foreign Office. These give insights in particular into the transnational aspects of the recruitment process, including not only the question of issuing visas, but also the contact with Indian institutions. Furthermore, these archival sources document the negotiations with other state authorities and non-state actors. I did not carry out the research in this archive myself, but rather was given access to the documents by Susanne Kreutzer (with the consent of the archive).[19] As a result, in this case I lack the archival experience, did not decide myself which documents to copy and which not, and lack knowledge about the context from which the documents were taken.[20]

Secondly, I used sources from the state archive of North Rhine-Westphalia (NRW) and, in particular, documents produced by the Ministry of the Interior of this federal state. These give insights into the handling of transnational nurse recruitment within West Germany. The state ministry acted, amongst other things, as an intermediary between the local authorities and the federal state. Furthermore, this archive – like the Federal Foreign Office archive – includes documents about the negotiations between state authorities and between state and non-state actors. It was a former student, Daniel Schumacher, who first identified the archive as relevant for my research and visited it to carry out some initial research. He provided me with his notes and a list of relevant files,[21] which I then examined myself in the archive.

Since both archives include correspondence with and documents from other state authorities involved in handling the recruitment, I am able to assess their reactions to a certain degree. My insights are, however, restricted to their correspondence with the Federal Foreign Office and with the Ministry of the Interior of North Rhine-Westphalia, and constrained by the archival practices of these two organisations. Tobias Großmann's analysis[22] allows me to gain access beyond this, but it is restricted by his decisions in the archives and in writing.

Thirdly, my analysis is also informed by my archival research in the archives of the Archdiocese of Cologne (including the archive of the German Bishops' Conference), the Diocese of Rottenburg and the German Caritas Association in Freiburg, as well as in the archives of the municipal hospital in Karlsruhe[23] and the university hospital in Tübingen[24]. The material from these various archives provides a broader framework for understanding and interpreting both transnational nurse recruitment in general and individual documents. The materials from the different archives also speak to each other, thereby creating meaning. In this article I occasionally refer to these other sources.

Fourthly, my attempts to identify relevant archives in India have been less successful. I was only able to find some parliamentary debates on the recruitment of nurses in the online archive of the Indian Parliament. Accordingly, references in this article to Indian state responses are based primarily on the German archives.

[19] I want to thank Susanne Kreutzer for this generous sharing of material, which started my own archival research.
[20] Cf. Imeri and Schneider 2013 for the importance of reflecting on the archive and the research within it.
[21] I want to thank Daniel Schumacher for his research and for providing me with his list of sources and his notes.
[22] Großmann 2024.
[23] Archived in the municipal archive of Karlsruhe.
[24] Archived in the university archive in Tübingen.

Finally, as a cultural anthropologist, my starting point for the research was not archival research, but rather fieldwork in the nurses' communities in West Germany.[25] This has informed my archival research, the reading and contextualisation of the documents as well as the manner in which I pursue my research.

4 SHORTAGE OF NURSES AND DEVELOPMENT AID

In November 1964, the Ministry of Education of Baden-Württemberg wrote to the university hospitals in the state:

> The Ministry of Education has learned that Father Debatin has for years been actively counter acting the shortage of staff in German hospitals by recruiting Indian girls suitable for the hospitals of Catholic religious orders based in South Baden. In view of the severe shortage of staff at university hospitals and the difficulties in recruiting staff for university hospitals in Germany and Europe, the Ministry of Education has approached Father Debatin with a request to become active in this regard for university hospitals as well. The Ministry of the Interior has also sought to recruit such staff for the state psychiatric hospitals. According to the surveys carried out, the university hospitals are primarily in need of housemaids and kitchen maids.[26]

The Ministry of Education and the Ministry of the Interior of Baden-Württemberg were responsible for the state's university hospitals and psychiatric hospitals respectively. Like the other hospitals in West Germany, these were facing a shortage of staff, which could not be met from within West Germany and Europe. As a result, when they became aware that Debatin was recruiting nurses for religious orders,[27] they contacted him. Through him they hoped to recruit 90 housemaids and kitchen maids as well as ten trainee nurses.

In this eight-page letter to the administrative departments of the university hospitals, the Ministry of Education gave detailed information about how the recruitment was to be organised, what the hospitals were to expect and how they should look after the young women. Training for the migrants from India was mentioned only in passing. It was not specified who should receive what form of training (other than language courses). Judging from the archival sources of the university hospital in Tübingen, the housemaids and kitchen maids were not supposed to receive any training.[28] A former German teacher in Tübingen later claimed that a conflict arose because the Indian women demanded training, which had been promised to them in India.[29]

What this document reveals is that, early in the 1960s, two ministries in Baden-Württemberg were actively involved in recruiting women from India. Their interest lay in countering the staff shortages in their hospitals. No mention was made of any intentions with respect to India, such as development aid.

The document also claimed that the granting of work and residence permits was already organised.[30] Residence permits were issued by the immigration authorities, which came under the Ministry of the Interior. Work permits, however, were the responsibility of the Federal Agency for Employment Services

[25] I have done participant observation, conducted interviews and collected material from private and community archives on many occasions since 1997. Due to the focus on state actors in this article, however, I hardly refer to this directly in the following.

[26] Kultusministerium Baden-Württemberg to Akademische Rektorate – Verwaltungen der Kliniken der Universitäten Freiburg, Heidelberg und Tübingen, H 0503/24, 15.11.1964, Beschäftigung von indischen Mädchen bei den Universitätskliniken, SAK, Abt. 1/Klinikum, Nr. 217. Translated with the help of deepl.com.

[27] Großmann 2024, pp. 107–115.

[28] UAT 389/16.

[29] Former German teacher to Landrat, Schwäbisch Gmünd, 10.04.1967, AEK, DBK Sekr. 203/543. – For an analysis of the conflict cf. Goel 2024.

[30] My copy of the page about the work permit and residence permit is barely readable beyond the headings.

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and Unemployment Insurance, which also held the sole right to recruit workers from abroad.[31] In other words, the two ministries had to involve this federal agency in their endeavours, and the agency had to justify why the recruitment was legitimate. It argued that the recruited Indian workers were not genuine employees, which meant their recruitment did not violate the rules concerning recruiting labour from abroad.[32] It based this interpretation on the way Debatin organised the recruitment process:

Together with Indian clergy he had founded a religious community called "The Nirmala Seva Dalam."[33] Rather than employing the migrants directly in the hospitals, the ministries signed a kind of secondment contract (Gestellungsvertrag) with Debatin, who acted as the representative of this community. A Gestellungsvertrag used to be the usual way of employing, or rather not formally employing, nurses in Germany.[34] The hospitals would sign a contract with a sisterhood of nurses. The sisterhood provided the nurses, received the financial compensation and distributed part of it to the nurses. The nurses themselves were members of the sisterhood and not employees of the hospitals. The ministries and Debatin used this construct for their own endeavours. It gave Debatin total control over the income of the nurses, who were known as Nirmala Sisters. He gave the young woman their pocket money, decided what was sent to their parents, how much and how this was saved for their return, and did not give any account of what he was doing to anybody.[35] It also made him the sole negotiation partner of the ministries. Großmann shows that there was no sound legal basis for this construct, but the ministries did not seem to mind.[36] Indeed, it helped them and the federal agency to justify the recruitment. The agency argued that because the aims of the community were purely religious and charitable, the recruited women were not to be considered as employees.[37] Furthermore, in 1970, when the newly founded Nirmala Association, which had been set up by the Catholic Church in order to end the extra-legal activities of Debatin,[38] wanted to terminate the contracts of the Indian nurses with the psychiatric hospital in Emmendingen, the ministry refused to recognise the Nirmala Association as a contract partner and referred to Debatin as the legal representative of the migrants.[39] It was thus able to prevent the premature departure of the nurses from the hospital. In doing so, it also prevented them from taking up internships in general hospitals, which the Nirmala Association had planned in order for the psychiatric nurses to gain a qualification, which would be recognised in India.[40]

The contracts had been signed for six years. From the beginning, it was clear that the Indian women would return after this time. In November 1967, Debatin wrote to West Germany's Federal Minister of Labour claiming to have recruited almost 800 young Indians for nursing training (and not as employees), who were to serve their home country once they returned.[41] Consequently, he asked the minister to help with the recognition of the German qualification.

The interdepartmental working group on the employment of foreign workers had decided that recruitment should be authorised only if there was an irrefutable need on the West German labour market, or

[31] Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung to Deutsche Lufthansa, Calcutta, Vermittlung von indischen Krankenschwestern in die Bundesrepublik Deutschland, 04.09.1968, PA AA B85 REF 505/V6/699.
[32] Der Bundesminister für Arbeit und Sozialordnung to Bundesminister des Inneren and Bundesminister für wirtschaftliche Zusammenarbeit, Zulassung von ausländischem Krankenpflegepersonal zur Arbeitsaufnahme, 14.04.1965, PA AA B85 REF 505/V6/699.
[33] Großmann 2024, pp. 128–139.
[34] Kreutzer 2005, pp. 110–114.
[35] Großmann 2024, pp. 235–237.
[36] Großmann 2024, pp. 57–163.
[37] Der Bundesminister für Arbeit und Sozialordnung to Bundesminister des Inneren and Bundesminister für wirtschaftliche Zusammenarbeit, Zulassung von ausländischem Krankenpflegepersonal zur Arbeitsaufnahme, 14.04.1965, PA AA B85 REF 505/V6/699.
[38] Großmann 2024, pp. 201–205.
[39] Großmann 2024, pp. 245–247.
[40] Stadtpfarrer Maier to Psychiatrisches Landeskrankenhaus Emmendingen, 31.12.1969, quoted in: Großmann 2024, p. 245.
[41] Pfarrer Hubert Debatin to Arbeitsminister Katzer, 03.11.1967, PA AA B85 REF 505/V6/699.

if the training was beneficial from the perspective of development aid,[42] i.e. if the recruitment met either West German or Indian interests. This prompted a range of responses from the various state authorities. The Federal Ministry of Labour had nothing against the immigration of Indians who wanted to work in the field of nursing.[43] The Federal Ministry for Economic Cooperation, on the other hand, referred to this matter and concluded that, from the perspective of development aid, the recruitment of significant numbers of trained nurses was not in the interests of India.[44] The federal agency for recruitment acknowledged that, because of the shortage of nursing staff, recruitment from Asia was acceptable, even though this was associated with problems and could harm the interests of the sending countries.[45] It concluded, like the Federal Ministry of Labour, and in contradiction with the position of the Federal Ministry for Economic Cooperation, that qualified nurses could apply for a position in West Germany.

Shortly afterwards, the working group discussed whether the residence and work permits of the non-European nurses could be extended beyond five years, although this would give them access to a more secure status and would make it impossible to return their contributions to the pension insurance schemes.[46] It agreed that, given the shortage of trained nurses, the permits should be extended. Nevertheless, the Ministry of the Interior of North Rhine-Westphalia informed its authorities that, as a rule, they should not extend the permits beyond five years.[47]

A year earlier, the ministry had already argued that providing training for foreign nurses was reasonable only within the context of development aid.[48] For this to apply, however, the West German qualifications needed to be recognised in the countries of origin. Accordingly, no residence permit should be issued if this was not the case. An exception could be made in individual cases if the returnees could use the acquired skills, for example in the context of a religious order.

In this way, development aid was used increasingly to legitimise a more restrictive response to the recruitment of non-European nurses.[49] However, this response did not go unchallenged. A retired government official turned to the Minister of the Interior of North Rhine-Westphalia to complain about the non-extension of the residence permits beyond five years:

> The [Chief District Director, UG] obviously completely fails to realise that we do not bring in nursing students from Asian countries in order to patronisingly conduct 'personal development aid', for which these 'underdeveloped' countries should possibly even be grateful to us, but because we constantly need thousands of foreign nurses for our hospitals and nursing homes.[50]

He argued that, since the West German examination was not recognised in India, the nurses would not be able to work there after their return, so it would be irresponsible to send them back. He attached an

[42] As summarised in: Bundesministerium für wirtschaftliche Zusammenarbeit to Bundesminister für Wirtschaft, Bundesminister für Arbeit und Sozialordnung, Bundesminister des Innern, Beschäftigung indischer Krankenschwestern in Deutschland, 05.10.1965, PA AA B85 REF 505/V6/699.

[43] Der Bundesminister für Arbeit und Sozialordnung to Bundesminister des Innern, Bundesminister für Gesundheitswesen, Bundesminister für Wirtschaft, Bundesminister für wirtschaftliche Zusammenarbeit, Beschäftigung indischer Krankenschwestern in Deutschland, 05.04.1966, PA AA B85 REF 505/V6/699.

[44] Bundesministerium für wirtschaftliche Zusammenarbeit to Bundesminister für Wirtschaft, Bundesminister für Arbeit und Sozialordnung, Bundesminister des Innern, Beschäftigung indischer Krankenschwestern in Deutschland, 05.10.1965, PA AA B85 REF 505/V6/699.

[45] Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung to Deutsche Lufthansa, Calcutta, Vermittlung von indischen Krankenschwestern in die Bundesrepublik Deutschland, 04.09.1968, PA AA B85 REF 505/V6/699.

[46] Arbeitskreis für ausländische Beschäftigte, 29.01.1969 (handwritten), LAV NRW NW 760 Nr. 180 (according to notes made by Daniel Schumacher).

[47] Innenministerium NRW to Regierungspräsidenten, Ausländerbehörden, Oberverwaltungsgericht und die Verwaltungsgerichte, 07.05.1969, LAV NRW NW 760 Nr. 180 (according to notes made by Daniel Schumacher).

[48] Innenministerium NRW, Ausbildung von Schülerinnen für Krankenpflegeberufe aus außereuropäischen Staaten, 20.06.1968, LAV NRW NW 760 Nr. 180 (according to notes made by Daniel Schumacher).

[49] Similar processes of using development aid as a justification can be seen also with respect to other non-European migrants. Cf. Goel 2006, pp. 130–132.

[50] Ltd. Ministerialrat a.D. to Innenminister des Landes NW, Ausländerrechtliche Behandlung indischer Krankenschwestern und -schülerinen, 21.09.1974, LAV NRW NW 760 Nr. 180. Translated with the help of deepl.com.

overview of the residence permits that had been denied an extension, or granted only very short-term extensions, in North Rhine-Westphalia. In his letter he also pointed out that, rather than returning to India, the nurses concerned would migrate further, for example to Switzerland. In this way he argued that terminating the nurses' residence in West Germany did not support development aid. A few months later, the representative of the Federal Ministry for Economic Cooperation argued in the working group that, from a development aid perspective, there was no need to train Indian nurses in West Germany.[51]

The argument that the recruitment of Indian nurses was a development aid matter was, therefore, on shaky ground. The non-recognition of the West German nursing examination made this quite obvious. This was an issue pursued in particular by the director of Caritas Cologne, Josef Koenen. From 1969, if not earlier, he took many initiatives to obtain universal recognition by the Indian Nursing Council.[52] In 1970, the Indian Nursing Council asked the German Embassy to provide English translations of the relevant legal regulations in order to assess the examinations for potential recognition.[53] The Federal Foreign Office approached the Ministry for Economic Cooperation, i.e. the ministry responsible for development aid, but it declined to finance the translation, since the recruitment was not part of its responsibility.[54] Since the Federal Foreign Office did not want to provide the necessary funds either,[55] the translations were eventually provided by the Federal Ministry of Health.[56] The ministry was, however, surprised that the qualification had not yet been recognised, since that was a prerequisite for recruiting the trainee nurses. However, the translations did not settle the issue. The Indian Nursing Council suggested that their General Secretary should visit West Germany to find a solution.[57] The Ministry of Health organised the trip, but it proved impossible to convince the General Secretary of the value of universal recognition of the qualification.[58] She argued that India was not interested in nurses trained in West Germany.[59]

In view of this, the argument that the Indian nurses were recruited as a matter of development aid does not appear to be very convincing, even though the argument appears repeatedly in the archives. Instead, the main driver of the nurses' recruitment seems to have been the shortage of nurses in West Germany. Because of this, exceptions to the restrictive immigration rules were made. As long as there was a need for the nurses, recruiters like Debatin could go ahead with their endeavours and could be quite certain that this would be legitimised by the relevant state authorities. However, it also becomes quite clear from the archives that the West German state did not follow a coherent policy with respect to the recruitment of nurses from non-European countries. Rather, the different state actors involved pursued their respective interests and interpreted the rules and regulations accordingly. Because of the need for nurses, those who interpreted the rules liberally, were able to implement this. But there had always also been counter-voices.

[51] Ergebnisprotokoll über die Sitzung des Arbeitskreises für Fragen der Beschäftigung ausländischer Arbeitnehmer im Bundesministerium für Arbeit und Sozialordnung am 5. Dezember 1974 (Protokoll vom 30.12.1974), LAV NRW NW 760 Nr. 105 (according to notes made by Daniel Schumacher).

[52] Josef Koenen to Ambassador of India to the Federal Republic of Germany, Recognition of the German Nursing Diploma by the Indian Nursing Council, 02.06.1976, PA AA B85 REF 513/1262.

[53] Deutsche Botschaft to Auswärtiges Amt, Anerkennung des deutschen Krankenpflegediploms in Indien, 08.07.1970, PA B85 REF 513/1262.

[54] Der Bundesminister für wirtschaftliche Zusammenarbeit to Auswärtiges Amt, Anerkennung deutscher Krankenpflegediplome in Indien, 11.08.1970, PA AA B85 REF 513/1262.

[55] III B2 to Referat V6, Anerkennung deutscher Krankenpflegediplome in Indien, 25.08.1970, PA AA B85 REF 513/1262.

[56] Der Bundesminister für Jugend, Familie und Gesundheit to Auswärtiges Amt, Anerkennung des Deutschen Krankenpflegediploms in Indien, 22.12.1970, PA AA B85 REF 513/1262.

[57] Fernschreiben Deutsche Botschaft to Auswärtiges Amt, Anerkennung des deutschen Krankenpflegediploms, 04.08.1971, PA AA B85 REF 513/1262.

[58] Der Bundesminister für Jugend, Familie und Gesundheit to Auswärtiges Amt, Anerkennung des deutschen Krankenpflegeexamens, 23.08.1971, PA AA B85 REF 513/1262.

[59] Botschaft der Bundesrepublik Deutschland to Auswärtiges Amt, Anerkennung des deutschen Krankenpflegediploms, 16.09.1971, PA AA B85 REF 513/1262.

5 RESTRICTING RECRUITMENT

Right from the beginning, there was criticism of the recruitment of nurses from India. A number of different archives hold a copy of, or a reference to, a confidential report by a German priest about his conversation with a regional passport officer in Madras, in which the Indian official expressed concern about the high number of young women going to West Germany.[60] The Consulate General of West Germany in Madras investigated this report and came to the conclusion that it seemed implausible and exaggerated and, since nothing illegal was happening, the consulate did not need to interfere.[61] In its investigation, the consulate also spoke to Chakkalakal:

> Father Chakkalakal reckons that only 10 to a maximum of 25% of the girls will decide to stay in Germany after completing their education. It is doubtful whether the purpose of recruitment will be achieved under these conditions. It should also be borne in mind that some of the Catholic hospitals in Kerala are themselves suffering from a shortage of junior nursing staff.[62]

At this stage then, the Consulate General in Madras was worried not only that the recruitment would harm the interests of Kerala, but that it was not in the interests of West Germany either, because the recruited nurses would not stay there.

Furthermore, the archives also contain many references to, and copies of, an article by Harry Haas and Albert Otto in the journal "Priester und Mission" that is highly critical of the recruitment from India.[63] In particular, the authors criticise the fact that the recruitment did not promote a religious mission, but was rather driven by the lack of sisters in the religious orders. Haas, who worked for the Catholic Academic Foreigners Service (KAAD), also replied at length to a request for a statement by the Federal Foreign Office.[64] He criticised the non-recognition of the German examinations, argued that the recruitment was happening because of staff shortages and not as an instrument of development aid, and, in particular, criticised the fact that at the hospital in Tübingen, there were no plans to train the recruited women.

Several years later, in 1973, the Consulate General in Madras wrote to the Federal Foreign Office with concerns about the recruitment.[65] It complained, in contrast to its concerns in 1965, that the doors to West Germany were wide open since, due to the shortage of nurses, all applications were accepted. It argued that the claim of serving development aid was false, in particular since the examinations were not recognised. And it demanded a bilateral agreement between India and West Germany to restrict this form of immigration. Two years later, in 1975, the Consulate General again voiced similar concerns in a similarly derogatory way, but with a different signature.[66]

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[60] Abschrift, vertraulich, 65 (handwritten), AEK Gen. III 20.38, Ordner 54 aus Zug. 554. Cf. Großmann 2024, 3.3.6.

[61] Generalkonsulat Bundesrepublik Deutschland Madras to Auswärtiges Amt, Einreise von jungen Inderinnen aus Kerala in die Bundesrepublik Deutschland, 16.03.1965, PA AA B85 REF 505/V6/699.

[62] Generalkonsulat Bundesrepublik Deutschland Madras to Auswärtiges Amt, Einreise von jungen Inderinnen aus Kerala in die Bundesrepublik Deutschland, 16.03.1965, PA AA B85 REF 505/V6/699. Translated with the help of deepl.com.

[63] Jos. Alb. Otto/Harry Haas, Indische Mädchen in deutschen Ordensgenossenschaften, Sonderdruck: Priester und Mission 1 (1965), ADCV 380.40 (540) Fasz. 01. Pater Chakkalakal (Footnote 13), for example reacts to the article. See also Großmann 2024, p. 113.

[64] Katholischer Akademischer Ausländer-Dienst to Auswärtiges Amt, 29.07.1965, PA AA B85 REF 505/V6/699.

[65] Generalkonsulat der Bundesrepublik Deutschland Madras to Auswärtiges Amt, Familiennachzug außereuropäischen weiblichen Krankenpflegepersonals, 13.06.1973, PA AA B85 REF 513/1262.

[66] Deutsches Generalkonsulat Madras to Auswärtiges Amt, Aufenthaltserlaubnis in Form von Sichtvermerken an indische Krankenschwestern und Angehörige, 25.03.1975, PA AA B85 REF 513/1262.

Following the letter of 1973, the Federal Foreign Office pursued the request for a bilateral agreement.[67] From the manner of the correspondence between the ministries, one can see that the sociopolitical atmosphere had changed and the critical voices were gaining in importance. The Federal Ministry of the Interior argued that the training capacities in West Germany were restricted and that there was a need to examine whether the recruitment of trainee nurses from India should be stopped.[68] In the working group discussion, the representative of the Ministry of the Interior objected to such a bilateral agreement, since Indians would not have much inclination to return to India.[69] The working group then decided that, since the numbers of Indian applicants were small, no bilateral agreement would be sought.

The absence of a bilateral agreement became relevant later.[70] In 1975, the working group discussed more restrictive policies for the recruitment of non-European nurses.[71] Although the Ministry of Health still identified a considerable shortage of nurses, all the representatives agreed that recruitment should be restricted. It was argued that exceptions should only be made for the countries with which bilateral agreements had been signed (South Korea and the Philippines). The Ministry of Labour wanted to restrict the recruitment to specific fields of nursing (e.g. psychiatric nursing). The Ministry for Economic Affairs argued that recruitment should be restricted because of rising unemployment. The decisions of the working group were later communicated to the relevant state authorities in order to inform their decisions.[72]

The arguments in favour of more restrictive policies were not coherent. While the Consulate General and the Ministry of the Interior had feared attracting too many Indian migrants in 1973, the working group had abstained from a bilateral agreement because the numbers were small. Rising unemployment rates in West Germany were used as an argument even though there was still a shortage of nursing staff, and exceptions were made in order to counter this. Therefore, there does not seem to have been an economic or demographic necessity to become more restrictive. There is also no reference to development aid to legitimise this change of policy. It seems rather that the general sociopolitical atmosphere had changed so much that a restrictive policy became the legitimate response and these counter-voices were listened to.

6 TERMINATING RESIDENCE PERMITS

The retired government official quoted above criticised the immigration authorities for giving the nurses the feeling that they were facing bureaucratic arbitrariness without recourse to justice and were being humiliated in the process.[73] Caritas officials complained about this repeatedly in letters – and also in interviews with me.

67 Auswärtiges Amt to Bundesministerium des Innern, Bundesministerium für Arbeit und Sozialordnung, Bundesministerium für wirtschaftliche Zusammenarbeit, Bundesministerium für Jugend, Familie und Gesundheit, Familiennachzug von außereuropäischen weiblichen Krankenpflegepersonal, 22.06.1973, PA AA B85 REF 513/1262.

68 Der Bundesminister des Innern to Bundesminister für Arbeit und Sozialordnung, Einreise von außereuropäischen weiblichen Krankenpflegepersonal, 11.07.1973, PA AA B85 REF 513/1262.

69 Arbeitskreis ausländische Arbeitnehmer (BMA), 06.09.1973, PA AA B85 REF 513/1262.

70 Der Bundesminister für Arbeit und Sozialordnung to Deutsche Krankenhausgesellschaft, Beschäftigung außereuropäischen Krankenpflegepersonals, 14.08.1975, PA AA B85 REF 513/1262.

71 Der Bundesminister für Arbeit und Sozialordnung, Ergebnisprotokoll über die Sitzung des Arbeitskreises für Fragen der Beschäftigung ausländischer Arbeitnehmer im Bundesministerium für Arbeit und Sozialordnung am 9. Juli 1975, 30.07.1975, LAV NRW NW 760 Nr. 105.

72 Der Innenminister des Landes Nordrhein-Westfalen to Regierungspräsidenten Arnsberg, Detmold, Düsseldorf, Köln, Münster and Ausländerbehörden, Ausländerrecht, 13.10.1975, LAV NRW NW 760 Nr. 180.

73 Ltd. Ministerialrat a.D. to Innenminister des Landes NW, Ausländerrechtliche Behandlung indischer Krankenschwestern und -schülerinnen, 21.09.1974, LAV NRW NW 760 Nr. 180.

In December 1976, this threat became existential in Karlsruhe. The immigration authority informed a nurse that his residence permit was being extended for the last time and that he should prepare to leave the country.[74] The nurse had been employed by the hospital since November 1973 and had been on a permanent work contract since April 1975. While the immigration authority argued that unemployed Germans were available, his boss stated that it would not be possible to replace him with a similarly qualified nurse and that the functioning of the department would be hampered if he left.[75]

This nurse was not the only one who was faced with the threat of deportation. It seems that in Baden-Württemberg and Bavaria many more received such notices. This led to a whole range of reactions. The appeal by the German Caritas Association of the Archdiocese of Freiburg quoted at the beginning of this article and the accompanying memorandum by nurses was one.[76] Other nurses made similar complaints with the help of their local Caritas Associations.[77] In Karlsruhe, the German wife of a North Indian migrant started a petition and sent this to the German Caritas Association[78] and many state authorities and politicians[79]. In her letter to Caritas she compared the threat to terminate residence with the colonial practices of exploiting labour. Meanwhile, the director of Caritas Cologne travelled to India and informed the Indian Ministry of Health of the developments.[80] As a consequence, the Indian Ministry of External Affairs expressed its concern to the German Embassy.[81] All this caused much media coverage.[82]

The issue of recognition of the German examination became urgent. The Mayor of Karlsruhe requested that the local employment agency strive to obtain this recognition, since this was a matter of care and fairness towards the women.[83] The Caritas director, Koenen, was also still pursuing it, but to no avail. The Indian Embassy informed him:

> The Indian Nursing Council Act does not provide for universal recognition of foreign qualifications by the Indian Nursing Council. Till a provision of that type is made, we will have to continue the present arrangement of recognising the qualifications of individual institutions.[84]

This letter later found its way into the archive of the German Federal Foreign Office, but I cannot find a further reference to this legal argument. Rather, there are traces of parallel activities happening. Already at the beginning of the year, the German Embassy had suggested taking up negotiations with the relevant government authorities in India.[85] The head of the Western Europe department of India's Ministry of Foreign Affairs had said he would instruct the Indian Embassy accordingly.[86] Two months

[74] Stadt Karlsruhe, Polizeibehörde, Ausländerabteilung to Nurse, Aufenthaltserlaubnis für die Bundesrepublik Deutschland, 13.12.1976, PA AA B85 REF 513/1262.
[75] Oberarzt der Klinik für HNO-Krankheiten und plastische Gesichtschirurgie, Bescheinigung, 18.01.1977, PA AA B85 REF 513/1262.
[76] Caritasverband für die Erzdiözese Freiburg e.V. to Frau Minister Annemarie Griesinger, Ministerium für Arbeit, Gesundheit und Sozialordnung Baden-Württemberg, 04.02.1977, PA AA B85-REF 513/1262.
[77] Goel 2019, 2025.
[78] Desai to Deutscher Caritasverband e.V., Nichtverlängerung der Arbeits- und Aufenthaltsgenehmigungen für indisches Pflegepersonal, 10.02.1977, PA AA B85 REF 513/1262.
[79] For example: Rita Desai to Bundesaußenminister, Bittschrift, 17.02.1977, PA AA B85 REF 513/1262.
[80] Botschaft der Bundesrepublik Deutschland New Delhi to Auswärtiges Amt, Indische Krankenschwestern in der Bundesrepublik, 08.02.1977, PA AA B85 REF 513/1262.
[81] Botschaft der Bundesrepublik Deutschland New Delhi to Auswärtiges Amt, Indische Krankenschwestern in der Bundesrepublik, 08.02.1977, PA AA B85 REF 513/1262.
[82] For example: Meine Welt (1977).
[83] Stadt Karlsruhe to Oberverwaltungsdirektor Städt. Krankenanstalten, Beschäftigung von indischen Krankenschwestern bei den städtischen Krankenanstalten, 14.03.1977, SAK, Abt. 1/Klinikum, Nr. 217.
[84] Embassy of India Bonn to Koenen, 03.03.1977, PA AA B85 REF 513/1262.
[85] Botschaft der Bundesrepublik Deutschland to Auswärtiges Amt, Indische Krankenschwestern in der Bundesrepublik, 19.01.1977, PA AA B85 REF 513/1262.
[86] Botschaft der Bundesrepublik Deutschland New Delhi to Auswärtiges Amt, Indische Krankenschwestern in der Bundesrepublik, 08.02.1977, PA AA B85 REF 513/1262.

later, however, the embassy had still not received an instruction, but had scheduled a meeting with the nurses.[87] A month later, the German Embassy spoke again with the Indian Nursing Council, but still did not achieve universal recognition.[88] Another month later, the Federal Foreign Office informed the Federal Ministry for Labour that the Indian Embassy had not been instructed, for understandable reasons, and that this would not happen in future.[89] However, it remains unclear what these reasons were. Was it the state of emergency in India,[90] which had just ended after two years? Was it a lack of interest on the part of the Indian government in the nurses' recruitment? If the latter, was that understandable? In any case, the non-recognition of the German examinations had been known about since recruitment started. The German state authorities had proceeded with it regardless, as the nursing staff was needed. The German Caritas Association of the Archdiocese of Freiburg stressed this fact in its appeal for a humane treatment of the nurses.[91]

Meanwhile, Indian nurses seem to have left West Germany in large numbers. The German Caritas Association estimated that between 1976 and 1978, 1,500 of 4,000 Indian nurses had left, most of them from Bavaria and Baden-Württemberg (about 1,000).[92] Because of negative press coverage in Kerala,[93] the Federal Foreign Office also made investigations:

> It is true that there have been cases in both Bavaria and Baden-Württemberg in which a work permit could not be issued, despite more than 5 years of uninterrupted lawful work residence in the Federal Republic, because the legal residence requirements for the issue of the work permit were not met due to non-renewal of the residence permit.
>
> In Baden-Württemberg, non-European nurses [...] who entered the country between 1967 and 1971 were informed by the responsible immigration authorities that they could not expect their residence permits to be extended again after the expiry of the last residence permits issued in that year.[94]

§ 19 of the Employment Promotion Act (Arbeitsförderungsgesetz) was the basis on which the extensions of the residence and work permits were refused in 1976/77. It stipulated that if there were German workers who could take the positions, the foreign workers could not have their permits extended. The Federal Minister of Labour, however, argued that this would not apply if the foreign worker had worked five years without a break in West Germany.[95] It was for this reason that the working group had been hesitant in 1969 to extend the stay of the non-European nurses beyond this time limit.[96] In 1977, however, the immigration authorities in Baden-Württemberg and Bavaria violated this right by not issuing residence permits. This made it impossible for the employment agencies to issue work permits,

[87] Auswärtiges Amt to Botschaft Neu-Delhi, Indische Krankenschwestern im Bundesgebiet, 06.04.1977, PA AA B85 REF 513/1262.
[88] Botschaft der Bundesrepublik Deutschland to Auswärtiges Amt, Indische Krankenschwestern in der Bundesrepublik Deutschland, 25.05.1977, PA AA B85 REF 513/1262.
[89] Auswärtiges Amt to Bundesministerium für Arbeit und Sozialordnung, Beschäftigung indischen Krankenpflegepersonals in der Bundesrepublik Deutschland, 14.06.1977, PA AA B85 REF 513/1262.
[90] Jaffrelot/Anil 2021.
[91] Caritasverband für die Erzdiözese Freiburg e.V. to Frau Minister Annemarie Griesinger, Ministerium für Arbeit, Gesundheit und Sozialordnung Baden-Württemberg, 04.02.1977, PA AA B85-REF 513/1262.
[92] Mitbürgerinnen auf Abruf. Die Situation der asiatischen Krankenschwestern. In: Informationen des Deutschen Caritasverbandes 3 (1978), 19, p. 2, PA AA REF 513/1464.
[93] Generalkonsulat der Bundesrepublik Deutschland Madras to Auswärtiges Amt, Indische Krankenschwester in der BRD, 14.10.1977, PA AA B85 REF 513/1262.
[94] Auswärtiges Amt to Generalkonsulat Madras, Indische Krankenschwestern in der Bundesrepublik Deutschland, 08.11.1977, PA AA B85 REF 513/1262. Translated with the help of deepl.com.
[95] Der Bundesminister für Arbeit und Sozialordnung to Vizepräsidenten des Deutschen Bundestages, Beschäftigung koreanischen Krankenpflegepersonals in deutschen Krankenhäusern, 27.05.1977, PA AA B37-ZA/107632.
[96] Arbeitskreis für ausländische Beschäftigte, 29.01.1969 (handwritten), LAV NRW NW 760 Nr. 180 (according to notes made by Daniel Schumacher).

since these required residence permits. The Federal Foreign Office justified this breach of the law by arguing that the nurses had known that they would only stay in West Germany for a limited time.[97]

In the archive of the Federal Foreign Office there is a document with no author or addressee that contains a recommendation about how to talk about what was happening in 1977:[98]

> The Indian nursing staff [...], who came to Germany mainly in the years 1964–1970 for the purpose of training and development aid, are very popular with patients and German colleagues. For this reason, the measures envisaged in some cases due to the labour market situation and the legal provisions on the regulation of the labour market, such as the non-renewal of work permits and residence permits, have met with a strong response from the German public. We are particularly grateful for the remarkable contributions that Indians have made to the development and expansion of the German health and hospital system in difficult times. We believe that they can also use the knowledge they have acquired in Germany for the benefit of their own country.[99]

This recommendation clearly aims to pacify negative reactions to the forced return of the nurses by speaking warmly of them. However, it contains several misrepresentations in claiming that the return was a legal necessity, that the nurses had been recruited in the context of development aid and that the returnees would be able to use their acquired skills in India. The immigration authorities' breach of the law was thus not only legitimised, but also disguised, by a verbal (but not material) recognition of what the nurses had contributed to Germany's health sector, and the pretence that they would also contribute to India's.

7 "IN THE GERMAN INTEREST"

Behind these attempts at legitimising what was happening, the state authorities were anything but united in how they assessed the forced return of foreign nurses. Early in 1977, the German Embassy was already asking questions:

> At the same time, the embassy is raising concerns as to whether it is really in Germany's interest to send back the Indian nurses, who have performed a difficult task with recognised commitment and success over the past few years.[100]

The Ministry of Labour shared the concern of the German Embassy about the immediate return, and suggested that alternative employment should be found for the nurses in West Germany.[101] The Federal Foreign Office shared this concern for political reasons.[102] It and the embassy had to deal with the negative image of West Germany that had developed in India as a result of the forced returns. As a consequence of this, the Federal Foreign Office pursued recognition of the examinations and tried to

[97] Auswärtiges Amt to Generalkonsulat Madras, Indische Krankenschwestern in der Bundesrepublik Deutschland, 08.11.1977, PA AA B85 REF 513/1262.
[98] Betr.: Arbeitserlaubnisse für indische Krankenschwestern. Gesprächsführungsvorschlag, 31.8. (handwritten), PA AA B85 REF 513/1262.
[99] Betr.: Arbeitserlaubnisse für indische Krankenschwestern. Gesprächsführungsvorschlag, 31.8. (handwritten), PA AA B85 REF 513/1262. Translated with the help of deepl.com.
[100] Botschaft der Bundesrepublik Deutschland to Auswärtiges Amt, Indische Krankenschwestern in der Bundesrepublik, 19.01.1977, PA AA B85 REF 513/1262. Translated with the help of deepl.com.
[101] Der Bundesminister für Arbeit und Sozialordnung to Auswärtiges Amt, Beschäftigung indischen Krankenpflegepersonals in der Bundesrepublik Deutschland, 04.02.1977, PA AA B85 REF 513/1262.
[102] Auswärtiges Amt 302.516-INI to Referat 513, Indische Krankenschwestern in der Bundesrepublik Deutschland, 17.02.1977, PA AA B85 REF 513/1262.

assess the extent to which Indian nurses were finding employment in other regions.[103] The Ministry of Labour claimed that by July 1977 there had been no termination of work permits.[104]

Although it was the immigration authorities that were mainly responsible for the threat of return, the Ministry of the Interior also became critical of what had happened:[105]

> However, I do not consider such a regulation [the non-extension of the work and residence permits, UG] to be justifiable, for the following reasons:
>
> Due to the shortage of nursing staff that prevailed here until some time ago, which could not be remedied even by recruiting in European countries, the Federal Republic of Germany was dependent on turning to non-European countries, in particular India, South Korea and the Philippines, to meet its labour needs in this area. [...]
>
> [...] We are particularly indebted to this group of people, whom we brought in to care for our sick in an emergency situation. [...] I believe, however, that the state's duty of care towards foreign workers, which is particularly pronounced in the case of these nurses, does not allow these people to be sent home now. In my opinion, therefore, non-European nurses should be granted a residence permit beyond the period mentioned above.[106]

The Ministry of the Interior seems to have responded to the ethical appeal made earlier in the year by the Caritas Association. Rather than arguing in the interest of West Germany, it stressed the state's responsibility to care for the nurses. It recognised the essential work they had done, admitted that they were recruited because of a shortage of staff and argued that the residence permits should be extended. The Ministry of Labour supported this, since it was the non-extension by the immigration authorities in particular which had prevented an extension of the work permits.[107] In North Rhine-Westphalia an official of the state's ministry of the interior captured this moral obligation in its instructions: "Apparently, this is intended to honour the work done by non-European nurses in times of a shortage of German staff."[108]

However, not all state interior ministries were willing to follow this line. Berlin's Senator for the Interior did not consider it justifiable to privilege non-European nursing staff over other foreign employees.[109] The Ministry of the Interior of Schleswig-Holstein agreed with this view.[110] Consequently, the Ministry of the Interior of Baden-Württemberg, which had initiated a survey on the question among the state interior ministries, requested that the Federal Ministry of the Interior put the topic on the agenda.[111] There was obviously a political struggle about whose interests should be looked after.[112]

[103] Auswärtiges Amt to Bundesministerium für Arbeit und Sozialordnung, Beschäftigung indischen Krankenpflegepersonals in der Bundesrepublik Deutschland, 14.06.1977, PA AA B85 REF 513/1262.

[104] Der Bundesminister für Arbeit und Sozialordnung to Auswärtiges Amt, Beschäftigung indischen Krankenpflegepersonals in der Bundesrepublik Deutschland, 04.07.1977, PA AA B85 REF 513/1262.

[105] It would be interesting to do more research into how this difference between the Federal Ministry of the Interior and its (through the intermediary state ministries of the interior) subordinated immigration authorities. It is likely that differing political majorities played an important role in it. However, organisational differences in the state authorities and differences in the way topics such as the recruitment of nurses manifested themselves at municipal, state and national level, should also be taken into account.

[106] Der Bundesminister des Innern to Innenminister (Senatoren für Inneres) der Länder, Ausländerrecht: Beschäftigung von Krankenpflegepersonal aus außereuropäischen Staaten in der Bundesrepublik Deutschland, 15.11.1977, PA AA B37-ZA/107632. Translated with the help of deepl.com.

[107] Bundesministerium für Arbeit und Sozialordnung to Staatssekretär im Bundesministerium des Innern, Beschäftigung außereuropäischen Krankenpflegepersonals in der Bundesrepublik Deutschland, 06.12.1977, PA AA B85 REF 513/1286.

[108] Handwritten note attached to: Der Bundesminister des Innern to Innenminister (Senatoren für Inneres) der Länder, Ausländerrecht, 07.02.1978, LAV NRW NW 760 Nr. 180. Translated with the help of deepl.com.

[109] Der Senator für Inneres Berlin to Innenministerium des Landes Baden-Württemberg, Ausländerrecht, 14.03.1978, LAV NRW NW 760 Nr. 180.

[110] im kiel to alle im, Ausländerrecht, 07.04., LAV NRW NW 760 Nr. 180.

[111] Innenministerium Baden-Württemberg to Bundesminister des Innern, Ausländerrecht, 25.04.1978, LAV NRW NW 760 Nr. 180.

[112] Baden-Württemberg, for example, was ruled by a very conservative government, which may account for its restrictive policies. Reference to the ruling political parties alone, however, does not explain the difference in the way the states reacted. Further research is needed to analyse this.

The archival sources suggest that the debate about the Indian nurses almost ceased after this. Baden-Württemberg and Bavaria had reduced their numbers drastically. North Rhine-Westphalia, which was the other state with a sizeable number of Indian nurses, had refrained from doing this. The German Hospital Federation established that there was still a shortage of nursing staff in some places.[113] Because this was the case in North Rhine-Westphalia too, the immigration authorities were instructed to extend the residence permits.[114] The instructions ended with praise of the achievements of the non-European nurses and a claim that the state government`s policies concering the employment of foreigners reflected this.[115] Caritas Cologne, however, complained that it was still difficult to obtain extensions to permits of residence and that some immigration authorities in particular pressured the nurses to sign a statement accepting a termination in a year's time.[116] This statement included the following:

> My training took place within the framework of development aid, and I am aware that I normally have to leave the Federal Republic after my training. [...] I was told today that I must return to my home country at the expiration of this year, on 23 April 1979.[117]

It can be seen then that even though several ministries at federal and state level expressed their gratitude and obligation to the nurses from India, immigration authorities continued to threaten them and also continued to make the false claim concerning development aid. The practice of forcing migrants to sign statements like this one when they applied for an extension of their residence permit had been in existence for some time.[118] The immigration authorities seem to have considered the departure of migrants to be in the interest of West Germany.[119]

8 ON REPEAT

Despite these developments, many Indian nurses stayed in West Germany, in particular in North Rhine-Westphalia. They were also joined by new nurses from India, even though it was not easy to organise the necessary documents, at least as long as the staff shortages in the hospitals were not significant. Once the shortages increased again, the voices demanding transnational nurse recruitment became louder.[120] In 1989, the Ministry of Education of North Rhine-Westphalia joined these voices, because the nursing school of the university hospital in Bonn was no longer receiving enough applications.[121] In my field research I discovered that in the early 1990s some of the nurses who had been forcibly returned in the 1970s were re-recruited.[122]

[113] To Präsidenten des Landtags Nordrhein-Westfalen, Verlängerung der Arbeitsverträge von koreanischen Krankenpflegekräften, Juni 1978, LAV NRW NW 760 Nr. 180.
[114] To Präsidenten des Landtags Nordrhein-Westfalen, Verlängerung der Arbeitsverträge von koreanischen Krankenpflegekräften, Juni 1978, LAV NRW NW 760 Nr. 180.
[115] To Präsidenten des Landtags Nordrhein-Westfalen, Verlängerung der Arbeitsverträge von koreanischen Krankenpflegekräften, Juni 1978, LAV NRW NW 760 Nr. 180.
[116] Caritasverband für die Stadt Köln e.V. to Innenminister des Landes Nordrhein-Westfalen, Erteilung der Aufenthaltserlaubnis für indische Pflegekräfte, 27.09.1978, LAV NRW NW 760 Nr. 180.
[117] Verhandlungsniederschrift, 06.02.1978, LAV NRW NW 760 Nr. 180. Translated with the help of deepl.com.
[118] Goel 2006, p. 129.
[119] Further research into the functioning of the immigration authorities could make their actions more understandable.
[120] For example: Heinz Schemken, MdB to Innenminister des Landes Nordrhein-Westfalen, Runderlaß des Innenministers vom 16.04.1984, 16.08.1988, LAV NRW NW 760 Nr. 180.
[121] Der Minister für Wissenschaft und Forschung des Landes Nordrhein-Westfalen to Innenminister des Landes Nordrhein-Westfalen, Ausbildungsplätze in der Kranken- und Altenpflege, 19.10.1989, LAV NRW NW 760 Nr. 180.
[122] Goel 2023, p. 261.

Ever since the 1960s, Indians have been coming to Germany to work as nurses.[123] The recruiters were primarily former migrants from Kerala. For some time, official recruitment was prohibited by the rules of the World Health Organisation (WHO) in an attempt to prevent brain drain. At some point, however, India was taken off the WHO list. Faced with a new care crisis,[124] Germany signed an agreement with the federal state of Kerala to recruit nurses in 2021. Nurses are recruited through its Triple Win programme,[125] which promises benefits for the German employers, the nurses and the countries of origin. Interestingly, Germany itself is not mentioned as a beneficiary. It seems to be acting altruistically. Following this, a large number of recruitment agencies have been established. Most have little knowledge of the former recruitment processes, but former migrant nurses or their children are involved in some of the agencies.[126]

This recruitment programme is likely to continue in the future. The recruitment of skilled labour is a much-debated topic at the moment and one in which many actors have an economic interest, so the German Embassy will be occupied with organising it over the coming years.[127] Fair recruitment is in demand. Certification processes that are intended to guarantee ethical procedures are being implemented. Given the huge shortage of nursing staff, however, recruitment is not restricted to certified agencies. Moreover, my explorative field research about the current recruitment processes raises doubts about the extent to which certification can guarantee a recruitment process that caters to the interests of the recruited nurses.[128] Furthermore, in view of the earlier recruitment situation in the 1960s, the question arises as to what will happen once the labour market situation deteriorates or the general political atmosphere in Germany becomes much more restrictive again. Will the current recruitment drive once again be followed by a termination of residence permits on false claims? How sure can the recruited nurses be that they will be treated fairly in the future?

While many state authorities, politicians and representatives from the economy currently consider the recruitment of skilled workers, including nurses, to be in the interests of Germany, other political actors claim that Germany's interest lies in the remigration of all those who cannot claim German heritage. In this way, we are once again experiencing a struggle about what is in the interests of Germany, and this is, among other aspects, an ethical question. The historical perspective raises doubts about whether in this struggle the interests of the recruited nurses – or those of the hospitals – will be the decisive factor.

[123] Goel 2023, pp. 261–263.
[124] Dowling 2021.
[125] https://www.arbeitsagentur.de/vor-ort/zav/projects-programs/health-and-care/triple-win/india (13.01.2025)
[126] I have recently started a research project on current recruitment of skilled labour from India and am conducting field research, in which I have interviewed agencies.
[127] Personal communication from the Ambassador in March 2023.
[128] In 2024 I started researching current recruitment of butcher apprentices from India to work in Germany. In the margins of this research I am also in contact with agencies recruiting nurses, have done field research in preparatory German classes in India and have talked to various German state authorities involved in the recruitment processes.

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ADCV	Archiv des Deutschen Caritasverbandes (Archive of the German Caritas Association)
AEK	Archiv des Erzbistums Köln (Archive of the Archdiocese of Cologne)
LAV NRW	Landesarchiv Nordrhein-Westfalen (State Archive of North Rhine-Westphalia)
PA AA	Politisches Archiv des Auswärtigen Amtes (Political Archive of the Federal Foreign Office)
SAK	Stadtarchiv Karlsruhe (City Archive of Karlsruhe)
UAT	Universitätsarchiv Tübingen (Tübingen University Archive)

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THE ROLE OF FEAR IN THE LIVE-IN CARE DISCOURSE. AN ETHICAL ANALYSIS OF GERMAN NEWSPAPERS

Matthias Hauer and Mark Schweda

Abstract

Migrant live-in care is an essential but controversial part of the care system in Germany and is therefore discussed emotionally in public discourse. While there is already plenty of research on conflicts arising at the micro-level of these care arrangements, the public discourse on live-in care and its emotional dimension has received less scientific attention. The role of fear appears particularly significant as it points to moral assumptions about migrant live-in care. In our contribution, we analyse the communication of fear in the German live-in care discourse in various newspapers between 2017 and 2023, and explore the moral assumptions behind these fears. Two events turn out to be especially relevant: the Covid-19 pandemic and a decision by the Federal Labour Court on payment for on-call times of live-in carers. In both cases, the discourse is replete with predictions of the impending collapse of the care system, which correspond to fears about the future of eldercare in Germany. Fear functions as a moral call to action. Its public communication expresses a perceived lack of political solutions to fundamental problems in (live-in) care.

Keywords: live-in care; fear; discourse analysis

1 INTRODUCTION

"The bad news came just over a week ago," an older lady is quoted as saying in the German newspaper *Die WELT*. Her struggles to organise the care of her 89-year-old sister feature in an article from spring 2020 entitled "On the verge of collapse": "Fearing Covid, her sister's carer packed her bags at short notice and went back to Poland. Her children had urged her to take this step for fear of infection."[1]

The example illustrates three things: Firstly, carers from Eastern Europe who live and work in care recipients' homes play an important part in the German care system. Secondly, this form of migrant live-in care is susceptible to risk and gives rise to considerable uncertainty. A clear legal framework and reliable information are largely missing. Carers, care recipients and families often operate in an opaque and barely regulated market. Thirdly, due to its precarious nature, live-in care has become a subject of emotionally charged and controversial public media coverage and debate. However, while there is a growing body of research on conflicts arising at the micro-level of these care arrangements, this public discourse on live-in care and its emotional dimension have received much less scientific attention so far.

[1] Pieper 2020.

Our contribution presents an analysis of the recent public media discourse about migrant live-in care in Germany. The main focus is on the communication of fears, as this appears particularly prominent and often conveys assumptions about future developments and their moral implications. We first provide a short overview of live-in care in Germany and a description of the research methods of our study. We then identify the main perspectives portrayed in the media and trace the central timeline that structures the discourse. On this basis, we describe the scope of different narratives of fear, focusing on the relatives, the care recipients, the live-in carers, the brokering agencies, and the care system in general. We discuss our findings in light of recent studies on live-in care and draw conclusions for future research, media coverage and the public debate.

2 BACKGROUND: LIVE-IN CARE IN GERMANY AND CONCEPTIONS OF FEAR

In Germany, live-in care is considered a relevant part of the care system. Yet the number of live-in carers working here is not recorded. In 2017, a study estimated that 163,000 households employed a live-in carer.[2] In 2020, the estimate was 210,000 households.[3] Since the need for care is continuing to increase, it seems likely that this trend will also continue and accelerate. Current estimates of the number of live-in carers in Germany range from 300,000 to 700,000.[4]

The legal status of live-in care in Germany is often unclear. There are various employment models, ranging from hiring a live-in carer through an agency to employing a self-employed worker directly without any intermediaries. In most cases, the live-in carers rotate every few months. For families, the regulations are hardly transparent. In many cases, live-in care takes place in a legal "grey area" or is illegal under labour law.[5] This precarious situation nurtures manifold uncertainties and fears.

Live-in care in Germany is subject to an increasing body of research. Most studies focus on the perspective of live-in carers[6], caring relatives[7], or brokering agencies[8]. Fear in the context of live-in care has not been systematically investigated in Germany. A study about fears of care recipients and families with live-in carers in Israel highlights the fear of intrusion of privacy and abuse in the micro-setting.[9] While Israel has a different legal framework, privacy concerns are most likely also present within German families. A German interview study suggests that the fear of something happening to your older relatives constitutes a starting point for live-in arrangements.[10] Another study states that relatives are uncertain about the legal status of live-in workers, for example regarding their insurance.[11] While these studies do not focus on fear, they make it seem plausible that fears play a role in live-in care.

The media discourse on live-in care in German newspapers from 2004 to 2016 was analysed by Christiane Bomert, focusing on the position and agency of live-in carers.[12] This study also provides a list of events that influenced the discourse during the period of analysis, including the expansion of the European Union to countries from Eastern Europe in 2005 and 2007, new regulations like the introduction of a minimum wage for care workers in 2010, and a general minimum wage in 2015.[13] While a

[2] Hielscher et al. 2017, p. 95.
[3] Jacobs et al. 2020, pp. 73–75.
[4] Sachverständigenrat für Integration und Migration 2022, p. 77.
[5] Städtler-Mach/Bünemann 2023, p. 97.
[6] e.g. Karakayalı 2010.
[7] e.g. Rossow 2021.
[8] e.g. Aulenbacher et al. 2024.
[9] Ayalon 2009.
[10] Kniejska 2016, p. 166.
[11] Rossow 2021, p. 181.
[12] Bomert 2020.
[13] Bomert 2020, p. 118.

minimum wage had been discussed in connection with fairness before these events, at the time, it was primarily addressed as a financial problem for families.[14] Here, uncertainties and fears already seem to be playing an important role.

In general, the concept of fear is contested.[15] Jack Barbalet describes fear as an "emotional response to danger"[16] and sees danger as referring to "a liability or prospect of injury"[17]. This definition comprises two main aspects that lead our analysis and coding process: First, fear is based on *descriptive* assumptions about the plausibility or probability of certain future developments or situations. Second, these developments or situations are *evaluated* as harmful or otherwise problematic.

Of course, the discursive negotiation of fears does not simply express individual emotions but conveys cultural narratives about these emotions and the underlying descriptive and evaluative assumptions. Judith Eckert notes that the rhetoric of fear is connected to issues of safety and uncertainty.[18] Paulina and Rafał Matera also define fear following Zygmunt Bauman as "uncertainty that results from ignorance about danger and a lack of knowledge about what to do with this threat."[19] For our analysis, the connection between fear and uncertainty is crucial since fear can be seen as connected to future uncertainties, such as *potential* dangers. The connection between narratives of fears and uncertainties is something we noticed during our coding process and added to our conception of fear for our analysis.

As we analyse narratives of fear, the reason why fear is narrated is relevant. In the context of ecological discourse, Niklas Luhmann noted that fear functions as a tool to make a moral statement.[20] This viewpoint focuses on a specific dimension of fear within narratives. Fear functions in narratives as a moral call for change. Moral in this case refers to a perspective where a subject views an action as correct according to their normative standards. Fear in narratives is not only the description of a situation and the assessment of a danger, but also the moral appeal for this situation to be fixed. Accordingly, Eckert notes that it is necessary to analyse the function of fear in its specific context.[21]

3 METHODS

Our study is part of the research project "Eastern European live-in carers in domestic care triads for people with dementia: Informal care concepts, communicative power and care responsibilities" (TriaDe) funded by the German Research Foundation (Deutsche Forschungsgemeinschaft, DFG). It follows Keller's approach to discourse analysis in terms of sampling and structuring the data.[22] We also used his methodological framework to guide our content analysis process, especially when it came to looking for relevant events and perspectives within the discourse.[23] As the previous analysis by Bomert ended with 2016, the timespan we investigated started in January 2017 and ended in June 2023. The corpus was compiled from newspaper archives. The newspapers selected match those of Bomert and range from conservative to more liberal papers to cover a range of political perspectives: *Frankfurter Allgemeine Zeitung* (FAZ), *Focus* (Focus), *Frankfurter Rundschau* (FR), *Der Spiegel* (Spiegel), *Süddeutsche Zeitung* (SZ), *Die WELT* (WELT). We added *die tageszeitung* (taz) which is perceived to be a liberal-left newspaper.

[14] Bomert 2020, p. 142.
[15] Matera/Matera 2022, p. 454.
[16] Barbalet 1998, p. 155.
[17] Barbalet 1998, p. 155.
[18] Eckert 2020, p. 172.
[19] Matera/Matera 2022, p. 456.
[20] Luhmann 2004, p. 244.
[21] Eckert 2020, p. 174.
[22] Keller 2011, pp. 88–93.
[23] Keller 2011, p. 70.

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Our search phrases were "24 Stunden Pflege" OR "24 Stunden Betreuung" (24-hour care), which are the commonly used terms for live-in care in Germany. Additionally, we searched for "häusliche Pflege" AND "Osteuro*" (home care AND Eastern Euro*), "häusliche Betreuung" AND "Osteuro*" (home care AND Eastern Euro*) and "Osteuro*" AND "Betreuungskr*" (Eastern Euro* AND care worker*). The online archive WISO was used for all newspapers except SZ and FAZ. We excluded duplicates and articles that did not involve live-in care. We analysed 137 articles from seven different newspapers. Most articles were found in SZ (35) and FAZ (33). Welt (25), Spiegel (15), FR (13), taz (13) and Focus (3) followed in this order. Out of 137 articles, 84 had live-in care as the main topic while the other 53 described other issues but mentioned live-in care. Within these articles we identified events that were relevant for the discourse by sorting them according to their main themes and looking at timeframes with a spike in published articles. These events are described in 4.2.

We conducted a structuring qualitative content analysis according to Kuckartz[24] to structure the material. We started with a set of deductive codes reflecting our research interest and supplemented them with inductive codes where necessary. Accordingly, as we were interested in narratives of fear in the discourse, we created a deductive code for all explicit mentions of fear ("Angst", "Furcht") or related words like "Sorgen" (worries/concerns). We also started with a deductive code for all mentions of crisis. Regarding perspective, we differentiated between groups *talked about* and *talked to*. An article can mention a person or a group without claiming to have talked to them, which we coded as *talked about.* When an article cites (directly or indirectly) a specific person or group, it claims to articulate their perspective, which we coded as *talked to*. The results of this coding were used throughout our analysis. Our findings about the perspectives are presented in 4.1 and 4.3.

All codes were inductively differentiated into subcodes in the course of analysis to distinguish variations. Next, connections between the codes were identified. Our first three empirical chapters therefore reference the coding of fears and the subcodes of the different perspectives we developed. The authors discussed the process of coding in analysis sessions. The empirical material was summarised and connections between the codes were analysed. This was done by discussing the coded sections and comparing them with other sections to differentiate content. As we connected fear to different perspectives, these perspective-codes were relevant for this analysis. Links to the narratives of crisis were evident and therefore were also connected to our analysis of fears. Lastly, we included other aspects in our analysis, such as the article format and the publication date (e.g. early or later in the pandemic).

Following Willy Viehöver, we understand discourses as being structured by narratives, which are patterns of communication.[25] Viehöver also points out that the title, subtitle and last paragraph are often especially relevant for the content and tone of an article,[26] which is also the case in our analysis. Summarising our methodological approach, we conducted a content analysis following Kuckartz, while also acknowledging the characteristics of our empirical data, and paying attention to distinctive features of the discursive material. Our content analysis is a step towards identifying thematic patterns in the live-in discourse and how different perspectives are constructed regarding fear within the discourse. The identified narratives are summarised with examples in 4.3.

[24] Kuckartz/Rädiker 2022.
[25] Viehöver 2011, p. 194.
[26] Viehöver 2011, pp. 207–208.

4 EMPIRICAL RESULTS: MEDIA DISCOURSE ON LIVE-IN CARE IN GERMANY

A discourse does not usually articulate only one narrative or argument but a variety of perspectives, arguments and narrative structures that overlap, build on or contradict each other. Our analysis aims to unlock this range of perspectives and arguments. Accordingly, we will first distinguish the main perspectives and events that are addressed in the discourse, highlighting two major events: the Covid-19 pandemic and a decision by the Federal Labour Court on payment for on-call times for live-in carers. We then trace how narratives are linked with fears in these two contexts, focusing on the structure of the respective narratives and their moral functions.

4.1 PERSPECTIVES REPRESENTED IN THE MEDIA DISCOURSE ON LIVE-IN CARE

The perspectives of the groups that shape the care setting itself are also the ones most frequently portrayed in the articles we analysed: live-in carers, care recipients and their relatives. In addition, brokering agencies figure prominently in the live-in discourse. Other groups mentioned are: politicians and political parties, unions and lobby groups. The perspectives of these groups overlap. For example, unions are usually on the side of the live-in carers, endeavouring to see things from their perspective and focusing on good labour conditions.

The most prominent perspective in the discourse is that of brokering agencies. This is not least due to their lobby group, Verband für häusliche Betreuung und Pflege (VHBP) (Association for Home Care), which was very active during the pandemic. VHBP distances itself from "bad" brokering agencies conducting malpractice, thus promoting the image of a clear distinction between "good" and "bad" agencies.

While live-in carers are central to all the analysed articles, they are often written *about*. In particular, articles that portray the general debate tend to cite brokering agencies and other formalised perspectives, like those of unions or scientists. Live-in carers themselves are mainly talked *to* in longer reports that focus on the micro-setting. The perspectives of caring relatives are mainly considered when the organisation of live-in care is portrayed. The perspectives of care recipients are largely missing.

4.2 TIMELINE OF THE LIVE-IN DISCOURSE

In the period analysed, we identified two major events. One is the Covid-19 pandemic, especially the first lockdown in Germany in March 2020 and the following months. The second event is a Federal Labour Court case in 2021 in which a live-in carer sued a brokering agency for the payment of on-call times, mostly during the night. The court ruled in favour of the live-in carer, which started a debate about the fairness and affordability of live-in care in Germany.

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Both events highlighted specific problems with live-in care and intensified the discourse. This is mirrored in the distribution of articles over the years, as shown in figure 1. In 2020 alone, 23 articles with a main focus on live-in care were published, while between 2017 and 2019 only 16 articles were published in total. In 2021, this number was even higher, with 40 articles published. In both cases, this can be traced back to the discussion of the two events. These events were most relevant for the live-in discourse in the analysed newspapers.

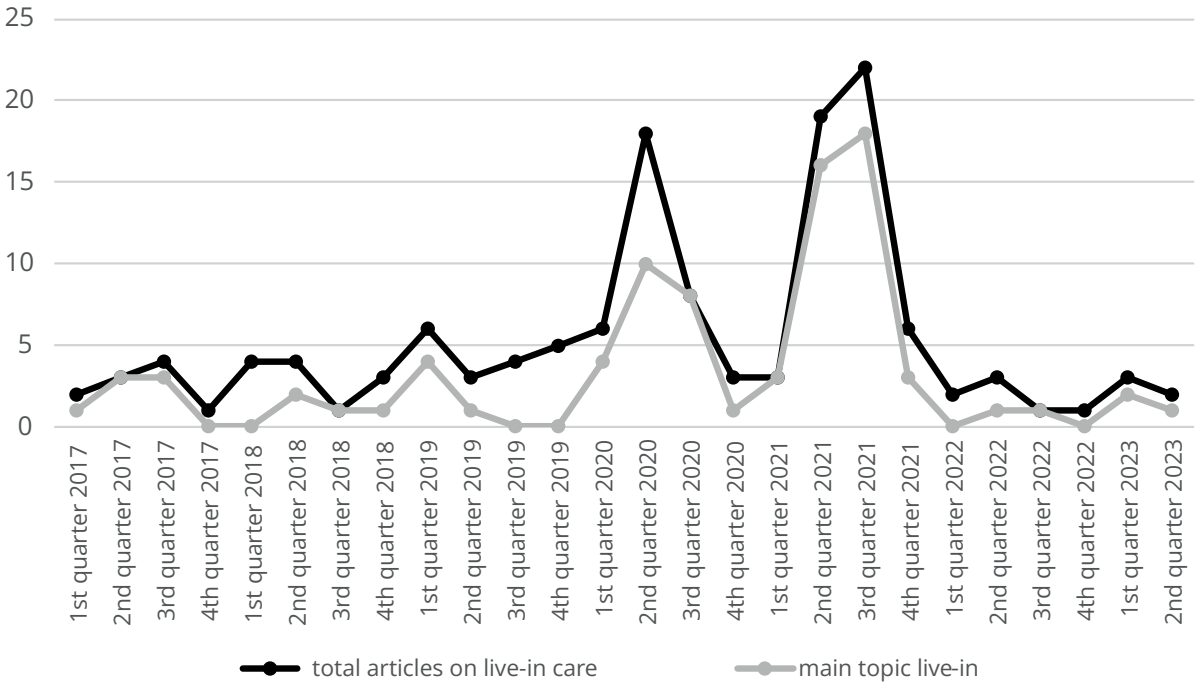

Figure 1 Number of articles per quarter

Both events were described as threats to live-in care in a number of different ways, frequently through fear-evoking metaphors. Words like "Krise" (crisis), "Notstand" (emergency situation), "Katastrophe" (catastrophe) and "Zusammenbruch" (breakdown/collapse), alongside verbs like "drohen" (threaten) and "(be)fürchten" (to fear), were employed to describe the situation. After the Federal Court decision in 2021, the possible consequences for live-in care were labelled as a "tsunami" or "Armageddon" by representatives of two associations representing caring relatives. As we will show, the corresponding narratives express fear of perceived uncertainty of the future. They shed light on different perspectives and narratives of fears in the context of live-in care in Germany.

4.3 NARRATIVES OF FEAR

Relatives in Need

The central perspective regarding problems arising in the care setting itself was that of relatives. The border closures during the pandemic were described as a major problem for them. It seemed uncertain if the current model of switching live-in carers every other month could be continued. If this system had failed, a viable alternative would have been necessary to cover the existing care need. It was said that the closure of national borders caused many live-in carers to return to their homeland or stay there. This was portrayed as creating or increasing a gap between the need for care and the available live-in carers.

> If Iwona and Maria are not the only ones leaving and not returning, families face a problem. Not everyone is as fortunate as Heidi Jung, whose daughter took her in, knowing "that as a freelance photographer, I won't get any work anyway." Many families are now frantically searching for emergency solutions. While you are supposed to avoid contact with elderly relatives, you can't just leave them on their own.[27]

Relatives were depicted as being in need. If the live-in system had not provided sufficient support, they would have needed to organise a substitute. In many cases, this would have meant caring for their relatives themselves. In this narrative, the language reflected urgency. The relatives were described as "frantic", suggesting that a feared situation was becoming reality. If relatives were not described as frantic, they appeared at least "worried". In this narrative, the worst had not yet happened, but it would only be a matter of time.

A second fear of relatives is addressed in the quote above. Especially in the early stages of the pandemic, it was unclear how the virus was transmitted and how to avoid infection. Articles during the first lockdowns pointed out that any contact with older people, who counted as a particularly vulnerable group, should be avoided. This was clearly not possible when living together with a live-in carer. Hence, it was pointed out that relatives were torn between their family members' need for care and the responsibility to avoid infections by isolating as much as possible. While there was a general fear of infection, the need for care was prioritised.

After the Federal Labour Court decision in 2021, relatives were also faced with the fear of live-in care failing, as it appeared uncertain whether they would still be able to afford it. A typical headline asked: "How expensive will Grandpa's care become now?"[28] Relatives were quickly identified as those suffering most from the decision, as they were the ones who needed to organise the care. The headline about the more expensive care for Grandpa does not address "Grandpa" as an active agent. The people responsible are the caring relatives.

In the cases described, fear (mostly) referred to situations that might occur in the future and that were portrayed as a possible danger. In the narrative, however, the possibility almost seems to turn into a certainty that must be managed. In many cases, a solution appears next to impossible, leaving the relatives "frantic". This narrative suggests an intense sense of responsibility on the part of relatives to organise care for their dependent family members. At the same time, being frantic points to a feeling of being overwhelmed by the responsibility while not being allowed to fail, as there is no further safety net.

[27] Mihm 2020 a.; all cited articles were published in German. The translation of cited articles was carried out with Google Translate and adjusted by the authors.
[28] Balzter 2021.

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Helpless Care Recipients

While relatives were pictured as the ones having to fear *for* their dependent family members, the care recipients themselves were portrayed with very little agency. In many articles, their own fear was accompanied by a sense of helplessness: "Mrs. H. cried and stroked her [the live-in carer's] hand and asked her a thousand times if she would really come back."[29] While there is desperation in the narrated picture of the care recipients, they are at the same time not the ones managing the situation. In the quote, Mrs. H. is portrayed as crying and fearing that the live-in carer might never return. In this case, the care recipient's perspective is reported through the live-in carer. In many other articles, their perspective was narrated from the point of view of caring relatives. While there were a few articles that interviewed people in need of care, these generally did not pertain to the two crisis events. It appears that the care recipients' own perspective is less relevant in the live-in discourse, at least in these crisis events.

The picture of helpless care recipients becomes vital in the aftermath of the Federal Labour Court decision. "The decision triggers a tsunami for all those who depend on the support of foreign nursing staff at home."[30] This quote by a representative of an association for patient rights was cited in several articles. It employs the metaphor of an unstoppable and devastating natural disaster. The fear addressed was that many families would no longer be able to afford live-in care. However, when it comes to (re)acting, it is the families or the relatives that are in a position to do something by way of preparation, not the care recipients themselves. The portrayed helplessness and the lack of agency in the narrative of care recipients point towards a moral problem. Not only is there little knowledge of the perspective of care recipients, especially in moments of crisis, but their perspective seems to be of secondary importance.

Live-in Carers and Covid-19

For live-in carers themselves, the two crisis events had very different implications. The Federal Labour Court's decision had the effect that their morally problematic position as potentially exploited workers was recognised. During the Covid-19 pandemic, their status as migrant workers was highlighted in the debate and whether they would stay in Germany to care for the care recipients or leave to be with their own families. This question related to their fear of infection with Covid-19.

In one article, a representative of a brokering agency, when asked about the risk of too few live-in carers remaining in the country after Easter, answers: "This is related to the fear of the virus, fear for one's own families, and also the situation at the borders."[31] In this quote, there is a clear distinction between the live-in carers' working-life in Germany and their family life abroad, with the latter being prioritised.

However, several articles highlighted that some live-in carers decided to stay in Germany and continued to work. Sometimes this was narrated as an exception because they had decided to wait with the care recipient until a new live-in carer arrived, but the new carer was either unable or unwilling

[29] Klovert 2020.
[30] Beeger/Jung 2021.
[31] Pütz 2020.

to come. In other cases, it was portrayed as an opportunity to receive better healthcare than in their home countries, or to work for a longer period than would normally be possible and therefore earn more money. These views became more prominent over time. At the beginning, the dominant narrative was that large numbers of live-in carers were leaving. After a few weeks, it was said that the situation was not so bad after all.

In this narrative, the live-in carers' fear appeared as a reaction to the unknown virus and its consequences. It was a fear for their own families. They did not want to be separated from their relatives for a longer period of time or to be away from home in case someone fell ill. In this situation of uncertainty, they were depicted as wanting to be at home. However, especially in the articles that focus on real micro-settings, it becomes clear that this decision was not taken lightly. There was also a feeling of responsibility for the care recipients, which is why some live-in carers stayed for a longer time than contractually stipulated. While the fears of the live-in carers were portrayed as a reason for them to leave, the general focus remained on the problems connected to their departure, like the urgent need to organise alternative care for the care recipients.

In this case, the fear revealed an enormous dependency on migrant workers, as well as the ensuing dangers when these workers are no longer available. The current system of live-in care does not involve any integration of live-in carers into German society or an option to migrate as a family, which poses a risk in unexpected events like a pandemic. Here, the narrative that live-in care constitutes an irreplaceable part of the German care system is in evidence (see *Live-in Care in Danger*).

Brokering Agencies as Managers of Uncertainty

For brokering agencies, the perspective on fear was different. They were very vocal during the pandemic, trying to react to the fears described. "He considers some of the highly critical portrayals of the availability of caregivers to be exaggerated. This unsettles those in need of care and their families."[32] This statement by the manager of one agency is a good example of the way agencies were portrayed during the pandemic. They responded as experts who knew more about the situation. In the quote, there is an assessment of the appropriateness of fear. And in this case, the verdict was: There is no need to unsettle care recipients and their relatives.

The actual assessment might differ between articles, as some brokering agencies were less optimistic: "'Many agencies no longer have enough caregivers to send to Germany,' he says, estimating: 'Tens of thousands of families are now affected.'"[33] The assessment of the situation also changed over time, as we already noted when describing the narrative about live-in carers leaving the country. However, the general tone of the articles suggested that brokering agencies were the ones that knew most about the current situation. Almost no article offered an assessment of the current situation without asking an agency. While problems were described in the beginning of the first lockdowns, these were also solved by the agencies: "'There's enough staff,' says Blassnigg. 'The market isn't completely empty. If necessary, they can also rely on harvest workers who are currently unable to find work there during the crisis.'"[34] Brokering agencies were acknowledging problems, fears and uncertainties, but they were

[32] Mihm 2020 b.
[33] Mihm 2020 a.
[34] Mihm 2020 b.

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also depicted as the ones providing solutions, like giving care jobs to other migrant workers who could not find work in their sector.

This role of managing fears was vital during the pandemic. The problems associated with closed borders or fewer live-in carers were mostly problems of organisation. This means they fell within the domain of the agencies. This changed in 2021 when the Federal Labour Court decision was made. The decision revealed a problem with the agencies' business model and simultaneously questioned whether live-in care can be affordable and fair at the same time. "Brokers often attract families in Germany seeking help with the promise of 24-hour care – usually for little money."[35] Here, the brokering agencies appeared rather as part of the problem. Their business model was framed as a false promise. Despite becoming much less vocal in the discourse, they were still trying to manage the problem, for example by proposing a legal framework like the Austrian one – a self-employment model which still includes agencies as intermediaries – as standard for Germany. Overall, however, agencies were asked less frequently about their assessment of the situation after the Federal Labour Court decision.

In the case of brokering agencies, fear pointed towards the need to tackle and control perceived dangers. During the pandemic, agencies were able to fill this role. Fear needs to be met with possible solutions. Every fear described above raises the question of how to deal with the danger. In the aftermath of the Federal Labour Court decision, however, the agencies could not provide a viable solution to the resulting problems.

Live-in Care in Danger

The narratives of fear analysed so far mostly referred to personal fears about possible future events and, in the case of the brokering agencies, dealing with these fears. Yet there is another, more abstract fear on a systemic level which is nevertheless still linked to these individualised fears: the fear that the system itself might no longer work. While this fear is also the frame in which the described individual fears are located, it is effective on a larger scale.

Headlines during the pandemic, like "On the verge of collapse"[36] or "The care crisis"[37] and "Finished, amen, catastrophe,"[38] or "Trapped in the care dilemma"[39] in the aftermath of the Federal Labour Court decision, illustrate this systemic level of fear. All these headlines highlight the perceived fragility of the live-in care system. This systemic fear predates the two analysed events. For example, in 2018, FAZ published an article with the headline "Care collapse under German roofs"[40]. In this article, fairness was highlighted as a problem in live-in care. In the context of the two analysed events, this abstract fear was intensified and translated into concrete individual fears. Furthermore, live-in care was narrated as the last resort to avoid collapse. Both the pandemic and the Federal Labour Court decision cast doubt on the sustainability of the current system.

As previously described, agencies proposed hiring harvest workers to fill jobs in care. "'Anyone who wants to get on the bus can be placed,' reports a Bavarian broker."[41] The need for live-in care seemed

[35] dpa 2021.
[36] Pieper 2020.
[37] Pütz 2020.
[38] Prantl 2021.
[39] Beeger et al. 2021.
[40] Beeger/Pennekamp 2018.
[41] Spinrad 2020.

so desperate at one point during the pandemic that quality of care was perceived as a secondary problem. The rationale seemed to be: better bad care than no care. This shows how live-in care was viewed within the bigger picture of care in Germany. For many people, there is no other option. Not only do the families depend on live-in care, but so does the care system itself, because there is no alternative way of caring for those currently cared for by live-in carers. Live-in care is the last resort for many families.

This narrative also sheds light on the role of politics. During the pandemic, brokering agencies took on the role of managing the crisis. Government policy was mentioned only occasionally, and politicians were cited making statements about the bigger picture of live-in care. While policymakers were identified as being responsible, they were also seen as not meeting the task. A brokering agent states that while Austria's Home Secretary chartered a plane for live-in carers, "he does not see such solutions"[42] in Germany. Problems related to the pandemic were also seen as being rooted in political complacency in the face of more fundamental systemic problems: "According to Isfort, Germany is currently sliding unchecked into a care crisis. A development that is also a consequence of years of political inaction […]."[43] This narrative became even more vital in the aftermath of the Federal Labour Court decision, probably because of the shift in the perceived role of brokering agencies as managers, after which a lack of solutions became apparent. Here, again, political actors were portrayed as ignoring the problem: "Such structural problems have been known for a long time, even in politics – but nothing has changed so far"[44]. The narrative clearly addressed political actors as the ones needing to find solutions. At the same time, it made clear that their negligence contributed to the current crisis. Within our sample, there was no article reporting new policies or regulations. While in 2021, live-in care was reported to be on the political agenda after the election, this was never carried forward afterwards.

5 DISCUSSION: FEAR AND MORAL CONFLICTS IN THE MEDIA DISCOURSE ON LIVE-IN CARE IN GERMANY

Our findings highlight the central role of fear in the German media discourse on live-in care. In general, we were able to identify two different types of narrative of fear. One focuses on individual fears, like the fears of relatives and live-in carers. The other one refers to a more systemic fear. These narratives include several core stakeholders of live-in care: the overwhelmed relatives who are responsible but might not be able to organise care for their family members; the person in need of care who is portrayed as helpless; and the live-in carers who are torn between their own family and their work responsibilities. All these narratives address an uncertain situation demanding security.

Relatives feared that the care needed would not be carried out due to closed borders or financial problems and were uncertain about who would provide this care in the future. They knew that, if everything else failed, they would have to provide a solution themselves. This media portrayal of relatives as those ultimately responsible for care provision corresponds to findings on relatives' own perspectives. For instance, an interview study shows that caring relatives will hand over the responsi-

[42] Lindenbach 2020.
[43] Pieper 2020.
[44] Beeger/Jung 2021.
[45] Rossow 2021, p. 63.

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bility of daily care to the live-in carer but retain general responsibility for the organisation of care.[45] In the context of the pandemic and the Federal Labour Court ruling, this may have caused considerable uncertainty. In both cases, relatives were described as being responsible in situations they could not control, which was then narrated in terms of uncertainty and fear. Apart from this *felt* moral responsibility, there is also a legal responsibility for the care of relatives in Germany. The narrative of fear in this case can be interpreted as a call for help directed towards policymakers.

Regarding the persons in need of care, the newspaper articles analysed create the impression of a fundamental lack of voice and agency. While some articles portray the perspectives of care recipients themselves, they are generally represented to a much smaller extent than those of caring relatives. This neglect corresponds to a general desideratum regarding the perspectives of cared-for persons in research on live-in care. Given that many live-in arrangements are initiated to meet the specific requirements arising in the context of dementia care, this may add to the widespread and pervasive epistemic injustice vis-à-vis people with dementia in research and public discourse.[46] They do not seem to be considered to be equally credible or relevant respondents or sources of information. In consequence, those at the centre of live-in care arrangements remain silent and their needs, interests and concerns are left out of the discussion of this form of care.

For the live-in carers, the situation was different. In the pandemic, they were the ones facing an actual decision, but all available alternatives had their downsides. On the one hand, they did not want to leave the person they cared for, and they also wanted to keep their financial security. On the other, they might have been separated from their home and family for a longer period of time. This is in line with previous research showing that 9 out of 15 interviewed live-in carers "mentioned stressors with regard to their own family, including separation from their family, children, or partner".[47] The live-in carers' primary motivation was found to be financial, but intrinsic motivations like altruism also played a part.[48] This aligns with the narrative in the articles we analysed. However, while relatives were under an obligation to organise care for the care recipient, the live-in carers' responsibility was not narrated as a strict moral obligation. Relatives in the micro-setting seem to have a different view, as they attribute considerable moral responsibilities to live-in carers. There were no articles claiming that live-in carers should stay or blaming them for leaving. The need for regulations is even more prominent in the context of live-in carers than in the narrative about relatives in need. The live-in carers' fears about Covid-19 and about their families were described as plausible and therefore valid. The moral appeal was to have more security and fairness for these workers, and addressed the regulating authorities. However, this narrative might also serve another purpose: to show how fragile the live-in system is in general. After all, the analysed articles are aimed at relatives in need, care recipients and those who might become part of these groups in the future. The prioritisation of needs of caring relatives over live-in carers does align with findings of Ewa Palenga-Möllenbeck about the live-in discourse during the pandemic.[49]

Overall, our empirical findings indicate that the moral call to the authorities was not seen as very successful. The discourse remains static during the period analysed in the sense that no new regulations were announced. The events analysed here triggered specific fears among all groups involved in the

[46] Halonen et al. 2024.
[47] Kriegsmann-Rabe et al. 2023, p. 6.
[48] Kriegsmann-Rabe et al. 2023, p. 12.
[49] Palenga-Möllenbeck 2024, p. 162

micro-setting of live-in care. These fears seemed to originate from a fear on a more abstract systemic level: the fear of the (live-in) care system collapsing. The moral obligation to save this system and the fears and uncertainties arising from its failure lie with the political authorities. In the analysed articles, politicians are rarely vocal about these issues, while there is no change in regulations at all. A recent policy discourse analysis found six policy statements and papers in the timespan from 2020 to 2023.[50] However, these were not picked up by the newspaper articles we analysed. Therefore, the efforts in question either do not appear convincing or are not communicated well enough. These findings confirm that despite the need for more sustainable solutions, there is no perceived effort towards such solutions. This is also noted by another policy analysis during the pandemic, which concludes that solutions were only short-term fixes and did not solve underlying issues of live-in care.[51]

5.1 LIMITATIONS

Our study has several limitations. Our sample only comprises articles from quality newspapers. Tabloids and other media, like television and social media, have not been analysed so far. Especially with the rise of social media, such an analysis could shed light on different aspects of the live-in discourse. Furthermore, the sample has limitations regarding the timeframe and the specific national context. Comparative studies could help explore historical variation and international differences. Finally, our analysis employed qualitative methods. Further, quantitative research is needed to make more general statements, e.g. about the prevalence of the identified narratives.

5.2 CONCLUSION

Our analysis illuminates how fear functions as a moral call to action that points towards a problem and postulates responsibilities in the German media discourse on live-in care. Yet the discourse also exhibits particular foci, biases and blind spots that need critical reflection. For example, the discursive focus on the caring relatives appears problematic as it can reinforce the responsibilisation of the family and the neglect of structural and systemic responsibilities. At the same time, the perspectives of live-in carers and especially care recipients are marginalised in the discourse, meaning their concerns are hardly addressed in public. In assessing live-in care, these viewpoints should be more prominently covered in public discourse.

By contrast, brokering agencies are frequently consulted and portrayed as neutral managers of and experts on live-in care, especially during the pandemic. This appears highly problematic as these agencies are by no means neutral and have substantial stakes and economic interests in the field. Here, media coverage of live-in care needs a more critical approach towards one of its major sources of information. Public authorities could support this by collecting and providing information on relevant facts and figures.

Our findings highlight the media portrayal of live-in care as a last resort in the care system. There seems to be no other form of care that could replace it. This means that even though live-in care is

[50] Leiblfinger et al. 2020, p. 147.
[51] Leiblfinger et al. 2020, p. 147.

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fraught with manifold uncertainties and substantial problems, these cannot simply be resolved by choosing an alternative. According to the newspaper discourse, this paradox of live-in care as a last resort and, at the same time, an ignored problem needs to be tackled by policymakers. Indeed, the long announced political debate and regulation appear highly desirable.

As our analysis focuses on fears in the newspaper discourse, we cannot draw conclusions about the actual emotions of those involved in live-in care settings. However, existing literature suggests that some of our findings correspond to the micro-setting. This can be seen as a first hint that the perceived lack of political solutions is rooted in real problems within the German (live-in) care system. Hence, a more systematic exploration of fear in the micro-setting seems worth pursuing.

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Primary Sources

No.	Date	Title	Type of publication
1	01/23/2017	Eine legale Betreuung kann ich nicht bezahlen	Süddeutsche Zeitung (SZ)
2	02/08/2017	Jeder zehnte Euro wird illegal kassiert	Die WELT (WELT)
3	04/04/2017	Pflege rund um die Uhr – und mit wenigen Rechten	Frankfurter Allgemeine Zeitung (FAZ)
4	07/06/2017	Zu Hilfe	SZ
5	07/06/2017	Auf dem Rücken der anderen	SZ
6	08/06/2017	„Das sind eigentlich sittenwidrige Löhne“	FAZ
7	08/07/2017	Wer kümmert sich um die, die sich kümmern?	FAZ
8	08/11/2017	Alles nicht so schlimm?	Frankfurter Rundschau (FR)
9	09/16/2017	Wenn die Eltern altern	Focus
10	11/22/2017	Die neuen Diener	Der Spiegel (Spiegel)
11	01/27/2018	Mamas hilflose Helfer	Spiegel
12	02/12/2018	Altenpflege kostet – bald wohl noch mehr	FAZ
13	03/06/2018	Wer kennt diesen Pfleger?	FAZ
14	03/07/2018	Tödliche Pflege	Spiegel
15	03/07/2018	Pfleger soll Rentner mit Insulin ermordet haben	SZ
16	05/10/2018	Pflegekollaps unter deutschen Dächern	FAZ
17	05/25/2018	Wenn die Pflege zur Lebensfalle wird	FAZ
18	05/xx/2018	Polnische Engel	FAZ
19	07/18/2018	Die einzige Option	WELT
20	10/15/2018	Unser Engel hieß Danuta	Spiegel
21	11/13/2018	Hilfspfleger steht unter sechsfachem Mordverdacht	Spiegel
22	11/13/2018	Hilfspfleger soll sechs Senioren mit Insulin ermordet haben	WELT
23	02/08/2019	Wie ein polnischer Haushaltshelfer offenbar etliche deutsche Pflegebedürftige töten konnte	Spiegel
24	02/11/2019	In der Pflege droht der Kollaps	FAZ
25	02/11/2019	Schwarzarbeit in der Pflege: Forscher fordern Hinschauen	WELT
26	02/14/2019	Wie zwei Polinnen die Pflegelücke schließen	WELT
27	03/07/2019	Verbraucherschutz berät zu häuslicher 24-Stunden-Pflege	WELT
28	03/19/2019	Mal ausgebeutet, mal unterfordert	FAZ

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No.	Date	Title	Type of publication
29	04/13/2019	Pflegemigrantinnen für viele unverzichtbar: Grauzone	WELT
30	04/15/2019	Was dürfen Pflegekräfte?	WELT
31	05/11/2019	In ganz Europa unterwegs	SZ
32	08/06/2019	Beratung zur Pflege	FR
33	08/12/2019	24-Stunden-Betreuung nicht wörtlich verstehen	WELT
34	08/22/2019	Wie viele Sklaven arbeiten für dich?	Spiegel
35	08/27/2019	Eine vollkommen einseitige Diskussion	FR
36	11/24/2019	Wohin im Alter?	FAZ
37	11/25/2019	Pfleger wegen sechsfachen Mordes angeklagt	SZ
38	11/27/2019	„Danach ging ich schlafen“	Spiegel
39	12/02/2019	Abgezockt, ausgeraubt und totgespritzt	WELT
40	12/14/2019	„Franz hat ihm nichts getan“	SZ
41	03/21/2020	Notbetreuung	SZ
42	03/24/2020	Und wer betreut die Oma jetzt?	FAZ
43	03/24/2020	Die Betreuungskrise	Spiegel
44	03/27/2020	AUFSCHREI DER PFLEGE Häusliche Pflege in Gefahr	FR
45	03/27/2020	Immun, was nun?	Spiegel
46	03/27/2020	Corona: Betreuungskrise für Behinderte und Senioren	WELT
47	04/02/2020	Der Landwirtschaft fehlen Zehntausende Erntehelfer	SZ
48	04/03/2020	Flucht der Pflegekräfte	SZ
49	04/03/2020	Kurz vor dem Kollaps	WELT
50	04/06/2020	Die polnische Pflegerin kann nicht mehr kommen – und jetzt?	Spiegel
51	04/06/2020	Wenn die Pflegerin plötzlich weg ist	SZ
52	04/07/2020	Wenn Pflege töten kann	taz
53	04/07/2020	Infektiologe warnt vor hoher Totenzahl bei einseitiger Isolation	WELT
54	04/08/2020	Verband: Bei Betreuung alter Menschen droht große Lücke	WELT
55	04/08/2020	„Die Älteren weinen viel, kommen mit der neuen Lage nicht klar“	WELT
56	04/12/2020	Das Leid der Alten	FAZ
57	04/15/2020	Die Kosten für Pflege und Betreuung steigen	FAZ
58	04/17/2020	Fragen zu Corona Die FR gibt Antworten	FR

No.	Date	Title	Type of publication
59	04/25/2020	„Relevanter als die Spargelernte“	FAZ
60	05/05/2020	Achterbahnfahrt für die Angehörigen	SZ
61	05/12/2020	Küche, Wäsche, Schwarzarbeit	SZ
62	05/12/2020	Den richtigen Pflegedienst finden	SZ
63	05/18/2020	Frau Popescu will nach Hause	SZ
64	06/30/2020	Einblicke ins wirkliche Leben	FAZ
65	07/17/2020	Rund um die Uhr im Dienst	SZ
66	07/20/2020	Eine faire Pflege für Oma und Opa	FAZ
67	07/22/2020	Die 24-Stunden-Pflege gerät unter Druck	taz
68	07/24/2020	Verband kritisiert Arbeitsbedingungen osteuropäischer Pflegekräfte	Spiegel
69	07/25/2020	Ausbeutung mit System	FR
70	08/17/2020	Gericht: Pflegerin steht Mindestlohn zu	WELT
71	08/18/2020	24-Stunden-Pflege ist kein Teilzeitjob	SZ
72	09/03/2020	Suche: Vollzeitkraft, biete: Teilzeitbezahlung	SZ
73	10/06/2020	„Todespfleger“ von Ottobrunn muss wegen Mordes lebenslang in Haft	SZ
74	10/06/2020	„Nicht friedlich eingeschlafen“: Lebenslang für Hilfspfleger	WELT
75	10/07/2020	Lebenslang für „Todespfleger“	SZ
76	11/04/2020	Verbände: Amnestie bei Schwarzarbeit in häuslicher Pflege	WELT
77	01/08/2021	Gute Pflege tut not, nicht Erbenschutz	FAZ
78	01/14/2021	Wie vereinbare ich Beruf und Pflege?	FAZ
79	01/29/2021	Dann wurde Svetlana ohnmächtig	SZ
80	07/03/2021	Die Jungen gehen, die Alten leiden	FR
81	03/12/2021	So beschäftigen Sie Ihre ausländische Pflegehilfe legal	FAZ
82	05/09/2021	Wenn Oma ruft, ist sie da	FAZ
83	05/11/2021	Neues Konzept fordert Rechtssicherheit für häusliche Pflege	WELT
84	05/18/2021	Vorschläge für bessere Pflege	taz
85	06/24/2021	Ausländischen Pflegekräften steht der Mindestlohn zu	FAZ
86	06/24/2021	Ausländische Pflegekräfte haben Anspruch auf Mindestlohn	Spiegel
87	06/24/2021	Häusliche Pflege wird teurer	SZ
88	06/24/2021	Ausländische Pflegekräfte können auf Mindestlohn pochen	WELT

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No.	Date	Title	Type of publication
89	06/25/2021	Mindestlohn für Pfleger aus dem Ausland	FAZ
90	06/25/2021	Böses Versäumnis	FAZ
91	06/25/2021	Preisschock für die Pflege zu Hause	FAZ
92	06/25/2021	Rund um die Uhr pflegen	FR
93	06/25/2021	Was kostet Würde?	SZ
94	06/25/2021	VdK-Präsidentin Bentele zur Pflege: „Jetzt muss gehandelt werden“	SZ
95	06/25/2021	Mindestlohn gilt auch für Frau D. aus Bulgarien	taz
96	06/25/2021	Praktikable Modelle gefragt	taz
97	06/26/2021	Streit nach Urteil	FR
98	06/26/2021	Schwierige Pflege	taz
99	07/03/2021	„Nach der Wahl“	FR
100	07/03/2021	Nachforderungen können Pflege bedrohen	Spiegel
101	07/04/2021	Wie teuer wird jetzt Opas Pflege?	FAZ
102	07/06/2021	Wenn das Altern zu Hause unerschwinglich wird	SZ
103	07/08/2021	Häusliche Notgemeinschaft	taz
104	07/09/2021	Aus, Amen, Katastrophe: Was tun, wenn häusliche Pflege unerschwinglich wird?	SZ
105	07/09/2021	Würde im Alter dank Opfer und gratis Arbeit der Frauen	taz
106	07/12/2021	Ausbeutung von Pflegekräften	WELT
107	07/17/2021	Worauf Angehörige achten sollten	Focus
108	07/17/2021	Der Preis der Pflege	Focus
109	07/25/2021	Pflege ohne Recht	WELT
110	08/02/2021	Gerecht und unerschwinglich	SZ
111	08/09/2021	Gefangen im Pflege-Dilemma	FAZ
112	08/09/2021	Pflege-Blindflug	FAZ
113	08/17/2021	Todespfleger-Urteil rechtskräftig	SZ
114	08/21/2021	„Ohne diese Frauen würde das System kollabieren“	taz
115	08/23/2021	Rund um die Uhr versorgt	FR
116	08/24/2021	7. weil Existenzängste und ausbeuterische Arbeit unmenschlich sind	taz
117	08/25/2021	Pflegekräfte im Dauereinsatz	FAZ
118	08/25/2021	Angehörige tragen die Hauptlast	SZ

No.	Date	Title	Type of publication
119	09/04/2021	Was die Parteien für die Pflege planen	FR
120	10/26/2021	Eine Lösung für die Pflege zu Hause	FAZ
121	11/05/2021	„Kriminelle Machenschaften" – wie Arbeitgeber beim Mindestlohn tricksen	WELT
122	11/06/2021	Die Vergessenen	Spiegel
123	11/16/2021	Wenn die Kraft zur Neige geht	FR
124	11/30/2021	An Mamas Seite	taz
125	12/23/2021	Immer da, aber unsichtbar	taz
126	01/21/2022	„Dabei wissen doch alle Bescheid"	SZ
127	01/27/2022	„Lieber Kassiererin im Supermarkt als impfen lassen"	FAZ
128	04/01/2022	„Geflüchtete nicht nur in Helferjobs bringen"	FAZ
129	05/07/2022	Das große Vergessen	SZ
130	05/13/2022	Frauen-Union will 24-Stunden-Betreuung aufwerten	SZ
131	09/06/2022	24-Stunden-Pflege muss entsprechend bezahlt werden	FAZ
132	10/18/2022	Neues Angebot für Pflegebedürftige	SZ
133	03/11/2023	6,6 Milliarden und kein Plan	WELT
134	03/11/2023	Wenn was mit Opa ist, hilft Frau Himmelmann	WELT
135	04/02/2023	Eine Frau, die ihre Pflege selbst in die Hand nimmt	SZ
136	05/10/2023	Das hausgemachte Pflegedesaster	taz
137	05/23/2023	Das bittere Ende	SZ

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FAIR RECRUITMENT OF NURSES THROUGH VOLUNTARY ETHICAL CODES: EVOLUTION AND DISCOURSE

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Abstract

The global migration of nursing professionals has increased significantly in recent years, driven in part by skills shortages in the healthcare sector. Today's migration infrastructure is far more sophisticated than it was in the 1960s. Labor migration intermediaries (LMIs) are playing an expanding role in labor migration processes, not only in Germany but worldwide. Ensuring ethical recruitment has become increasingly important in international discourse, even though initial frameworks and guidelines were first established in the 1970s by organizations such as the World Health Organization (WHO) and International Labor Organization (ILO). This article provides a systematic literature review on the discourse and on the role of voluntary ethical codes as regulatory instruments to ensure the fair recruitment of nurses. It identifies three main strands of research: the development and evaluation of such codes, conceptual ambiguities around "ethical recruitment", and structural and regulatory challenges linked to the role of LMIs. The findings highlight both the historical continuities and the current trends in the migration industry concerning ethical recruitment practices.

Keywords: labor migration, governance, ethical codes, recruitment, healthcare

1 INTRODUCTION AND BACKGROUND

The globalization of labor markets has led to an increase in the migration of nursing professionals.[1] The shortage of nurses, particularly in the Global North, is addressed by recruiting personnel from abroad. According to migration sociologist Cleovi Mosuela, the "migration of health workers, or the crisis of human resources for health, has transpired into a critical global health challenge, hence encompassing ethical, structural, political, societal, and economic aspects of governance".[2] According to political scientist James F. Hollifield, high-income liberal democracies are economically dependent on the international recruitment of workers.[3] As the recruitment of nurses from countries in the Global South through private labor migration intermediaries (LMIs) continues to increase, various strategies have been developed to facilitate this process. However, the recruitment of nurses from the Global South to the Global North raises ethical concerns, as it often depletes healthcare systems in countries that are already struggling to meet the medical needs of their own populations and suffering from "brain drain".

[1] OECD 2019.
[2] Mosuela 2020, p. 33.
[3] Hollifield 2004.

In order to show that countries of the Global North are not causing harm in the countries of origin through active recruitment, these countries are increasingly committed to *ethical* and *fair* recruitment. Instruments designed to ensure ethical international recruitment pursue different objectives: protecting individuals from unscrupulous recruitment processes and employers, or protecting the countries of origin.[4] Although there are widespread global standards, there is little specification of what "ethical" or "fair" recruitment means in detail.[5] Given the fact that structural imbalances arise when high-income countries benefit from an influx of trained nurses, while source countries receive little compensation or systemic support, most voluntary ethical codes do not take sufficient account of this.[6] This structural imbalance is increasingly analyzed through the lens of neocolonialism, highlighting how high-income countries continue to extract skilled labor from low- and middle-income countries without providing adequate compensation or structural support.[7]

Labor migration and immigration to meet the demand for skilled workers is not a new phenomenon. For example, nurses from non-EU countries have been recruited to work in health and care facilities in Germany since the 1960s.[8] The first non-binding framework dealing with the role of nurse recruitment appeared in 1977 in the form of the International Labor Organization (ILO) Nursing Personnel Recommendation (No. 157). Even this early document emphasized that international recruitment should only take place under strict conditions – namely, if there is a proven shortage in the destination country and no critical shortage in the country of origin – and called for migration processes to be voluntary, transparent, and aligned with international labor standards.[9] The ILO later established a binding framework for private employment agencies in Convention 181[10] in 1997. According to Article 7 ff., this convention excludes charging job-seekers recruitment fees, prohibits fraudulent practices and child labor, and prioritizes the protection of workers. The long period of time that elapsed between the first international recruitment activities and the conceptual frameworks for regulating them can be explained by the fact that labor migration at that time was almost exclusively carried out through bilateral agreements.[11]

Nicola Yeates and Jane Pillinger, both transnational social policy scholars, have observed a notable "rise of ethical recruitment"[12] since the 2000s, underscoring a growing recognition of the imperative for ethical recruitment codes. In 2019, the ILO's General Principles and Operational Guidelines for Fair Recruitment outlined a comprehensive framework for promoting ethical recruitment, with a particular focus on regulating the global migration industry, understood as the network of private agencies and intermediaries facilitating international labor migration.[13] The establishment of quality seals and codes of conduct at the national level underscores the growing need to shape migration ethically and fairly, and to regulate the actors involved accordingly.

The aim of this systematic literature review (SLR) is to examine the extent to which voluntary ethical codes are discussed and evaluated in the scientific literature as regulatory instruments for governing the expanding market of international healthcare recruitment, with a particular focus on the role of private LMIs.

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4 Martineau/Willets 2006.
5 Hanrieder/Janauschek 2025.
6 Angenendt et al. 2014.
7 Mosuela 2018; Hanrieder/Janauschek 2025.
8 Arend/Klie 2016.
9 ILO 1977.
10 Private Employment Agencies Convention.
11 Mosuela 2018.
12 Yeates/Pillinger 2019, p. 85.
13 ILO 2019.

2 REVIEW DESIGN AND LITERATURE SELECTION PROCESS

To capture the state of research on voluntary ethical codes designed to regulate recruitment of healthcare personnel, an SLR was conducted. This approach aims to minimize researcher bias in the selection of literature and increase the reliability of the selection.[14] To identify relevant literature on the topic of voluntary ethical codes as an appropriate regulatory instrument for health sector labor migration, a search was conducted across a number of databases: Google Scholar, EBSCOhost, JSTOR, BASE, and the Social Science Open Access Repository (SSOAR). PubMed was not searched separately, as the results from the aforementioned databases already included relevant PubMed content. The search strategy was based on context-specific keywords such as "regulation", "recruitment", "nurse", "self-commitment", combined into search strings with cross-cutting keywords like "labor migration", "governance" and "healthcare". The results of the searches were systematically set out in an Excel spreadsheet. The search strings were adjusted in an iterative process. Included in the research are both English and German-language articles and publications published after 2004, as they should not be older than 20 years old. The review and documentation followed the method proposed by Mark Petticrew and Helen Roberts.[15]

The initial search based on title screening yielded 134 results. Following an abstract review and relevance rating, 64 publications were deemed suitable for further analysis regarding the research topic of voluntary ethical codes to ensure ethical recruitment of healthcare personnel, with an additional 29 labeled as "unsure". All 93 publications were examined based on key messages, methods, and findings. Ultimately, 38 were selected for in-depth analysis (28 from the "sure" and 10 from the "unsure" category). A detailed overview of the selection process is provided in Table 1 in the appendix.

3 VOLUNTARY ETHICAL CODES IN THE SCIENTIFIC DISCOURSE: GOVERNANCE INSTRUMENTS FOR REGULATING INTERNATIONAL NURSE RECRUITMENT

The discourse on migration of healthcare personnel is approached from an interdisciplinary perspective, drawing on migration studies, global health, social policy, and governance research. Even if there is a broad scientific discourse on the separate aspects of labor migration, the review indicates that there is limited scientific literature focusing specifically on voluntary ethical codes as a regulatory instrument for private-sector recruitment of nurses. It is striking that the literature on regulation of migration processes considers both regulation of the profession itself and of LMIs. Scholarly discussions on the individual aspects of the research question (migration policy, nurse migration research, and governance of international organizations) continue to evolve, accompanied by a notable rise in studies and reports on migrant recruitment in recent years.[16] Particularly prominent is the observation that most of the publications fall into the category of gray literature.

[14] Tranfield/Denyer et al. 2003.
[15] Petticrew/Roberts 2006.
[16] Agunias 2013; Pittman 2016.

One dimension of the scientific discourse concerns the development, regulatory design, and implementation of national codes, as well as their critical evaluation. National-level codes first began to take shape in the early 2000s. Examples specific to the regulation of LMIs in the healthcare sector are the codes produced by the Department of Health and Social Services, UK (Code of Practice for the International Recruitment of Health and Social Care Personnel in England) and by the Alliance for Ethical International Recruitment Practices, USA (Health Care Code for Ethical International Recruitment and Employment Practices). Franklin Shaffer, Mukul Bakshi, Julia To Dukta, and Janice Phillips, all affiliated to CGFNS International (Commission on Graduates of Foreign Nursing Schools, now: TruMerit), emphasize that voluntary codes can serve as important instruments to address ethical challenges in global healthcare recruitment. According to their analysis, such codes help increase transparency, shape professional conduct, raise awareness, and mitigate harm to internationally educated health professionals.[17] The Fair Recruitment Healthcare Germany quality mark introduced in Germany in 2021 has not yet been the subject of scientific discourse.

Another stream of literature focuses on the absence of clear definitions of ethical recruitment, as the concept itself has rarely been explicitly defined in the academic discourse. Vivien Runnels, Ronald Labonté, and Carolin Packer explore the tension between market logic and global health ethics in the context of international health worker recruitment. Along with other scholars, they have pointed out that ethical recruitment is understood to mean different things, and is often only measured by the impact on countries of origin (as per the WHO Code[18]).[19] According to the WHO's latest statement, "[e]thical international recruitment should result in direct benefits to health systems of both source and destination countries and should ensure the rights and welfare of migrant health workers".[20] The ILO made an initial attempt to standardize ethical recruitment with its Fair Recruitment Initiative, but the debate on what constitutes ethical practices continues. Recently, for example, Tine Hanrieder and Leon Janauschek critically assessed the proliferation of "ethical recruitment" schemes, revealing how these ostensibly protective frameworks often serve as instruments of liberal health worker extractivism, privileging individual labor safeguards while perpetuating structural inequities in global care labor flows.[21]

Building on this conceptual critique, another part of the scientific discourse offers a more practice-oriented and institutional perspective, particularly regarding the enforceability of voluntary ethical codes. Labor migration scholars such as Clémence Merçay, Steffen Angenendt, and Ivy L. Bourgeault emphasize the lack of binding enforcement mechanisms, the inconsistent implementation of ethical codes, and their tendency to prioritize normative recruitment principles rather than addressing the root causes of migration, such as poor working conditions and underfunded healthcare systems in source countries.[22] Critical reflections on the WHO Code dominate the literature, particularly with regard to its limited ability to safeguard the interests of countries of origin.[23] This critique is further reinforced by the lack of standardized data collection on nurse migration, which hinders any systematic evaluation of the effectiveness and long-term sustainability of such voluntary codes.[24]

The gap that has to be bridged when translating normative frameworks for ethical recruitment into enforceable and measurable policy reflects a broader challenge in the regulation of labor migration. As Dovelyn R. Agunias, a policy analyst at the International Organization for Migration (IOM), argues,

[17] Shaffer et al. 2016.
[18] The WHO Code, introduced in 2010, became one of the central international codes in this area and is therefore the subject of research in many publications.
[19] Runnels et al. 2011.
[20] WHO 2024.
[21] Hanrieder/Janauschek 2025.
[22] Merçay 2014; Angenendt et al. 2014; Bourgeault et al. 2023.
[23] Bourgeault et al. 2016; Yeates/Pillinger 2019.
[24] Buchan et al. 2009; Angenendt et al. 2014; Schneider 2023.

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current regulatory efforts often target the wrong issues, neglect agency-to-agency dynamics, and fail to address deeper root causes such as information asymmetries or systemic job shortages. Although consensus on the need to regulate LMIs is increasing, the ideal form that such regulation should take remains a subject for debate. Moreover, enforcing accountability across multiple jurisdictions with divergent legal frameworks proves difficult, enabling unethical LMIs to exploit existing regulatory loopholes.[25]

The findings indicate that voluntary ethical codes, while normatively significant, cannot be assessed in isolation. Their effectiveness is embedded within a broader migration infrastructure, which increasingly relies on private actors.[26] The following section therefore widens the analytical lens to examine the structural dynamics and governance challenges associated with the regulation of LMIs.

4 THE MIGRATION INDUSTRY AND STRUCTURAL CHALLENGES IN REGULATING LMIs

While earlier sections have focused on normative frameworks and voluntary ethical codes, the following section shifts the analytical lens toward the structural conditions under which international nurse recruitment takes place. At the center of this shift is the concept of the "migration industry",[27] a networked system of state and non-state actors who mediate, profit from, and increasingly shape labor migration flows. It is essential to analyze the role of LMIs in governance frameworks addressing ethical recruitment, extending beyond the scope of voluntary codes.

According to the political scientist Beate Andrees, the migration industry is understood as an economic structure comprising a large number of actors who benefit from migration and/or are involved in the management of migration flows. The term refers to the commercialization of migration, where a wide range of actors – both state and non-state – are involved in regulating, facilitating, or financially benefiting from migration processes.[28] Traditional state-led migration control mechanisms have been replaced or supplemented by a mix of private recruitment agencies, consulting firms, and other intermediary actors.[29] Answers to policy questions – such as: What are the most effective vehicles for government intervention in recruiters' operations? – have begun to take shape. Beate Andrees, Alix Nasri, and Peter Swiniarski identify several mechanisms for regulation, such as legislation, licensing, registration, voluntary regulation through codes of conduct, and certification.[30] The political and social scientist Davide Calenda highlights the challenge posed by the fact that, while policies are not perfect, the biggest issue is generally getting the Global North on board.[31] Patricia Pittman, a professor of health policy and management, analyzes the importance of including multiple stakeholders in labor migration regulation and envisages several options for regulating LMIs.[32]

Migration scholars Dimitria Groutsis, Diane van den Broek, and William S. Harvey argue that the shift from state-centered governance to network governance has led to an increasing reliance on private intermediaries, many of whom operate without adequate regulation and are, in some cases, involved in malpractice. This transformation has produced a fragmented regulatory landscape, marked by in-

[25] Agunias 2013.
[26] Mosuela 2020.
[27] Groutsis et al. 2015.
[28] Andrees et al. 2015; Andrees 2021.
[29] van den Broek et al. 2016; Khan 2019.
[30] Andrees et al. 2015.
[31] Calenda 2016.
[32] Pittman 2016.

consistent and overlapping mechanisms of regulation and self-regulation. Nevertheless, there is limited empirical research on the complex roles and operational practices of these LMIs.[33] In general, policy and governance analysis often focus on labor migration as a whole, without specific attention to nurses.

Research on the role and significance of LMIs has intensified in recent years, reflecting a broader shift in governance approaches. It is argued that the shift to network governance has granted considerable autonomy to migration intermediaries, a role that was previously overlooked. The lack of research into the evolving role of LMIs highlights this transformation. Literature now increasingly examines the governance and regulation of these intermediaries, emphasizing the growing need for oversight. Earlier reviews of existing codes of conduct had already pointed to significant shortcomings in their implementation and monitoring. Scholars such as Catherine Pagett and Ashnie Padarath highlighted these weaknesses in regulatory practice.[34] At the same time, researchers like Maddy Thompson and Margaret Walton-Roberts have drawn attention to the structural limitations of national policy systems in addressing global migration processes. One key challenge is the economic dependence of many source countries on remittances from migrant healthcare workers, which makes it politically difficult to curb the outflow of nurses, even when such migration undermines the resilience of domestic healthcare systems.[35]

Taken together, the reviewed literature reveals a growing awareness of the need to go beyond voluntary codes and to develop more coherent governance frameworks that take account of the structural role of LMIs in global nurse migration. The increasing scholarly attention on the migration industry and the call for multi-stakeholder regulation highlight the necessity of embedding ethical recruitment in broader systems of transnational labor governance. Despite these advancements, challenges remain, particularly in ensuring coherent and consistent application of regulations across different jurisdictions.

5 LIMITATIONS

The literature presented here represents only a fraction of the research on fair migration discourse in general, as the deliberate focus on ethical recruitment of nurses through voluntary ethical codes shaped the selection criteria. The method may also have been limited at the stage of deciding which publications continued to be relevant after reading the abstracts. This decision may differ from one researcher to another. Also, the matrix for the search could vary from one researcher to another and produce different search strings and, in consequence, different hits in the database. To address this, the selection process has been well documented. Although SLR is a common instrument in medicine and psychology and when reviewing quantitative studies, the method is a helpful tool in social science research to reduce researcher bias.[36]

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[33] Groutsis et al. 2015.
[34] Pagett/Padarath 2007.
[35] Thompson/Walton-Roberts 2018.
[36] Tranfield/Dreyer 2003.

6 CONCLUSION

This SLR explores the scientific discourse on voluntary ethical codes as a regulatory instrument for international nurse recruitment. The evolution of the discourse on the migration of nurses reveals a gradual shift in focus from general labor migration to more specific concerns about ethical recruitment and the regulation of private LMIs as the migration industry changes. It reveals that voluntary ethical codes are often not adequate when it comes to addressing the structural imbalances of international nurse recruitment, particularly due to vague definitions, fragmented implementation, and the lack of political will in the Global North. At the same time, the growing influence of private, often unregulated, LMIs highlights the governance vacuum in current international recruitment practices.

The review underscores the need for more precise definitions of ethical recruitment, stronger oversight mechanisms, and a rethink of voluntary governance instruments within the broader frameworks of transnational labor regulation. In particular, empirical research is needed to assess the concrete effects of voluntary ethical codes on intermediary practices and migrant nurses outcomes. Without such evidence, ethical recruitment risks remaining a rhetorical commitment rather than a transformative governance tool.

	ID	Author(s)	Title	Year of publ.	Type of publication
1	GS8	Buchan, James; McPake Barabara; Mensah, Kwadwo; Rae, George	Does a Code Make a Difference – Assessing the English Code of Practice on International Recruitment	2009	journal article
2	GS10	Angenendt, Stefen; Clemens, Michael; Merda, Meiko	The WHO Global Code of Practice: A Useful Guide for Recruiting Health Care Professionals? Lessons from Germany and Beyond	2014	comment
3	GS13	Shaffer, Franklin A.; Bakhshi, Mukul; To Dukta, Julia; Phillips, Janice	Code for Ethical International Recruitment Practices: The CGFNS Alliance Case Study	2016	journal article
4	GS15	Martineau, Tim; Willetts, Annie	The Health Workforce: Managing the Crisis Ethical International Recruitment of Health Professionals: Will Codes of Practice Protect Developing Country Health Systems?	2006	journal article
5	GS16	Kordes, Jan; Pütz, Robert; Rand, Sigrid	Migrationsmanagement als migrationspolitisches Paradigma: das Beispiel der Anwerbung von Pflegefachkräften	2021	journal article
6	GS18	Angenendt, Steffen; Knapp, Nadine; Kipp, David	Germany is Looking for Foreign Labour: How to Make Recruitment Development-orientated, Sustainable and Fair	2023	research paper
7	GS21	Mosuela, Cleovi C.	Migrating Nursing Skills: Governmentality and Ethics of Care	2020	book chapter
8	GS24	Thompson, Maddy; Walton-Roberts, Margaret	International Nurse Migration from India and the Philippines: The Challenge of Meeting the Sustainable Development Goals in Training, Orderly Migration and Healthcare Worker Retention	2018	journal article
9	GS29	Merkur, Sherry	Policy Responses Facilitating Mobility or Mitigating Its Negative Effects: National, EU and International Instruments	2014	book chapter
10	GS34	Dia, Ibrahima Amadou	The International Health Labor Migration to Switzerland: Key Challenges for Its Governance	2018	journal article
11	GS47	Yeates, Nicole; Pillinger, Jane	The International Health Labor Migration to Switzerland: Key Challenges for Its Governance	2019	monography
12	GS70	Pagett, Catherine; Padarath, Ashnie	A Review of Codes and Protocols for the Migration of Health Workers	2007	research report
13	GS72	Runnels, Vivien; Labonté, Ronald; Packer, Corinne	Reflections on the Ethics of Recruiting Foreign-trained Human Resources for Health	2011	journal article

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	ID	Author(s)	Title	Year of publ.	Type of publication
14	GS75	Andrees, Beate; Nasri, Alix; Swiniarski, Peter	Regulating Labour Recruitment to Prevent Human Trafficking and to Foster Fair Migration: Models, Challenges and Opportunities	2015	journal article
15	GS76	Agunias, Dovelyn Rannveig	What We Know About Regulating the Recruitment of Migrant Workers	2013	comment
16	GS78	Khan, Maina	Contested Ground: Network Governance in Australia's Migration Industry	2019	journal article
17	GS79	Mieres, Fabiola	Migrant Labour Recruitment in a Globalizing World	2024	journal article
18	GS82	Maybud, Susan; Wiskow, Christiane	"Care Trade": The International Brokering of Health Care Professionals	2006	journal article
19	GS84	Van den Broek, Di; Harvey, William; Groutsis, Dimitria	Commercial Migration Intermediaries and the Segmentation of Skilled Migrant Employment	2016	research paper
20	JS3	Pittman, Patricia	Alternative Approaches to the Governance of Transnational Labor Recruitment	2016	book chapter
21	BA1	Underhill, Elsa; Groutsis, Dimitria; van Den Broek, Di; Rimmer, Malcom	Migration Intermediaries and Codes of Conduct: Temporary Migrant Workers in Australian Horticulture	2018	journal article
22	BA8	Schmitz-Pranghe, Clara; Oruč, Nermin; Mielke, Katja; Ibričević, Aida	Making Sure that the Emigration of Healthcare Personnel from Albania and BiH Works for All: What Germany Can Do	2020	book chapter
23	EB4	Axelsson, Linn; Hedberg, Charlotta; Pettersson, Nils; Zhang, Qia	Re-visiting the 'Black Box' of Migration: State-intermediary Co-production of Regulatory Spaces of Labour Migration	2022	journal article
24	EB6	Farbenblum, Bassin	Governance of Migrant Worker Recruitment: A Rights-based Framework for Countries of Origin	2017	monography
25	EB7	Jones, Katherine	A 'North Star' in Governing Global Labour Migration? The ILO and the Fair Recruitment Initiative	2022	research report
26	EB10	Battistella, Graziano	Multi-level Policy Approach in the Governance of Labour Migration: Considerations From the Philippine Experience	2012	journal article
27	EB12	Xiang, Biao	Predatory Princes and Princely Peddlers: The State and International Labour Migration Intermediaries in China	2012	journal article
28	EB13	Kushnirovich, Nonna; Raijman, Rebeca; Barak-Bianco, Anda	The Impact of Government Regulation on Recruitment Process, Rights, Wages and Working Conditions of Labor Migrants in the Israeli Construction Sector	2019	journal article

unsure after abstract analysis - suitable for further analysis					
	ID	Author(s)	Title	Year of publ.	Type of publication
29	GS7	Brugha, Ruairí; Crowe, Sophie	Relevance and Effectiveness of the WHO Global Code Practice on the International Recruitment of Health Personnel – Ethical and Systems Perspectives	2015	journal article
30	GS9	McIntosh, Tom; Torgerson, Renée; Klassen, Nathan	The Ethical Recruitment of Internationally Educated Health Professionals: Lessons from Abroad and Options for Canada	2007	research report
31	GS26	Ford, Michele; Kawashima, Kumiko	Regulatory Approaches to Managing Skilled Migration: Indonesian Nurses in Japan	2016	journal article
32	GS35	Chang, Andy Scott	Producing the Self-Regulating Subject: Liberal Protection in Indonesia's Migration Infrastructure	2018	journal article
33	GS40	Bach, Stephen	Going Global? The Regulation of Nurse Migration in the UK	2007	working paper
34	GS58	Connell, John; Stilwell, Barbara	Merchants of Medical Care: Recruiting Agencies in the Global Health Care Chain	2006	book chapter
35	GS69	Garcia-Dia, Mary J.	The Ethical Recruitment of Internationally Educated Nurses: A Leadership Perspective on Labor Migration	2022	journal article
36	GS92	Sha, Heila	Intermediaries and Inequalities: A Literature Review	2021	working paper
37	GS93	MacKenzie, R.; Lucio, M. M.	Regulation, Migration and the Implications for Industrial Relations	2019	journal article
38	EB14	Yakubu, Kenneth; Durbach, Andrea; van Waes, Alexandra; Mabunda, Sikhumbuzo; Peiris, David; Shanthosh, Janani; Joshi, Rohina	Governance Systems for Skilled Health Worker Migration, Their Public Value and Competing Priorities: An Interpretive Scoping Review	2022	journal article

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NURSES' MEMORIES OF CHILDREN'S HOSPITAL CARE IN THE FAROE ISLANDS FROM EARLY 1960S TO LATE 1980S

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Abstract

Interview data from retired Faroese nurses, along with photos, excerpts from folders, working sheets, and newspaper articles that the nurses brought with them, contributed to this oral history about children's care in hospital in the Faroe Islands from the early 1960s to the late 1980s. The study period represents decades during which human aspects of the special needs sick children have, such as attachment, closeness, comfort and compassion, were secondary, and hygiene, strict rules and regulations were primary. The children were hospitalized without parents until family-centered care was introduced in 1988. From that point on, parents were allowed to be with their hospitalized sick child at any suitable time. The nurses recalled the ward and the ward sister, their work within a strict hierarchical order, the emphasis on hygiene and quite detailed practical rules and regulations, and how and why they now and then were challenging the rules. The additional data shed light on these memories. The study adds knowledge about Faroese nursing history and gives modern nurses insight into the development of child nursing's history in a small-scale remote country.

Keywords: Faroe Islands, Children's Hospital Care, Ethics, Memories, Nursing History, Oral History, Roy's Adaptation Model

1 INTRODUCTION

Conditions for children in health and sickness have changed considerably over the course of nursing history. In the past, children were regarded as small adults. When they needed hospital treatment, they were placed among sick adults without their parents. Demands from parents and professionals, scientific developments and societal declarations about paying greater attention to the hospitalized child's emotional and psycho-social welfare, and their right to have parents present all the times, contributed to more child- and family-friendly hospital care. Consequently, children's hospital care underwent substantial changes. This was also the case in the Faroe Islands, a remote mountain islands nation in the middle of the North Atlantic Ocean.

From 1988, the year of the first conference of the European Association for Children in Hospital (EACH) held in Leiden from May 11 to 13,[1] Faroese parents were allowed to be with their sick and hospitalized child day and night. Before that time, hospitalized children were cared for without their parents; they were only allowed to visit their sick child briefly and during strictly enforced visiting hours. In this study,

[1] Brandazzi 2008.

we provide accounts of nursing care of hospitalized Faroese children in the decades leading up to the milestone year 1988. To place the Faroese situation within a broader context, we include research on what contributed to the change of attitudes concerning hospitalized sick children in other Western countries and what triggered us to study early hospital care of children in the Faroe Islands.

2 BACKGROUND

As a result of the influence of nurses, parents, the British psychologist and psychiatrist John Bowlby's and the Canadian psychologist Mary Ainsworth's research on attachment[2] and the social worker James Robertson's observations, including his 1952 film, *A two-year-old goes to hospital*, a gradual evolution took place in people's views of what it is like for a child to be hospitalized, opening the way for parental visiting hours in children's wards.[3] Robertson's film was an eye-opener that made people realize the significance of parent closeness and involvement for child wellbeing.[4]

1959 was a landmark year for the improvement of hospital care for children. That was the year the British Ministry of Health launched its report on *The Welfare of Children* in Hospital, often referred to as The Platt Report after the committee's chair Sir Harry Platt, a surgeon and President of the Royal College of Surgeons. The Platt committee, consisting of two surgeons, two physicians, one nurse/midwife and one registered sick children's nurse, regarded their central subject to be the child's emotional and psycho-social welfare. The recommendation included: "Parents should be allowed to visit their child whenever they can, and to help as much as possible with the care of the child".[5] Accordingly, individual hospitals started to change their visiting times even before the end of the 1950s, and they were enthusiastic about the results.[6]

However, it took decades for the Platt recommendations to change attitudes to children's hospital care and how it was organized. The British children's nurse Philip Darbyshire claimed that the very slow pace of implementation was due to the Platt committee's narrow vision and naive expectations.[7] The committee overlooked the meaning of the wider sociological implications of hospital practices. They were large institutions that did not manage to change easily. The recommendation to allow parents to visit day and night, and even stay with the child, demanded a total adjustment in the daily care of the children. As a result, the Platt Report recommendations were not followed in full in most countries until a new generation of doctors and nurses was in charge. After the EACH Charter was introduced in 1988, the principles of family-centered care were discussed more frequently and began to be adopted internationally.[8]

As little is known from the nurses' perspective about Faroese children's hospital care before 1988, this subject was included in a nursing history program. The program was inspired by the realization that Faroese nursing was largely invisible.[9] The first study in this program concerned accounts of how, for half a century (1897-1948), Danish deaconesses served in the Faroe Islands, and how their orderly and religious understanding of nursing shaped the development of professional nursing on

[2] Bowlby 1988; Bretherton 1992.
[3] Alsop-Shields/Mohay 2001; Bradley 2001; Lindsay 2003; Wierzchowska 2020.
[4] Coffin 1955; Callery/Smith 1991; Coyne 1995; Shields et al. 2003; Quaye et al. 2021.
[5] Davies 2010, p. 14.
[6] Coffin 1955.
[7] Darbyshire 1993.
[8] Jolly/Shields 2009.
[9] Joensen/Hall 2015.

the islands.[10] Another study presented accounts about the first nurses and their work and service in the early1900s.[11] A third study described accounts of conditions for Faroese individuals with a mental disorder up to the time when the first psychiatric hospital was established in the Faroe Islands in the late 1960s.[12]

In this Faroese nursing history, we wanted to explore how Faroese nurses experienced working on the children's ward prior to the adoption of the EACH Charter, and before hospital care regulations for children switched to a family-centered approach. These nurses would now be retired but would hopefully still have memories of their previous working lives. Our objective was to gain knowledge and understanding about children's hospital care in the 1960s to 1980s by addressing the following research questions: How do nurses remember the ward? How do nurses remember caring for the children? How do nurses remember their actions, thoughts and feelings? How do nurses remember parents' worries?

To add to historical knowledge, the study was conducted following a historiographic methodology using the method of oral history.[13] At first, the oral history was organized around individual interviews. However, since sampling followed the principles of convenience and snowball sampling,[14] the interviewees knew each other well. They asked to be interviewed together, something we agreed to. Consequently, the 16 retired nurses we contacted were interviewed in groups of two to four. Additional data included photos and written material from newspapers and the nursing journal *VØKA* that the participants brought with them.

The participants, all women, had an average age of 70,1 years, and a median age of 71 years (ranging from 64 to 82 years). All had worked at the children's unit during the 1960s, 1970s and/or 1980s, some for decades, others for some years or less. During their basic training, the participants had either two or four months' compulsory training in pediatric nursing. Coincidence and unemployment were common reasons given for working on the children's ward. Many of the nurses were mothers of young children at the time. During the interviews several of them remarked that talking about memories was a scary journey back in time. "Thank God that things today are changed and are better for children and their parents."

The interviews were recorded and took place from January to March 2023 in quiet places accessible for the participants - either at the Faroese nursing trade union or at the Department of Nursing, University of Faroe Islands - and they lasted from 85 to 110 minutes. No other people besides the interviewer and the interviewees were present and the interviews were conducted in Faroese by three of the authors.

We used an interview guide containing research questions about physical, relational, role and ethical issues and had interview questions that would elicit spontaneous and rich responses.[15] The theoretical framework for the interview guide was Sister Callista Roy's Adaptational Model (RAM).[16] The RAM conceptual model builds on a humanistic worldview and offers a pattern of human life processes such as containing, regulating, thinking, becoming, valuing, relating, feeling, and acting, as the core of nursing knowledge development.[17]

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[10] Malchau Dietz 2013; Hall/Joensen/Malchau Dietz 2022.
[11] Hall/Joensen/Malchau Dietz 2023.
[12] Hall/Mortensen/Joensen/Malchau Dietz 2024.
[13] Biedermann 2001; Wall/Edwards/Porter 2007; Miller-Rosser et al. 2009; Olden-Jørgensen 2016.
[14] Polit/Beck 2010.
[15] Kvale 1997.
[16] Roy 1980.
[17] Dobratz 2008.

RAM was chosen in part because it was inspired by Roy's observations as a young nurse in the 1960s, when she worked in a children's unit and observed how resilient the sick children were, and how they adapted to new circumstances.[18] Other reasons for using RAM included its continuous development and expansion to meet changes and emerging needs in nursing and society, in families and other groups.[19] Roy is widely recognized for integrative nursing knowledge based on theoretical, philosophical and epistemological underpinnings that demonstrate both unity and diversity. However, she is criticized for not referring to any nursing ethics literature, even though nursing theory and nursing ethics are mutually relevant.[20]

The study was conducted in accordance with the Helsinki Declaration[21] and was approved by the Faroese Regional Committee for Medical and Health Research Ethics.[22] All participants provided written consent by an invitation letter which included details about the study purpose, contact information, voluntary participation, anonymization, and the right to withdraw at any time. We were aware of the challenges to maintaining anonymity in small-scale societies such as the Faroe Islands.[23] Equally, as the Faroe Islands are a remote and small-scale society, it was important to manage the ethics involved in the ubiquitous and inevitable dual relationships that exist in such societies.[24]

Because some of the researchers are Danish and Norwegian, and the interviews had been conducted in Faroese, the data were transcribed in Danish by the interviewers (who are all fluent in both languages). We considered cultural equivalences and followed suggestions to translate early in the cross-language study.[25] The research team read the data several times. We discussed characteristics of and changes to child nursing, and the participants' perspectives of their work in caring for children, and we searched for commonalities and telling extracts. Throughout the analysis, we considered congruent values of words and expressions in the languages involved: Faroese, Danish and English. We successively processed accounts that answered our research questions and organized our data according to everyday terms and categories. What follows is, therefore, accounts of children's hospital care as told by the interviewed retired nurses and interpreted by the authors.

3 CHILDREN'S HOSPITAL CARE FOLLOWING STRICT HIERARCHICAL ORDER

Prior to a special children's ward at the Landsjukrahusið (National Hospital) in the capital Tórshavn, sick Faroese children older than six years of age were placed in hospital rooms alongside adult patients. Newborns and small children were cared for in a couple of children's rooms at one of the adult wards. Usually there were 24 small children admitted, but occasionally it was very crowded with up to 34 sick small children to take care of. On busy days, there were three caretakers in the small children's rooms, a nurse, a nurse trainee and an afternoon assistant. Daily care, such as washing and bathing, took place in the room. The children had some toys in the room, such as small play tables and chairs, and they could also play outside. The parents were only allowed to see their children through the door window, which often left the children feeling upset and distressed.

[18] Phillips 2006; Personal contact with Sister Callista Roy 1995.
[19] Roy 2011, 2018.
[20] Yeo 2009, p. 556.
[21] World Medical Association 2013
[22] Answer to E. Hall, 22. April 2022.
[23] Damianakis/Woodford 2012; Hayfield 2022.
[24] Lusk 1997; Halvorsen/Brownlee 2010.
[25] Regmi/Naidoo/Pilkington 2010; Santos/Black/Sandelowski 2015.

Toward the end of the 1960s, a children's ward was established at the national hospital, but it was furnished and organized exactly as hospital wards for adult patients. "In the 1960s and 1970s, the children's ward was a ward *with* children but not *for* children", one of the interviewed nurses stated, emphasizing the prepositions.[26] The ward contained four four-bed rooms, each with a bathroom (shower and toilet), and one one-bed isolation room with toilet. To begin with, the decoration was sparse, if any. One nurse stated: "I don't remember that we in the first years had anything pretty on the walls, but later after employing a teacher there were. I was there until 1985." [27]

Some of the nurses reminded each other about a faded picture of a member of the Danish royal family, and how one mother covered the picture with a big cloth because she found it ugly. Likewise, they remembered that, in the late 1970s, decorations became colorful and child-friendly and one of the bedrooms was converted into a playroom. It was not until the early 2000s that the walls were decorated to correspond to the four seasons, and the rooms were named the Spring, Summer, Autumn and Winter rooms. The participants recalled this as a big leap forward.

The nurses recalled that, during the 1960s and 1970s, the daily tasks and the cooperation among staff members were based on a strict hierarchical order. The physician and the ward sister were at the top of the hierarchy and decided what to do. One nurse stated, "We were silent workers at the bottom, following orders, schedules and regulations."[28] Another added, "The ward sister told us what to do, what patients and what room we had. We did not discuss, just accepted and went to work."[29]

The work schedule, divided into eight-hour day, evening and night shifts, was filled with regulated measures about practical tasks. These tasks were described in detail in notebooks and included cleaning medicine chests, bathing the children, washing their diapers, cutting their fingernails and toenails, feeding them, taking their temperature and making beds. There were specific instructions about when these tasks should be done and how, and how long each should take.

The nurses had mostly unpleasant memories of working evenings and nights shifts – memories of being a trainee or newly qualified nurse on one of these evening or night shifts and feeling overwhelmed by the responsibility placed on them. Some expressed it as "you shivered in your pants" or "being alone on an evening shift was horrible…." [30] Some nurses added that often, after working alone on busy night shifts, "we walked home tired and crying".[31]

Sometimes, following the hierarchical order proved too difficult. One nurse recalled an incident in which she criticized a medical doctor for his behavior towards parents from a faraway island. Two of their children had been admitted for meningitis, one of them died and now the parents had come to take their surviving child home. This is in brief what she stated:

> I had evening duty. The nurse on day duty reported that the physician would come later and talk with the parents. Parents who just lost a child. …There was much activity in the hallway. The physician arrived and talked to the parents… in the middle of the swarm of children, parents and everything. I asked him to take the talk in the examination room, but he did not want that … After the talk I told the physician that I had found what he did unacceptable. I said it quite decisively. You know what he said to me? That, what I said would have consequences. He would have a talk with the matron. I could expect to lose my job.[32]

[26] Interviewer 1, 26. Jan. 2023.
[27] Interviewer 3b, 2. Feb. 2023.
[28] Interviewer 1, 22. Jan 2023.
[29] Interviewer 3b, 2. Feb. 2023.
[30] Interviewer 3b, 2. Feb. 2023.
[31] Interviewer 3b, 2. Feb. 2023.
[32] Interviewer 1a, 31. Jan. 2023.

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Other nurses remarked that the examination room was small and dark, possibly justifying the doctor's reluctance. The ward, at the time, was not suitable for serious talks with parents. The nurse did not lose her job but commented: "He did not care about the parents in such a serious situation!"[33]

The nurses quite well remembered Olina Niclasen (1923–2003), who served as ward sister throughout the years at the children's unit. Niclasen (as she was called) was trained in Denmark in the care of both healthy and sick children. Initially she was trained in the care of healthy children. Then for four years she worked at children's units at Danish hospitals and became a nurse. In 1952, Olina Niclasen was recalled to the Faroe Islands and became the first ward sister at the sick children's ward, a position she kept for 36 years, until she retired in 1988.[34] Niclason was known for her strict orderliness. She meticulously documented all tasks in notebooks to help her staff adhere to specific procedures.

The nurses' memories of Niclasen varied. Some remembered her quite kindly and extremely orderly and well-educated but conservative. Some recalled a reprimand that they had been given when they had failed to follow the strict daily order of tasks by the clock. Yet, there were also instances where Niclasen turned a blind eye to rule-breaking. Sometimes she even believed that the nurses let the physician take too many decisions. So, despite being considered conservative and hesitant to talk to parents, Olina Niclasen governed the ward and cared for the patients according to what was broadly accepted as competent care standards for sick children at that time.[35]

A common memory among the nurses was Niclasen's deep love for the children – and the children's affection for her. Often while working on the daily roster, she would be carrying a toddler or sitting in her office with a small child on her lap. Niclasen cared especially about the small children with eczema who suffered harsh treatments during long stays in hospital. Interviewed after she retired, Olina Niclasen remembered that when she left for the day, children became upset. Some even wanted to go home with her and sleep there.[36]

When it came to the parents, the nurses recalled that Niclasen found the parents difficult to cooperate with. However, one of the nurses remembered suggesting to Niclasen that the parents were kind and approachable if one simply spoke to them with kindness. The nurse remembered this clearly as she was surprised that Niclasen accepted her feedback.[37] The ward sister's love and care for some children was compared to the strict rule that the nurses should not comfort or carry a crying child. The crying would stop after a couple of days, Niclasen said. The nurses were not allowed to have favorites even though Niclasen herself appeared to do so. They remembered that she expected all children to receive the same care. The nurses recalled obeying in silence but often with frustration. One nurse stated:

> We young nurses were not happy with the way we had to work. There was much talk in the corners about how unhappy we were about the way we had to care for the sick. We wanted to be close to the children, take them up and comfort them when they were unhappy and crying. It was unbearable![38]

In the 1960s and 1970s, there was no trained pediatrician in the Faroe Islands. Nurses recalled that the same physician who treated adult patients also examined the sick children. The physician had authority; he alone decided, and he shared little information with the family. The parents respected his authority and rarely asked questions. The same can be said of the nurses - they knew their place

[33] Interviewer 1a, 31. Jan. 2023.
[34] Samrøda vid Olinu Niclasson 1988; Landsjukrahúsid, Barnadeildin B4,1979.
[35] Interviewer 3a, 31. Jan. 2023.
[36] Interviewer 2a, 22. Jan. 2023. Samrøda vid Olinu Niclasen. VØKA 4(1988), pp. 28-31.
[37] Interviewer 2a, 22. Jan. 2023.
[38] Interviewer 1, 22. Jan 2023.

in the hierarchy, and most of them were obedient. Some nurses remembered that when in the 1960s, when the senior doctor came on his round, everything had to be in perfect order. The physician even remarked if the bed sheets were rumpled. Change arrived in the early 1980s when a younger doctor, the first trained Faroese pediatrician, was employed. From that point, the tone between pediatricians, nurses and parents shifted. The parents became involved; the pediatrician talked with them and there were new treatments for the children.

4 PLEASANT AND UNPLEASANT MEMORIES

As already mentioned, the nurses had both pleasant and unpleasant memories from their time working at the children's unit. Many of the memories were pleasant. They recalled well-functioning dynamics between fellow nurses. They reminded each other of small things that they did while caring for the sick children and their families. They recalled reading stories, playing cards or singing for them. One nurse stated, "I always kissed the babies when changing their diapers".[39]

Still, stories of unpleasant memories dominated, and affected the participants as they recalled them. These included memories of the sick children's admittance, their long stay at the hospital and their painful treatments. The nurses recalled the mothers' short visits and sudden departures, and they all remembered unpleasant duties from working evening and night shifts.[40]

One memory was that the children were sometimes admitted for reasons that one no longer sees nowadays. The children might be suffering from long-lasting and serious illnesses such as pyloric stenosis, asthma, eczema, meningitis or the thigh-bone Legg-Calvé-Perthes disease. Or they could be hospitalized because of malnutrition or obstipation because of being fed milk only.

The procedure when a child was admitted was remembered in detail and was a subject the nurses returned to repeatedly during the interviews. When a sick child was admitted, the hospital physician examined them in a small windowless room. When the physician had finished, and after he had given some information to the accompanying parents, the child was dressed in hospital clothing, placed in a hospital bed and brought to a bedroom with three to four other children. Immediately after, the parents were asked to leave, the child would be crying, and the nurse was not allowed to comfort. As one of them stated:

> We fed them, changed their diapers, took care of what else was of care and treatment. Then they just stood in their cribs and cried. Cried and were bored, were longing, probably homesick. We were told that the children were crying because then they got rid of their emotions. While the others, the apathetic ones who kept everything inside, felt worse.[41]

This rule forbidding the nurses from comforting unhappy and crying children when their mothers left or the child was given a painful treatment was: "so terrible that I hardly want to think about it."[42]

Extended hospitalizations were typical of the time; children could be in hospital for weeks, months, sometimes even years. However, when the weather permitted, the beds were pushed outside, and the

[39] Interviewer 2b, 23. Mar. 2023.
[40] Interviewer 1, 26. Jan. 2023.
[41] Interviewer 1, 26. Jan. 2023.
[42] Interviewer 1, 26. Jan 2023.

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children could enjoy fresh air and green grass. Likewise, everything took a long time, and this was seldom an issue; it could take up to a week to get the results of an examination. It did not matter whether the children were in hospital for one or several weeks; there was no hurry to return them to their family at home. Time and hospital care meant something different in those days. "It was as if the hospital owned the children".[43] The long hospital stays meant the nurses got to know some of the children and their parents quite well.

Often, the children were admitted at a late stage of their illness, largely because of the challenges involved in arranging a doctor's visit to the distant islands and the lengthy, difficult transportation of patients by boat to the hospital. Some nurses remembered with horror the seriously ill children and those children who died without their parents present. One of the nurses conceded: "Then, I never thought of parental sorrow when losing a child".[44]

Several episodes that stuck in people's memories concerned the parents. One painful memory was when, after the visiting hour, the parents had to say good-bye to their unhappy crying or screaming child. The rule was that the parents should leave instantly when the visiting hour ended. This was difficult for both parties. All nurses had several memories of mothers camouflaging their goodbyes by saying that they were going to the toilet. Instead, they disappeared. "It was hard work to persuade the mothers to be truthful and tell their children that they would come back another day." [45]

One specific issue that the nurses remembered well concerned the effort to provide snacks for the parents. Their desire was that the parents should get a snack when visiting their child. "... we struggled for some food for the parents. They visited after working in faraway hamlets. They needed a snack".[46] To begin with, the nurses used to hide snacks for visiting parents. But after years of advocacy and pressure on the management, their request was finally accepted and became standard practice.

The treatments for children were often unpleasant and painful. Treatment with intravenous cannula was introduced in the 1980s. Before that, children of all ages, even tiny infants, got fluids administered though quite painful subcutaneous drips.[47] Another common painful treatment that the nurses remembered clearly was the tar baths given to children suffering from extensive eczema. These tar baths were described as torture for these children.[48]

A strict rule remembered with horror was the early awakening of the children. Starting at 4.30 am, all the children were woken up one by one to have their temperature taken. Most of them were put back to sleep but some had to be washed "... in a very cold bathroom before the day shift arrived at 7 am." These children were given a shower and were washed thoroughly before being put back to bed again. "It was dreadful, so dreadful that it is hard to think back on." [49]

A particularly demanding and emotionally difficult task that the nurses recalled was accompanying a child to treatment in Denmark. Children with serious illnesses or disabilities, such as deafness, blindness, epilepsy, mental disorders or injuries of various kinds were transferred by ship to Danish hospitals or institutions, often for lengthy treatment and rehabilitation.[50] The accompanying nurse had to leave the child in another country with a foreign language and a different culture. Such memories made the nurses sigh and be silent for a while. One statement was: "I am happy that those conditions are in the past."[51]

[43] Interviewer 3a, 31. Jan. 2023.
[44] Interviewer 3b, 2. Feb. 2023.
[45] Interviewer 1, 26. Jan. 2023.
[46] Interviewer 3a, 31. Jan. 2023.
[47] Interviewer 2b, 22. Mar. 2023.
[48] Interviewer 3b, 2. Feb. 2023.
[49] Interviewer 3b, 2. Feb. 2023.
[50] Hansen 1996.
[51] Interviewer 1, 26. Jan. 2023.

5 CRITICAL REFLECTIONS ON UNPLEASANT MEMORIES

During the interviews, we encouraged the nurses to elaborate on both good and bad experiences. To our surprise, bad memories dominated. Consequently, we cannot but reflect critically upon the nurses' bad memories and their frequent use of the word terrible regarding treatments, rules and regulations. Statements such as "I think back on it with horror" and "It was so terrible that I can hardly bear to think about it" appear to carry unsolved moral distress,[52] which triggered feelings of guilt, regret and remorse during the interview. Of course, memories are shaped by policy, attitudes and nursing ethics over time, especially the family friendly childcare service of today. However, there could be several reasons for the frequent recall of terrible care issues.

One reason could be that loyalty, obedience and social constrictions put a lid on problematic ethical situations at the time. During the study decades, the nurses obeyed strict rules loyally, and they had long and rigid schedules. They were part of, and had to respect, rules governing and treatments such as painful subcutaneous drips, tar baths and cold bathroom showers very early in the morning.

An additional cause could be that, in this small-scale remote nation, the participants reacted with deep emotions because the sick children were part of their family or related to their friends or neighbors. Additionally, since some of the interviewed nurses had children of their own, the sick child might have been a cousin or a playmate of their own children. This meant that professional and private lives overlapped, creating ethical predicaments and moral distress.

As professionals, the nurses worked in a hierarchy, had a duty of confidentiality, and were ordered to disregard pain, suffering and to be, instead, dispassionate when caring for the children. It was far from easy to be obedient, silent professional workers who followed rules and treatments ordered down in a strict hierarchy. Not showing compassion and care for the children was one of the disgusting rules that the nurses challenged.

As private individuals, the nurses belonged to a rural nation where everybody knew everybody, encountered each other at church, and participated in large social events and celebrations, such as confirmations, weddings, anniversaries, baptisms, and burials. Consequently, the nurses were often related to, friends with, or neighbors of parents of some of the hospitalized sick children.

No wonder that overlapping relationships lingered as terrible memories that were difficult to ignore. We would argue, as have others,[53] that overlapping relationships inevitably exist and constitute ethical concerns in small-scale remote societies. The dual overlapping relationship was an ethical issue for the nurses when working at the children's unit in the study period; and it might still be an ethical issue to consider today.

Additionally, the nurses' tendency to remember bad, unpleasant and awful matters might be explained in terms of psychology. Bad memories are often remembered better than good memories because they touch deep emotions.[54] The emotional content of an experience influences the way in which the event is remembered and recalled. Biographical memories are imbued with emotions, they have meaning, and they help us to remember. Memories as such are not stored as perfect records but rather constructed from a store of knowledge. A metaphor used in this context is that bad memories

[52] Moral distress is experienced when prevented from doing what would be the right thing to do (Carnevale 2012, p. 44).
[53] Szumer/Arnold 2023.
[54] Holland/Kensinger 2010.

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stick like Velcro and good memories slide away like Teflon and are forgotten.[55] We would argue that the medical and nursing rules that were customary at the time fit well with this metaphor.

6 CHALLENGING THE RULES

The nurses recalled being obedient when it came to rules and restrictions. However, they acknowledged feeling disobedient, even rebellious, in relation to some of the strict rules. In particular, they resisted the rules about task regularity to the minute, parents' strict and limited visiting hours and the rule not comforting an unhappy, anxious or suffering child in pain. "We were even told to remove their pacifier at night!" Such rules created moral distress. Despite these restrictions, the nurses remembered how they tried to bend and break the rules. Their intention was to introduce some humanity. "There were always exceptions … we were not quite inhumane."[56] They talked about promising an ice cream to a child after painful treatment. "We went to the hospital kiosk and paid for it with our own money!"[57]

Over time and especially during evening shifts, the rules became less strict, and the parents were allowed to stay a little. Likewise, during the evening shift, it sometimes happened that the nurse on duty would sneak in visiting parents or let in fathers who wanted to say goodbye to their children before embarking on a long fishing tour. They remembered how, in secret, they would bring in a bed for a tired mother who lived a long way away, so she could sleep beside her sick child. Likewise, they talked about their efforts to remove this bed early in the morning before the ward sister found out. However, the ward sister who imposed rules and regulations strictly, was not completely inhumane. Probably, she knew about their actions but chose to turn a blind eye. She might have found them appropriate, maybe even the right thing to do. And with time, the changes came quite fast. "Parents and siblings were allowed in, and the rules about visiting hours were no longer so draconian".[58]

From the 1970s onward, the nurses became more open and secure. Their voices were heard, and their knowledge found an audience. Some dared to stand up for their beliefs after working in other Nordic countries where they had experienced more up-to-date children's care. Still, they found that changes took place slowly. "But we were the ones who redrew the borders," several of them stated.

However, the nurses were not the only hospital employees to shift hospital care for children towards a family-centered approach. In the 1980s, the conditions for hospitalized sick children were transformed. At this time, the staff included a trained pediatrician, a psychologist, and two teachers. Daily life became easier for all. "When a child was unhappy, you just asked the teacher to play with her." [59] And, after the ward sister Olina Niclasen retired in the middle of the 1980s, a younger ward sister with new ideas was employed.

[55] Hansen 2009.
[56] Interviewer 2b, 22. Mar. 2023
[57] Interviewer 2b, 22. Mar. 2023.
[58] Interviewer 2b, 22. Mar. 2023.
[59] Interviewer 3a, 31. Jan. 2023.

7 CRITICAL REFLECTIONS ON CHALLENGING THE RULES

In the decades in question, the Faroese healthcare system, like other hospital systems around the world, was characterized by a strict hierarchical order. Silent obedience was a much-valued quality. In the nursing profession, however, there was an increasing worry that a hospital system that was too strict and hierarchical might undermine the profession's intention to provide nursing care based on more humanistic values. Nurses should not be silent workers at the bottom of the hospital hierarchy. Thus, the new era signaled what was to come, namely doctors' and nurses' joint contribution to competent and compassionate patient care.[60]

Other factors that affected children's hospital care were an increase in nurses' writings. During the 1960s and 1970s, Nordic nurses coauthored new editions of child nursing textbooks that had previously been authored by medical doctors only.[61] Nordic nurses also argued for parent participation in children's hospital care.[62] In a guidebook for the everyday care of sick children, the British nurse June Jolly acknowledged staff nurses, not only as contributors, but as creators of the unit atmosphere.[63] Jolly encouraged nurses to develop a relationship with the families and urged them to overcome obstacles in children's hospital care.

It is doubtful whether the Faroese nurses in this study were impressed by written words. They remembered that the ward sister encouraged her staff nurses to be more visible, demonstrating a growing self-knowledge and professionalism. Our study demonstrated that the ward sister both followed rules and regulations and considered the future. Likewise, our study showed that, whether they were allowed or not, nurses were speaking up and bending rules. In hindsight, they recalled how they discriminated against the strict rules in favor of individualized care for the hospitalized children and their parents. They knew that both were suffering.

Seen in a caring context, taking the example of the Finnish nurse and caring theorist Katie Eriksson, the nurses' small rule-breaking actions were a sign of "caring communion", described as fighting together, being together and moving together to develop "the art of making something very special out of something less special".[64] Suffering has many faces according to Eriksson, and suffering is what motivates all kinds of caring. Encountering suffering in real situations (as the nurses really did) is to be there and, in the best possible way, through empathy and compassion, to share their suffering.[65]

Taking interdisciplinary views into consideration, as suggested,[66] this development in children's hospital care coincided with an attitude change among women in general. Research has shown that, during the decades studied, Western women were moving away from silence and male hierarchy; they were demonstrating a different, more meaningful voice; and they were gradually allowed to speak and were listened to.[67] The Faroese nurses in this study are good examples of women with a new, relatively open, different voice. They dared to bend strict rules, and they remembered it well.

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[60] Holler/Scheel 1980; Ottsen 1980; Schwamm 2023.
[61] Maunsbach 1971; Vesterdal 1970.
[62] Maunsbach 1980; Sundal/Petersen/Boge 2019.
[63] Jolly 1981.
[64] Eriksson 1992, p. 208.
[65] Eriksson 2006.
[66] Wall/Edwards/Porter 2007.
[67] Gilligan 1982; Belenky et al. 1986.

8 STRENGTH AND LIMITATIONS OF THIS ORAL HISTORY

What we refer to in this oral history is a concise compilation of essential issues in the nurses' memories of the past. However, personal accounts told in a narrative are not life itself.[68] A study like this reveals not only how the interviewees understand the past but also what they now think about their past actions and how they want to be remembered.[69]

A second limitation might be the snowball sampling used. This sampling method and the group interviews, instead of individual interviews originally planned, carry the methodological risk of interviewing friends who share similar experiences and views. As a result, group dynamics may have limited the nurses' narratives.

Even though we planned the interviews according to an interview guide, the participants came with their own presuppositions and expectations of what to highlight. Afterwards, we realized that some considered the interview guide to be restricting. It might have been. However, the interview guide stimulated the participants' memories, coordinated the three interviewers' questions, and helped the authors when it came to analyzing the data.

The interviews covered more subjects than have been presented here. Furthermore, we cannot ignore the fact that, in an interview where both the researchers and the participants are nurses, we are all informed by contemporary child and family care values and contemporary ethics. Thus, our decision to present only some features from the interviews has both strengths and limitations. Our oral history is a comprehensive presentation of the core issues of the retired nurses' shared memories. At the same time, it is limiting the richness of their narratives.

9 CONCLUSION

This oral history is about children's hospital care in the Faroe Islands from the 1960s to the late 1980s. As such it is a revisit of times, assumptions, philosophy and ethics of days gone by. Based primarily on nurses' memories, the study gives accounts of the ward, the patients and the staff as well as nurses' thoughts, feelings and actions. During the decades under review sick children were hospitalized for a long time without their parents, a situation the nurses found cruel and terrible. Likewise, it was a time of strict hierarchy where, to begin with, the nurses were silent and obedient but gradually moved towards working more independently.

Inspiration from abroad made nurses challenge rules and regulations in favor of a form of care that was centered on the child's health and welfare. In this, they were moving towards the forthcoming family-centered care, involving the care of mothers, fathers and siblings. The Faroese nurses were therefore following the same trend that led to updated children's hospital nursing in many countries at that time. Still, the study concerns nursing history from a small-scale remote country with close relationships and family ties and a strong religiosity. These issues make the story special; it is one of the first of its kind in the Faroe Islands.

[68] Sandelowski 1991.
[69] Wall/Edwards/Porter 2007.

Studies about healthcare in small-scale communities are crucial because they offer intriguing insights into previously under-researched areas.[70] For this reason, and to obtain deeper and broader pictures of the time, we suggest further research into early hospital care of children in the Faroe Islands, based on accounts of children who were hospitalized before the parents were allowed free visiting hours. Furthermore, it would be meaningful to learn about their parents' memories. Such oral histories would spark interest and show how, generations ago, hospitalization impacted children and their families in remote small-scale communities.

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[70] Butterworth 2020.

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ETHICAL SELF-EFFICACY AS EXPERIENCED BY NURSING PROFESSIONALS. WHY IT NEEDS ATTENTION AND A PROPOSAL FOR A DEFINITION.

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Abstract

The requirement to act ethically is inherent to the professional delivery of nursing care. It is in this context that nursing professionals' self-efficacy, and their expectation of self-efficacy, are drawing increasing research attention. Discourse on ethical challenges may reference individual actions and decisions, and may also engage with institutional and societal conditions. We recognise the utility, particularly in the context of nursing education generally and ethics education specifically, of setting out a distinct definition of ethical self-efficacy. Accordingly, this article seeks to outline the particular concept of perceived ethical self-efficacy among nursing professionals, alongside detailing the factors that influence experienced or perceived ethical self-efficacy.

Keywords: Ethical self-efficacy; ethical agency; nursing ethics; nursing practice; nurse education; nursing professional

1 INTRODUCTION

"Good" nursing care can be described as a complex interpersonal interaction incorporating aspects of emotional work, the building of cooperative relationships, and work on and with the physical body and lived body *(Leib)*; an interaction that resists standardisation to an extent, and that entails the use of both external and internal evidence, resulting in actions led by a dual logic.[1] The actions of nursing professionals take place in an institutional context, with or for individuals and groups who require support owing to health conditions and limitations on their ability to care for themselves and are therefore vulnerable, which endows the actions of nursing professionals with an inherent ethical significance.[2] In engaging with factors such as the lifeworlds of those who receive their care, nurses, in their professional actions, access a specific perspective centring on ethical argument, ethical reflection and a way of acting rooted in ethical considerations, from which, in turn, emerges a sense of the ethical significance attaching to the nursing profession in a manner distinct from other professions within healthcare.[3]

The analysis of and reflection on ethical matters and lines of argument grounded in ethics are therefore real and tangible components of nursing as a profession and its habitus[4]; accordingly, those working in the nursing profession find themselves the subjects of expectations regarding their

[1] Seefeldt/Hülsken-Giesler 2020; see also Remmers 2018.
[2] Wöhlke/Riedel 2023; Riedel/Lehmeyer 2022; International Council of Nurses (ICN) 2021; Hamric 2020.
[3] See also section 4 of this article.
[4] Monteverde 2019; Riedel/Lehmeyer/Monteverde 2022.

knowledge, methodological repertoire and attitudes in the ethical realm.[5] Such expectations may, however, appear to be undermined in the context of "grand challenges" affecting the whole of a society, particularly demographic change and the shortage of skilled workers, which is projected to worsen in the future, and the concomitant precarious conditions in which nursing professionals find themselves working, alongside further actual or potential implications[6] for their capacity to deliver "good" nursing care. That delivery of care now takes place via an increasingly diverse set of more or less highly qualified nursing-allied professions. In light of the challenges facing nursing practice today and its ethical significance, competence in ethical matters appears to be an elementary aspect of the emergent and established set of professional values that nurses need.[7] Issues of increasing relevance in the current professional landscape include the fact that nursing practice can only be standardised to a very limited extent, given the unique and highly individual character of each nursing interaction, the concomitant capacity of nursing professionals to act in a manner appropriate to the situation and founded on ethical reflection, and their confidence, drawing on their professional education, in their ability to manage a variety of situations with a moral component. In this context, the concept of self-efficacy, first set out by Bandura within his Social Cognitive Theory,[8] can evidently serve as a sphere of reference, from which we can derive the notion of ethical self-efficacy as a significant response to the demands and expectations placed on nursing professionals today.

Considering the properties of "good" nursing care with which we commenced this article, the resultant complexity of its delivery, and the ethical significance of what nursing professionals do, it would seem apposite, particularly in relation to nursing education and more precisely to education in nursing ethics, to expand Bandura's concept of self-efficacy and magnify its specificity for our context. We would not be the first to have considered this.[9] That said, the work published internationally in this area has made very little impact to date on the German-language discourse, which has yet to provide a solid underlying definition of ethical self-efficacy. Since we were prompted to attempt an engagement with the concept from a specifically German-speaking perspective, the specificities of nursing qualifications and pathways prohibit us from adopting concepts from the international sphere without careful examination and appropriate adaptations.

Against this backdrop, this article sets out to provide a rationale for expanding the concept of self-efficacy and to draw up a definition of ethical self-efficacy in relation to nursing professionals[10]. In adapting the notion of ethical self-efficacy for the German-language context, we seek to supply an example of and an inspiration for reviewing theoretical concepts for their applicability to other national discourses, adjusting them where appropriate, and applying theoretical scaffolds to their contextual extension. Having commenced by briefly outlining the current state of research in this area, we will discuss the ethical agency of nursing professionals and detail further components of a distinctly ethical[11] concept of self-efficacy, following this by setting out our proposed definition of ethical self-efficacy as it applies to nursing professionals. We will then proceed to consider implications of this definition for theoretical and practical nurse education, setting out the conclusions we draw for educational processes going forward and the requirements that the nursing profession will have of this education in the future. In our conclusion, we place the issues this article discusses in a broader societal and political context and point to possibilities for successfully translating the concepts we have outlined into nurse education.

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5 Wöhlke/Riedel 2023; ICN 2021; American Nurses Association (ANA) 2025.
6 See, for example, Destatis 2024; Rothgang/Müller/Preuß 2020; Drupp/Meyer 2020; also Klotz/Riedel 2023, 2025.
7 See, for example, Hülsken-Giesler 2015.
8 Bandura 1977.
9 One example is Ishihara et al. 2022; see also the next section of this article.
10 While we focus in this article on qualified nurses, our considerations may equally apply to, for instance, trainees/student nurses, nurse managers, and other groups of professionals training for or working in occupations related to nursing.
11 We mean this in contrast to a general conception of self-efficacy (see section 2.1) and "moral" self-efficacy (see section 3 in particular).

2 SELF-EFFICACY AND ETHICAL AGENCY

2.1 SELF-EFFICACY

Bandura defines self-efficacy as an ability pertaining to the individual.[12] His concept deems perceived self-efficacy to be people's confidence in their ability to reach a particular level of attainment which itself influences events that have an impact on their lives. Self-efficacy "produces personal accomplishments, reduces stress and lowers vulnerability to depression".[13] The definition of self-efficacy put forward by Schwarzer and Jerusalem regards it as

> the subjective certainty of being able, through one's own competency, to manage new or difficult situations that require one to act. These are not tasks that can be handled via simple routines, but rather ones whose difficulty requires processes of action entailing effort and stamina if they are to be completed.[14]

Self-efficacy involves an individual's self-assessment and their confidence in their own competency to act,[15] and as such is of significance in relation to the capacity to act ethically and make ethical decisions.[16] The degree of self-efficacy a person has also affects their choice of actions to take and their initiation of the actions chosen.[17] In the ideal case, an individual's personal self-efficacy can come into play in complex situations, thus laying vital foundations for that individual's perceived self-efficacy that are effective throughout the entire process of an action and "denote [...] [a person's] confidence in their own competency in setting actions, including difficult actions, in motion and seeing them through. It gives expression in particular to the surmounting of barriers via one's own intervention".[18]

Hartmut Rosa, setting out his considerations on the concept of resonance, likewise references Bandura's idea of self-efficacy: "a person with strong perceptions of self-efficacy is more confident, invests more energy in conquering difficulties, sets more demanding goals for themselves, and perseveres longer in the face of obstacles."[19] A perceived self-efficacy, in Rosa's terms, is effectively an expectation of "resonance",[20] that is, the expectation that, with each action, a response will come, in the relationship linking the "subject [to the] world".[21] In another passage, Rosa points out that the perceived self-efficacy "not only does not reduce the likelihood of experiencing resonance, but in fact [...] is apt to enhance the quality of such an experience".[22] Self-efficacy, in the terms of resonance theory, refers to "being able to reach something or someone as part of a responsive, open-ended encounter".[23] "Reachability", in turn, is about entering into contact with, letting ourselves be touched by another entity; "the experience, or at least expectation, of self-efficacy in the sense of being able to reach the object we come into contact with", with an additional "element of responsivity".[24] Self-efficacy and the expectation of self-efficacy, then, depend on resonance and responsiveness if they are to develop, unfold an effect, and intensify.

Following Schwarzer and Jerusalem, this, and of particular significance in the light of the high levels of fluctuation observable in the nursing profession, is the fact that self-efficacy represents "an important

[12] Bandura 1994.
[13] Bandura 1994, p. 71.
[14] Schwarzer/Jerusalem 2002, p. 35.
[15] Schwarzer/Jerusalem 2002.
[16] Stenmark/Redfearn/Kreitler 2021; Aoyanagi et al. 2022.
[17] Barysch 2016; Schwarzer/Jerusalem 2002.
[18] Schwarzer/Jerusalem 2002, p. 39.
[19] Rosa 2019, p. 159.
[20] Originally "Resonanzerwartungen". Rosa 2023, p. 273.
[21] Originally "Subjekt und Welt". Rosa 2023, p. 277.
[22] Rosa 2020, p. 55.
[23] Rosa 2020, p. 54.
[24] Rosa 2020, p. 56.

precondition of high motivation and high performance, of psychological and physical wellbeing, and of a high level of satisfaction with work and life".[25] It is further linked to confidence in practice, reduces nurses' inclination to leave the profession and improves the quality of nursing care.[26]

2.2 ETHICAL AGENCY

Self-efficacy and agency are connected in substantive ways. Bandura notes that "[e]fficacy beliefs are the foundation of human agency"[27] and that "many actions are performed in the belief that they will bring about a desired outcome".[28] Ethical agency, then, is a vital component of self-efficacy. We considered above how the concept of self-efficacy indicates that, rather than simply reacting to external influences, people are actively engaged in shaping and forming their experiences. Agency is a key concept in our context, as it describes the capacity of human beings to act consciously and direct their own lives. We can conceive of agency as the fundamental ability of people to regulate their actions, proactively and towards a specific purpose, and to adapt them as required. Bandura proposes three properties of agency: forethought, self-reactiveness, and self-reflectiveness. Forethought, in Bandura's definition, is forward-looking self-regulation aligned to objectives visualised and the likely consequences of actions taken. Practised over time, forethought gives direction, coherence and meaning to an individual's day-to-day life. Self-reactiveness refers to an individual's regulation of their actions in line with behavioural standards that that individual lays down for themselves. Self-reflectiveness, meanwhile, takes place whenever people consider whether their thoughts and actions are congruent with their values and their ideas of morality, and manage instances of conflict between competing values and alternative courses of action. Bandura's definition of agency transcends the behaviour of individuals and references people collectively.[29] Values and fundamental ethical assumptions are, therefore, key to self-reactiveness and self-reflectiveness in particular. It also bridges the gap between moral thinking and moral actions, in pointing to people's mechanisms of self-regulation, such as self-reactiveness and self-reflectiveness, that draw on ethical norms: "Abiding by one's moral standards supports positive self-regard, whereas violating moral standards rouses self-contempt. These self-sanctions keep behavior in line with moral standards."[30] We see, then, that acting in line with morality is not simply the upshot of cognitive judgements, but rather a process of self-regulation subject to the influence of self-efficacy beliefs, moral standards, and the capacity to self-reflect.

When people face ethical challenges, ethical agency emerges as a facet of their coping with these situations; it also arises from, and is driven by, social modelling. Role models both demonstrate and influence people's attitudes, values, behaviours, and strategies of action, and the process of learning from role models boosts self-efficacy. Actions demonstrated by role models reinforce people's expectations with regard to their aims and to the results of their future actions, and the values that role models embody feed into the development of abilities of self-regulation.[31] One of the core categories in the study of nurses' moral self-efficacy by Ishihara et al. – that participants in their education programme

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[25] Schwarzer/Jerusalem 2002, p. 36.
[26] Boswell et al. 2020; Eller et al. 2016.
[27] Bandura 2001, p. 10.
[28] Bandura 1997, p. 3.
[29] Bandura 2018.
[30] Bandura 2018, p. 132.
[31] Bandura 2018.
[32] Ishihara et al. 2022.

"progressed in nursing with ethical agency" – points to the central significance of ethical agency. The authors emphasise, in this context, the immanence of ethical behaviours in the delivery of professional nursing practice.[32]

2.3 MORAL EFFICACY

Hannah et al. define "moral efficacy" as a person's conviction that they have the motivation and the cognitive resources to act in situations with relevance to morality.[33] This encompasses the ability to organise and mobilise the resources and courses of action required for these moral actions, and to sustain these actions in the face of moral adversity.[34] Studies referring specifically to nursing indicate a link between moral distress and expectations of self-efficacy in settings including intensive care,[35] and point to the connection between moral distress and perceived moral self-efficacy in acute inpatient care.[36] The definition set out by Rullo et al. terms moral self-efficacy a person's ability to behave in line with their own ideas of morality,[37] a matter of significance with relation to skills in acting ethically and taking ethical decisions.[38] Lee et al. found that a high level of moral self-efficacy can indeed induce an individual to take a stand against immoral behaviours.[39]

Parciello et al., drawing on Bandura's Social Cognitive Theory, regard two facets of moral self-efficacy – its self-reflective and its behavioural dimension – as key.[40] Self-reflective moral self-efficacy, in this definition, centres on an individual's ability to reflect on behavioural errors they may have made in the past and to learn from them, while self-efficacy in behavioural morality is the individual's capacity to regulate their behaviour in situations that present them with a moral challenge. The effect of moral self-efficacy, then, can be both retrospective and situational. We can define, in this context, the expectation of moral self-efficacy as someone's personal conviction of and confidence in their own abilities, enabling them to actively take ethical decisions and actions in situations of ethical complexity, reflect on and reconsider those actions, and develop new strategies. We may combine the individual sphere of reference evident here with a collective angle, as touched upon above,[41] to generate relevant input for a definition of ethical self-efficacy. The act of ethical reflection in itself engages a supra-individual space,[42] a space occupied in our context by the nursing profession.

[33] Hannah et al. 2011.
[34] Hannah et al. 2011.
[35] Harorani et al. 2019.
[36] Rathert et al. 2016; Ishihara et al. 2022.
[37] Rullo et al. 2022.
[38] Stenmark et al. 2021; Aoyanagi/Shinod/Takahashi 2022.
[39] Lee et al. 2017.
[40] Parciello et al. 2023, p. 1099.
[41] Bandura 2018.
[42] See also Schicktanz/Buhr 2021.

3. ETHICAL SELF-EFFICACY AMONG NURSING PROFESSIONALS

3.1 DEFINITION

Having considered the context of nursing practice in the light of ethical agency and the concomitant challenges, we are able to derive from these a definition of ethical self-efficacy for the delivery of professional nursing care. Our choice to create a specific definition referencing "ethical" (as opposed to "moral") self-efficacy stems from the fact that the former concept addresses both the analysis and management of, and reflection on, situations with a moral component, and people's ability to handle situations with ethical competency. In general terms, morality relates to subjective values, while ethics encompasses a reflective engagement with and analysis of morality. In centring the concept of "ethical self-efficacy" rather than the internationally more widespread notion of "moral self-efficacy", we follow this distinction. While the moral substance of situations is of relevance, we note the central importance of ethical reflection upon and an ethical rationale for the action in which an individual perceives their moral self-efficacy and is able to experience an expectation of being self-efficacious.

A definition of nursing professionals' ethical self-efficacy

Nurses can experience themselves as possessing self-efficacy when they experience themselves as being in a living relationship of resonance with themselves and their – in this case, occupational/professional – environment, and accordingly have a high expectation of self-efficacy in relation to moral and ethical issues and challenges and are able to make use of this ability to effect change. It follows from this that someone's expectation of ethical self-efficacy is linked to their sense of, and confidence in, being capable of bringing about change for themselves and, in the context of work with colleagues, in relationship with and alongside others, including in situations of moral complexity. Subjective (individual) and collective experiences of self-efficacy build on this, reinforcing these individual and collective expectations of self-efficacy. In other words, when a nurse perceives and experiences herself or himself as ethically self-efficacious, they possess, by virtue of their expectation of self-efficacy, the skills to manage and reflect upon

- complex ethical challenges,
- situations featuring difficult demands and a moral component,
- issues of ethical complexity,

acting on the basis of and in line with the standards of professional nursing ethics. Furthermore, they are motivated to engage actively in establishing and advancing healthcare and nursing care that rests on a foundation of ethical reflection and to persist in addressing the associated issues and challenges.

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[43] Epstein/Hamric 2009.

Nurses with robust ethical self-efficacy benefit from it and also experience challenges linked to it.[43] Studies on moral distress have found that nurses' strong confidence in their professional and ethical skills – the competencies that enable nurses to handle complex and stressful situations in a way that is congruent with their values – is the decisive factor in their capacity to constructively manage stress in critical situations at work.[44] Strong professional and ethical competency alongside self-confidence and moral courage boost people's ability to make considered decisions that are in line with their values; this in turn fosters both individual and collective self-efficacy and supports the provision of effective care centred on patient needs, that is nursing practice that has a preventive effect against moral stress and injury and intensifies wellbeing, satisfaction at work and professional identity.[45] We conclude from this that it is necessary for nurses to take an active role in continuous reflection on and improvement of institutional conditions and organisational ethics which, once improved in this way, will help create a culture of ethics and a working environment that enables, supports and, in the best case, insists on the implementation of ethical standards.

Our definition of ethical self-efficacy, then, incorporates the particularities of nursing, as a profession embedded in the healthcare system, and in so doing validates the significance we attach to the concept of ethical self-efficacy in this context. In our view, this specific reference to the profession and this drawing up of a fundamental definition are vital in two respects: firstly, to make the concept in its significance accessible to further work in nursing ethics, and, secondly, to provide a concrete account of the expectation of ethical self-efficacy for the use of ethics in nursing education and, in the long term and in the ideal case, potentially making this expectation usable as a point of reference when evaluating relevant educational processes. The influencing factors in ethical self-efficacy set out in the following point to further specificities of nursing and therefore to the significance of our concept for the profession.

3.2 WHAT INFLUENCES ETHICAL SELF-EFFICACY, AND WHAT ITS DEVELOPMENT REQUIRES

When nurses take an active role in managing ethical challenges, they gain experiences of successful coping that can support their sense of ethical self-efficacy.[46] Alongside and beyond this, ethical self-efficacy requires, in order to emerge, an individual sensitivity that enables that individual to perceive when situations entail ethical challenges. This means that nurses require education on the actual or potential ethical components of specific situations they will encounter in their day-to-day work and on possibilities for intervening in these situations and the concomitant implications. Put another way, it is necessary for nurses not only to possess theoretical knowledge of ethical issues, but to be able to incorporate this knowledge into their practice and apply it where required. "Applying" it, in this context, means both being or becoming aware of the ethical import of the situation at hand and of the ethical conflict or disputes that may arise, and adopting an ethical position in response to the situation that is the result of professional reflection. It is evident here that, alongside nurses working in the delivery of

[44] Riedel et al. 2023.
[45] Lamiani et al. 2017.
[46] Ishihara et al. 2022.

care, nurse managers and other groups may, depending on the specific situation and its content, be called upon to engage ethically in this manner.

We consider it vital in this context to focus on sets of professional values[47] alongside personal ones, which can serve as a basis for the development of ethical self-efficacy, and knowledge of which will enable practitioners to incorporate these values into their actions. In view of the properties of "good" nursing care outlined at the outset of this article, particularly the bringing together of external and internal evidence in nursing practice and the limited amenability of "good" care to standardisation, a professional ability to reflect ethically appears essential when it comes to assessing specific situations. Developing high levels of ethical self-efficacy, and the expectation thereof, among qualified and trainee nurses seems to require an extension of processes in nurse education and an expansion of the framework in which it takes place. A lack of availability or uptake of training courses and of continuing professional development on ethical reflection in complex nursing situations may be a factor in poor professional and ethical competencies and limited self-confidence among nursing professionals.[48]

In their proposal for an ethics education programme for nursing, Ishihara et al. emphasise the importance, in placement settings, of identifying, and thus simultaneously supporting the ability to act morally in complex nursing situations, with the aim of advancing nursing practitioners' ethical skills and their ability to reflect on their practice, and of improving their professional self-confidence and resilience.[49] The authors list three key components of this process, drawn from Bandura's theory of self-efficacy: vicarious experiences, mastery experiences and emotional self-regulation, of which the latter references Bandura's emphasis on emotional states[50].[51] Processes of social learning via models provide prospective and qualified nurses alike with the opportunity to observe experienced colleagues successfully managing ethical issues and uncertainties in complex situations that occur in nursing practice and, in so doing, acting as role models, boosting their observers' confidence in their own ability to act ethically. The experience of competence and of engaging in consultations around ethics, leading to experiences of success, supports people's confidence in their abilities, which makes this experience instrumental in the emergence of moral and ethical self-efficacy.[52] The capacity for emotional self-regulation, implemented by the study authors through continuous analysis of cases and feedback from colleagues, enables people to sit with and work with difficult feelings they and others experience. The study sought to instil long-term change by emphasising the importance of positive feedback from management staff. Over time, the interventions resulted in lower levels of moral distress and more ethical nursing practice.[53]

Institutional settings can promote ethical self-efficacy by drawing up and implementing appropriate guiding principles in this context. Factors that can have an impact in this regard include whether institutional guidelines provide statements on ethical matters; whether, if they do, this guidance is in line with current views on ethics within the profession; the extent to which these principles come to life in the institutional culture; and whether leaders expect staff to take ethical stances that are impossible to realise or maintain in the day-to-day stresses of nursing practice. An institutional culture that prioritises cost-cutting and efficiency over ethical values can cause nurses to question their ability to act in ethical ways and induce moral stress and burnout.[54]

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[47] ICN 2021; ANA 2015.
[48] Rushton et al. 2023.
[49] Ishihara et al. 2022.
[50] Bandura 1997.
[51] Ishihara et al. 2022.
[52] See, for example, Morgan/Jones/Milliken 2024; Rushton et al. 2021; Ranisch et al. 2021; Albisser Schleger et al. 2019.
[53] Ishihara et al. 2022.
[54] Rushton et al. 2023; Albisser Schleger 2023; Dos Santos 2020; Rasoal et al. 2017. This points to the significance of ethical self-efficacy in leadership and organisational ethics. See Paciello et al. 2023; Zhang et al. 2022; Frömmer et al. 2021; Owens et al. 2019; Lee et al. 2017; May/Luth/Schwoerer 2014.

Building interprofessional networks represents another vital strategy in this regard. In institutional terms, opportunities for nurses to share their experiences with members of other professions, particularly in the form of reflection through dialogue that enables their distinct points of view to complement one another, can serve as a component of ethical self-efficacy – or of its experience. By acknowledging the fundamental institutional value of such sharing of experiences and ideas in the context of ethics, and by enabling professionals to give voice to their views in dialogue, these opportunities can potentially intensify their profession-specific experience and enable them to access it more readily for reflective practice. Such dialogue requires institutional spaces, in both a literal and a metaphorical sense. Examples could include "ethics cafés", case conferences and participatory processes for the creation of ethical guidelines.[55] A lack of adequate structures and processes and unclear responsibilities around matters of ethics present obstacles to both individual and collective ethical self-efficacy,[56] as can steep hierarchies, a lack of mutual support among colleagues, and the failure of managers to back up their staff,[57] which drive a tendency for people to acquiesce to decisions taken by others, even when these decisions go against their ethical convictions.[58]

Finally, political, legal and societal regulations and conceptions are further factors influencing ethical self-efficacy. In Giese's view, the ability to reflect on the conditions in which nursing practice takes place and on matters of professional recognition and of the acknowledgement of all care-related work, alongside the perception and fulfilment of the ethical obligations imposed by the profession, are concomitants of a nurse's professional identity,[59] expressly encompassing the potential for political activism. Nurses' ability to act as professionals, Giese writes, is "necessary if the nursing [profession] is to carry out its essential task in accordance with the commission society entrusts to it. The autonomy to draw up scientific and ethical standards which is required for this [...] is not an end in itself, but arises inevitably from the right of those in need of nursing care to receive care that achieves its objectives".[60] Situations or conditions which place nurses in conflict with their professional identity can lead to stress and uncertainty when they are faced with ambiguities, specifically ethical ambiguities.[61]

4 CONCLUSION: A LOOK AHEAD

We have set out the significance of ethical self-efficacy, or the expectation thereof, in ensuring that nursing professionals can retain their ability to act in the face of challenges facing society at large and the precariousness induced by the institutional frameworks that govern day-to-day nursing practice. We have found substantial benefit in formulating a specific variant of Bandura's original concept for nursing professionals and particularly for nurse education, in light of the constitutive roles of ethical competencies in professional nursing practice, their importance in the delivery of "good" nursing care, and the complexity characterising that care. It is on this basis that we consider the promotion of ethical self-efficacy to be a central component of the skills that nurses need to develop in their training. We have identified ethical agency as the foundation for an extended definition of self-efficacy as a general concept, and assume that further components of ethical self-efficacy among nursing professionals can be identified by examining the phenomenon at the micro-, meso- and macro-levels.

[58] Lamiani et al. 2017.
[59] Giese 2025.
[60] Giese 2025, p. 32.
[61] Wöhlke 2025; Kersting 2022; Schniering 2021.

Combining individual and collective professional development with institutional support can help nursing professionals acquire and build ethical self-efficacy and its perception. Well-structured ethics education programmes alongside a supportive organisational culture are vital in increasing nurses' confidence in their capacity to act ethically, and promote a working environment characterised by collaboration and ethical reflection. Institutions providing nurse education, such as universities, need to ensure that the practice of ethical reflection permeates all areas of the curriculum, so that student nurses learn about acting in line with their values and gain awareness of situations in which they can experience their ethical self-efficacy. We would mention again in this context the spaces for reflection we referenced above, which enable active engagement with ethical issues, and which might include ethics case conferences, clinical ethics ward rounds, and "ethics cafés". Furthermore, we note the importance of teaching methodological skills through collegial consultation and supervision within practical education settings.[62] Tried-and-trusted methods and approaches regarding the provision of advice on ethics can act as supportive spaces for reflection in the context of ethics education, enabling students and those teaching them to explore ethical matters arising from nursing practice across all nurse education settings.

The issues we have raised in this article are complex and have considerable implications, meaning that we have only been able to touch briefly on some of their aspects. As we set out in our introduction, we have focused on the German-language context; this article can therefore provide, at most, a certain impetus for appropriate adaptations or extensions of its conclusions to other national discourses. Some of the thoughts with which we close this article are likewise specific to German-speaking settings, and may not be fully or directly translatable to other countries, other cultures of nursing care, other practices, or other nursing workforces and qualification pathways.

As a next step, the theoretical work carried out here, requires review for its underlying theoretical robustness and its practicability, and extension and validation where appropriate. Besides raising other issues, further debate in this area would need to engage more closely with theoretical and political matters relating to the nursing profession and to explore experiences and knowledge in this context from other caring professions.[63] This will, for example, enable the continued process of creating an increasingly specific picture of the characteristics pertaining to nursing in particular and their links to ethical self-efficacy, while drawing on analytical work from nursing theory. We would also urge critical reflection on the power relations behind nurses' perceived capacity to take decisions and act and, where appropriate, the changes that may have taken place in this capacity over the course of the evolution of nursing from an occupation into a profession. Furthermore, we recommend that actors in this field consider whether, and to what extent, the issues we have raised in this article are applicable to other healthcare professions. There are doubtless parallels, but we would caution that the conception of ethical self-efficacy we have outlined in this article is specific to the nursing profession in its close engagement with patient lifeworlds – closer than that seen in other healthcare occupations – and the distinctiveness of the concomitant ethical issues. Incorporating our considerations into nursing care will require the review of existing education, training and professional development formats and the creation of new ones addressing particular target groups, alongside relevant information material. Besides this, we would note the necessity of systematically establishing appropriate education programmes and institutional structures to boost nursing professionals' ethical self-efficacy, and the

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[62] In our view, learning about ethics in "practical education settings" is not limited to those training student nurses, but also encompasses professional development for qualified nurses delivering patient care, placement supervisors, and nurse managers.
[63] See also Kuhn 2024; Käppeli 1988.

need for research into the similarities and differences between manifestations of ethical self-efficacy in the various fields in which nursing care takes place, and in what those fields require of it.

In our view, the selft-governing institutions of the various healthcare professions furnish opportunities creating standardised education programmes in the area of ethical self-efficacy. In Germany, nurses are partially organised in *Pflegekammern*, which both act as regulators and represent the interests of nursing professionals in policy matters.[64] As well as supporting individual nurses in the exercise of their professional responsibilities, *Pflegekammern* provide a framework within which the profession as a whole can meet the duties expected of it by society. One of the purposes of the *Pflegekammern* is to issue codes of conduct which lay down ethical standards for the delivery of nursing care, alongside the scientific and legal principles governing it. In so doing, they supply nurses with a specific framework which enables them to reflect on their professional actions and seek support where required, thus increasing confidence and safety in nursing practice and intensifying nurses' experience of ethical self-efficacy. As entities under public law, *Pflegekammern* additionally have the capacity to influence policy and guide governments[65] in creating conditions in which quality care, on the basis of thorough ethical reflection, can flourish.[66] The German federal states have further established ethics committees for nursing and care occupations,[67] which provide information and advice on current issues in ethics. Finally, it is our view that meeting the ethical requirements placed upon the nursing profession requires more active involvement of nursing professionals and specialist nursing researchers in policy matters[68] and the political will to engage more closely with issues relating to nursing care.

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[64] See also Giese et al. 2024. A more detailed account of Pflegekammern and their significance is in Kuhn 2024, 2025.
[65] In Germany's federal structure, the administration of health policy is the responsibility of each federal state, meaning that Pflegekammern primarily work with government at this level.
[66] Kuhn 2016.
[67] See, for example, https://www.pflegeethikkommission-nds.de/.
[68] See also Remmers 2023.

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HOW SWISS SOLIDARITY FUNDING REBUILT DUTCH DISTRICT NURSING – AN ARCHIVAL REDISCOVERY

Mia Vrijens

Figure 1: Collection of the North Sea Flood Museum (Watersnoodmuseum), object WNM Burgh-Haamstede 135, right from the windmill the Groene Kruis building (district nurse building) in Burgh-Haamstede Zeeland after the North Sea flood February 1953.

Abstract

Images of the 1953 North Sea flood that affected the coastal areas of the United Kingdom, Belgium, and the Netherlands are etched in many people's memories. Photographs and film footage brought this disaster vividly to life, making its terrifying scale visible. Iconic images include vast waterscapes with only a single farmhouse or tree remaining, as well as families on rooftops or in small boats as rescue approached. These are all representative of the visual narrative of the North Sea flood.

Among the materials related to district nursing in the collection of the Museum for Nursing in the Netherlands, photographs were found that did not depict the disaster itself, but rather the reconstruction of district buildings that formed the backbone of health care infrastructure in the Dutch province of Zeeland. At first glance, these photographs do not seem emblematic of the flood. On closer inspection and after further research, however, they reveal a surprising reconstruction story. An article in the August 1956 issue of the Groene Kruis's monthly journal[1] provides additional clarity.

Keywords: flood, district nursing, fundraising, Swiss solidarity, The Netherlands

[1] Het Groene en Witte Kruis, official organ of A.N.V. Het Groene Kruis

Figure 2: "district building" (photographer unknown). Source: Dutch Museum for Nursing, photo G1544.

1 THE DUTCH MUSEUM FOR NURSING AND ITS COLLECTION

The Dutch Museum for Nursing is an (online) museum and knowledge center for the history of nursing. In recent years, it has become part of the Dutch professional association for nurses and caregivers (V&VN).[2] The museum collection includes an extensive array of objects, personal documents, and photo, film, and audio materials related to the history of nursing and caregiving. Most of it is digitized and searchable. Like in any other museum collection some parts, however, remain undigitized or poorly documented, with unclear origin or context. Both known and unknown artifacts offer valuable material for research within specific themes.

Much is known about district nursing in the Netherlands. There are detailed books that describe its history chronologically.[3] The museum depot in Culemborg houses many objects that represent district nursing, including the furnishings of a district building which served as a health center and comprise loan materials, medical instruments, and even daily-use items like cups with logos of the district nursing organization. The aforementioned books serve as excellent references, placing these objects in a historical context, with insight into how they were used and the key figures, institutions, and events surrounding them.

Re-examining objects from fresh perspectives can yield new insights. Aspects relating to the object itself – such as date, maker, or subject – but also its context can uncover deeper stories, offering new angles on the heritage of district nursing. One striking example is a series of photographs from 1956 showing district buildings in the province of Zeeland, sometimes including groups of people. In this article for the *European Journal for Nursing History and Ethics*, the series of images connected to the North Sea flood of 1953 serves as a case study for Lost & Found that traces the rediscovery and investigation of the images and their context. Interpretation of this photo series is crucial for unlocking

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[2] Historisch College FNI | V&VN.
[3] Examples include: Huige 2011; Jamin 1999.

the broader district nursing collection at the Museum for Nursing and shines new light on the history of nursing and the position of health care, not only in the province of Zeeland but in the rest of the Netherlands as well.

Figure 3: "Group on boat in Zeeland" (photographer unknown). Source: Dutch Museum for Nursing, photo G1528.

2 LOST & FOUND: PHOTOS OF DISTRICT BUILDINGS IN ZEELAND

In 2023 the Netherlands commemorated the 70th anniversary of the flood of 1953 which affected the Dutch provinces of Zeeland and South Holland. Occurring in the early morning of February 1, 1953, this storm surge was caused by a combination of factors. An exceptional windstorm coincided with high tides, and the weak dikes were unable to protect the land behind them. Dikes were breached and the sea flooded the islands of Zeeland. It is reported that Zeeland suffered 1,835 casualties, and over 70,000 people were forced to evacuate. The flood is considered to be the defining traumatic event in that region and influenced daily life for many decades afterwards. Besides Zeeland, the provinces of South Holland, NorthBrabant and coastal areas of the UK and Belgium were also affected.

This 70th commemoration of the 1953 flood in 2023 led to the rediscovery of 49 photographs. A search in the museum collection database using the keywords "[wijkverpleging]" ("district nursing") and "[watersnoodramp]" ("flood") brought up several images directly related to the disaster. In 1953, district nurses had been called to assist and were active in emergency shelters, such as the one in Ossendrecht. These images show nurses in action. There are also images that clearly depict the devastating impact of the disaster.[4]

[4] Pictures and video of the North Sea flood in the Dutch province of Zeeland www.watersnoodmuseum.nl/en/the-flood

Additionally, another series of images appeared in the search results, although it was not immediately clear how they related to the flood. These show new district buildings with waving flags, groups of people listening to speeches, or scenes of the sea and dikes. The descriptions sometimes read "Flood 1953 and reconstruction of Zeeland district buildings" and occasionally include "realized with aid from Switzerland and Italy and others." But were these images really from 1953?

Artistically, the photographs are not remarkable because their composition, subjects, or print quality are not particularly engaging. Descriptions in the archive include phrases like "group on boat", "group by the sea", or "presentation of honorary medal", all of which are quite vague. In some cases, descriptions are more specific e.g., "group and two women in traditional dress visiting a district building built with Swiss and Italian help", but the overall story behind this photo series remains unclear.

What is certain is that the photos must be from the post-1953 period, as they involve the reconstruction of district buildings aided by Swiss and Italian contributions. The Swiss flag, white cross on red background, is also visible in some of the photos, easy to identify even in black and white. Only two out of the 49 photos list a location in the province of Zeeland: Stavenisse. All the others lack location data, and all are generically dated "1953".

Figure 4: "Stavenisse district building", July 1956 (photographer unknown). Source: Dutch Museum for Nursing, photo G1559.

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3 RESEARCH & CONTEXT

The full series of 49 photographs is archived at the Dutch Museum for Nursing under the title "1953 Flood Disaster and Reconstruction of Zeeland District Buildings". To accurately interpret these photos, it is crucial not to rely solely on archival descriptions. Gradually, a fuller picture emerges when external information is incorporated.

A search of Delpher, the Dutch online newspaper archive, using alternative terms such as "[stormvloed]" ("storm surge") instead of "[watersnoodramp]" (flood disaster"), a more modern term) yielded relevant results.[5] These articles revealed that, in July 1956, a Swiss delegation visited Zeeland to officially hand over 20 new health centers (district buildings) to the population. The effort had been funded by Chaîne de Bonheur ("Chain of Happiness"), a solidarity campaign organized by Swiss-Italian radio stations that raised over 2 million Swiss francs for the Netherlands in 1953.[6] Other reports indicate that, at the time, this amounted to more than 800,000 Dutch guilders, which is equivalent to approximately €3.8 million today.[7]

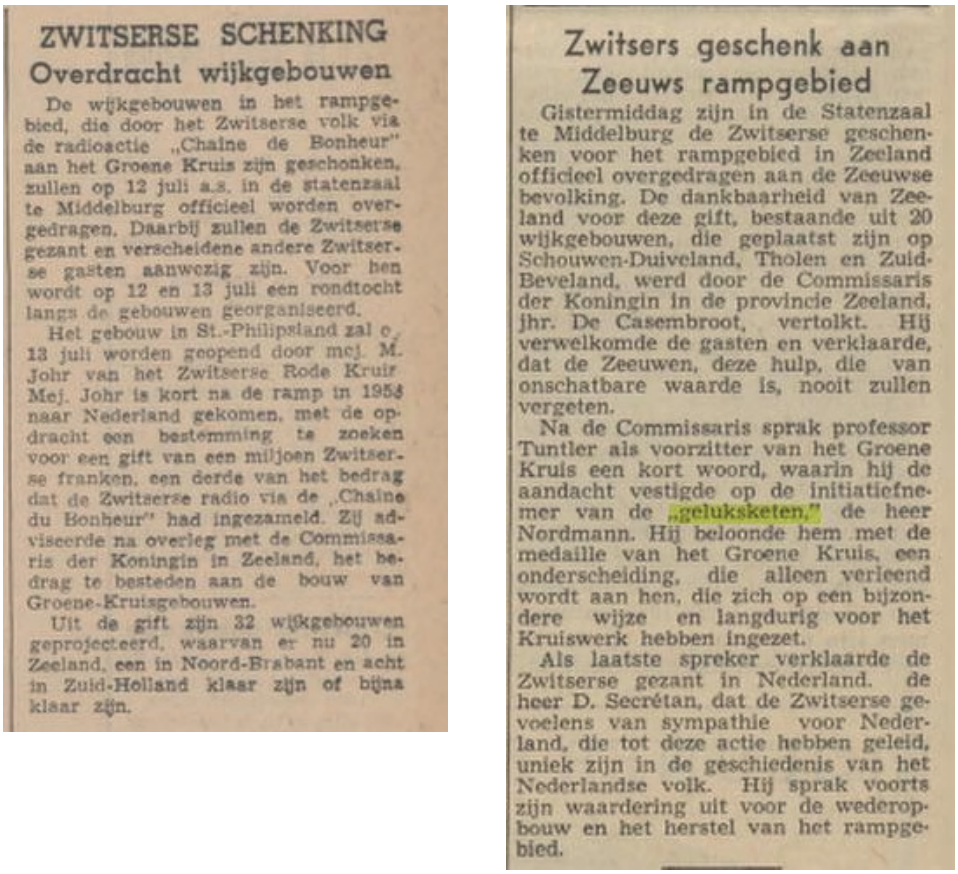
The goal of this fundraising was to construct a total of 32 district buildings, of which 20 had already been completed by 1956. Documents in the Zeeland archives, preserved by various local branches of the district nursing organization Groene Kruis ("Green Cross"), contain details of the construction, blueprints, and financing of these buildings from 1953 to 1956.

All this information recontextualizes the rediscovered photo series. It is no longer just a group of unremarkable images, but a key to understanding the international aid that supported the rebuilding of Dutch district nursing and local health infrastructure. This story can be summarized as follows:

The then Queen's Commissioner in the province of Zeeland, Mr. A.F.C. de Casembroot, received a Swiss delegation in July 1956. The group included Ms. M. Jöhr of the Swiss National Red Cross, who had advocated for spending the relief funds on district buildings. She had visited Zeeland in early 1953 and advised that project funds be allocated there. The photographs suggest she unveiled a commemorative plaque during the visit. That plaque, shown in the photo collection, is now in the possession of the Zeeland North Sea Flood Museum under inventory number WNM0289.[8]

The delegation also included Mr. Roger Nordmann (1919–1972)[9], the initiator of the successful Chaîne de Bonheur campaign, which raised funds via Swiss radio directly after the flood. He was awarded an honorary medal by the Groene Kruis in recognition of his contribution. The awarded medal appears to be unique, but exactly how unique remains unclear from the archive. Similar medals exist in the archive of the Museum for Nursing, but how often they were awarded, and whether that was decided regionally or nationally, is still unknown.

[5] Other terms for the 1953 North Sea flood include in Dutch: Springvloed, St. Ignatiusvloed, Beatrix-vloed, Februari-ramp.
[6] Chaîne de Bonheur is a Swiss non-profit organization that has been running solidarity campaigns since 1946. https://www.bonheur.ch/collectes/toutes-les-collectes-de-1946-a-aujourdhui/, accessed June 20, 2024. It is a foundation that collects contributions for emergency assistance after catastrophes, including natural disasters in Switzerland and abroad, through radio and television broadcasts. See Maurer
2003. The Swiss Red Cross is one of the parties that takes the lead in the realization of the emergency assistance projects.
[7] https://www.cbs.nl/nl-nl/visualisaties/prijzen-toen-en-nu, accessed June 20, 2025.
[8] Collection of the North Sea Flood Museum (Watersnoodmuseum), object WNM0289, https://hdl.handle.net/21.12128/322539488 accessed December 3, 2025.
[9] Mäusli 2006.



ZWITSERSE SCHENKING

Overdracht wijkgebouwen

De wijkgebouwen in het rampgebied, die door het Zwitserse volk via de radioactie „Chaine de Bonheur" aan het Groene Kruis zijn geschonken, zullen op 12 juli a.s. in de statenzaal te Middelburg officieel worden overgedragen. Daarbij zullen de Zwitserse gezant en verscheidene andere Zwitserse gasten aanwezig zijn. Voor hen wordt op 12 en 13 juli een rondtocht langs de gebouwen georganiseerd.

Het gebouw in St.-Philipsland zal o. 13 juli worden geopend door mej. M. Johr van het Zwitserse Rode Kruis. Mej. Johr is kort na de ramp in 1953 naar Nederland gekomen, met de opdracht een bestemming te zoeken voor een gift van een miljoen Zwitserse franken, een derde van het bedrag dat de Zwitserse radio via de „Chaine du Bonheur" had ingezameld. Zij adviseerde na overleg met de Commissaris der Koningin in Zeeland, het bedrag te besteden aan de bouw van Groene-Kruisgebouwen.

Uit de gift zijn 32 wijkgebouwen geprojecteerd, waarvan er nu 20 in Zeeland, een in Noord-Brabant en acht in Zuid-Holland klaar zijn of bijna klaar zijn.

Zwitsers geschenk aan Zeeuws rampgebied

Gistermiddag zijn in de Statenzaal te Middelburg de Zwitserse geschenken voor het rampgebied in Zeeland officieel overgedragen aan de Zeeuwse bevolking. De dankbaarheid van Zeeland voor deze gift, bestaande uit 20 wijkgebouwen, die geplaatst zijn op Schouwen-Duiveland, Tholen en Zuid-Beveland, werd door de Commissaris der Koningin in de provincie Zeeland, jhr. De Casembroot, vertolkt. Hij verwelkomde de gasten en verklaarde, dat de Zeeuwen, deze hulp, die van onschatbare waarde is, nooit zullen vergeten.

Na de Commissaris sprak professor Tuntler als voorzitter van het Groene Kruis een kort woord, waarin hij de aandacht vestigde op de initiatiefnemer van de „geluksketen," de heer Nordmann. Hij beloonde hem met de medaille van het Groene Kruis, een onderscheiding, die alleen verleend wordt aan hen, die zich op een bijzondere wijze en langdurig voor het Kruiswerk hebben ingezet.

Als laatste spreker verklaarde de Zwitserse gezant in Nederland, de heer D. Secrétan, dat de Zwitserse gevoelens van sympathie voor Nederland, die tot deze actie hebben geleid, uniek zijn in de geschiedenis van het Nederlandse volk. Hij sprak voorts zijn waardering uit voor de wederopbouw en het herstel van het rampgebied.

Figure 5: Two newspaper articles: one from Provinciale Drentsche en Asser Courant dated July 7, 1956, and one from *Nieuwsblad van het Noorden* dated July 13, 1956.

Swiss Donation: Handover of Community Buildings (district nurse offices)

The community buildings or district nurse offices (wijkgebouwen) in the disaster area, donated by the Swiss people through the radio campaign Chaîne du Bonheur to the Groene Kruis, will be officially handed over on July 12th in the State Hall in Middelburg. The Swiss envoy and several other Swiss guests will be in attendance at the event. A tour of the buildings will be organized for them on July 12th and 13th. The building in Sint Philipsland will be officially opened on July 13th by Ms. M. Johr of the Swiss Red Cross. Ms. Johr came to the Netherlands shortly after the 1953 disaster, tasked with finding a purpose for a donation of one million Swiss francs – a third of the amount raised by Swiss radio through the Chaîne du Bonheur campaign. After consulting with the Queen's Commissioner in the Netherlands, she advised that the funds be used to construct Groene Kruis buildings.

From this donation, 32 community buildings were planned. Of these, 20 are now complete, or nearly complete, in Zeeland, one in North Brabant, and eight in South Holland.

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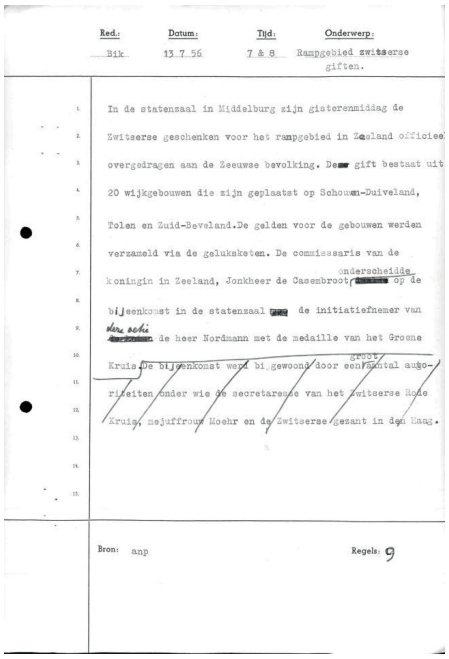
Swiss Gift to the Zeeland Disaster Area

> Yesterday afternoon, the Swiss donations for the disaster-stricken region of Zeeland were officially handed over to the people of Zeeland in a ceremony held in the State Hall in Middelburg. The gratitude of Zeeland for this gift – consisting of 20 community buildings, which have been constructed in Schouwen-Duiveland, Tholen, and Zuid-Beveland – was expressed by the Queen's Commissioner in the province of Zeeland, Mr. De Casembroot. He welcomed the guests and declared that the people of Zeeland will never forget this invaluable assistance. After the Commissioner's speech, Professor Tuntler, as chairman of the Groene Kruis, delivered a brief speech in which he drew attention to the initiator of the "chain of happiness", Mr. Nordmann. He awarded Nordmann the Groene Kruis medal, a distinction granted only to those who have made exceptional and sustained contributions to the work of the Groene Kruis. As the final speaker, the Swiss envoy to the Netherlands, Mr. D. Secrétan, stated that the Swiss feelings of sympathy for the Netherlands, which led to this action, are unique in the history of the Dutch people. He also expressed his admiration for the reconstruction and recovery of the disaster area.[10]

Although many questions remain, the period in which the buildings were constructed is mentioned in various Dutch newspapers. For example reports from June 1954 states that Queen Juliana paid a two-day visit to the affected areas in the provinces of Zeeland, South Holland and West Brabant, during which she opened a Groene Kruis consultation center in Heiningen.[11] This news item received wide coverage in both national and regional newspapers with circulations that extended well beyond Zeeland. The handover of the district buildings (health centers) in 1956 and the Swiss delegation's visit were reported widespread as well; not only in various national and regional papers, but also during the national radio (ANP) news bulletin of July 13, 1956. That bulletin reported on the first day of the visit with the following quote:



Red.: Bik | Datum: 13 7 56 | Tijd: 7 & 8 | Onderwerp: Rampgebied zwitserse giften.

In de statensaal in Middelburg zijn gisterenmiddag de Zwitserse geschenken voor het rampgebied in Zeeland officieel overgedragen aan de Zeeuwse bevolking. Deze gift bestaat uit 20 wijkgebouwen die zijn geplaatst op Schouwen-Duiveland, Tolen en Zuid-Beveland.De gelden voor de gebouwen werden verzameld via de geluksketen. De commissaris van de koningin in Zeeland, Jonkheer de Casembroot, onderscheidde op de bijeenkomst in de statensaal de initiatiefnemer van [redacted] de heer Nordmann met de medaille van het Groene Kruis. De bijeenkomst werd bijgewoond door een talrijk gezelschap autoriteiten onder wie de secretaresse van het Zwitserse Rode Kruis, mejuffrouw Moehr en de Zwitserse gezant in den Haag.

Bron: anp | Regels: 9

Yesterday afternoon, in the State Hall in Middelburg, the Swiss donations for the disaster area in Zeeland were officially handed over to the people of Zeeland. The donation consists of 20 district buildings located on [the islands of Zeeland] Schouwen-Duiveland, Tholen, and Zuid-Beveland. The funds for the buildings were raised through Chaîne de Bonheur. During the meeting, the Queen's Commissioner in Zeeland, Mr. de Casembroot, presented the initiator of this effort with the Groene Kruis medal.[12]

Figure 6: A section of the bulletin that was crossed out, but was still legible, reads: "The meeting was attended by a large number of dignitaries, including the secretary of the Swiss Red Cross, Miss Joehr, and the Swiss envoy in The Hague."

[10] Newspaper clippings translated with the help of Le Chat Mistral.
[11] E.g. Het Binnenhof, June 22 1954
[12] ANP Algemeen Nederlands Persbureau (national radio broadcasting bulletin) July 13, 1956.

Figure 7: "Group in front of district building" (photographer unknown). Source: Dutch Museum for Nursing, photo G1535.

4 THE PHOTOGRAPHER AND THE UNKNOWN CONTEXT

Although the photos may not stand out in terms of composition or quality, this Lost & Found item is special as a whole. It provides a snapshot of a moment in time: the opening of district buildings that might otherwise be forgotten. The destructive power of the 1953 flood remains a dominant visual in public memory. The reconstruction afterward is largely symbolized by the immense dike protection works, known as the Delta Works. Beyond the Delta Works, however, many smaller reconstruction efforts are less well remembered. The flood occurred not long after World War II, and materials were scarce. Foreign aid was essential to rebuilding affected areas. The fact that district buildings were considered a priority and that the reconstruction was commemorated with plaques and medals shows how deeply embedded district nursing was in local health care and society.

The awarding of the honorary medal from the Groene Kruis was described in newspaper reports as unique and emphasized the special appreciation shown for the creation of these buildings, witnessed by a large and attentive audience.

This transforms the photo series entirely. What were initially seen as unremarkable images, unsuitable for exhibition due to artistic quality or unknown origin, suddenly become a cohesive photo report of the visit, consisting of no fewer than 49 photos.[13] This places the photographer at the center of the story: Why were these photos taken? Was it a journalist who took them? A local amateur? Or was it an official commission? After all, film rolls and development were expensive. So who paid for them?

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[13] Museum for Nursing photos: G1527 to G1566, G1570, G1577, G1580 to G1583, G1585 to G1587.

Figure 8: "Group visiting district building", July 1956 (photographer unknown). Source: Dutch Museum for Nursing, photo G1561.

The series seems to suggest that someone accompanied the entire visit, but were there other journalists present? Was there a lot of press present, or was this photographer the only one? One of the photos appears to depict a radio interview, judging by the visible microphone. Yet research in the provincial Zeeland archives, the Delpher digital newspaper archive, and the Netherlands Institute for Sound and Vision (Beeld en Geluid) failed to provide the answer.

Closer study sometimes leads to answers and sometimes to new questions. It remains unclear exactly which islands and municipalities were visited. There are photos of a boat crossing, but from where? In one image, people are looking out from a dike toward the sea, but where exactly is this? Could one of the bus stops where the group gathers be the Coolsingel in Rotterdam? These details cannot be confirmed from newspapers and would require further research or local knowledge of Zeeland and Rotterdam. What is certain is that at least three different district buildings were visited, as these buildings can be identified and appear multiple times as background settings in different photos.

Given that no similar photos are found or stored in the Zeeland archives, and no photos like these were used in newspaper articles from July 1956, it is likely that the photographer was not a journalist. The assumption is that the photos were either taken by an amateur (and perhaps later donated to the Groene Kruis) or were taken by someone working for the Groene Kruis's PR or communications department. The latter seems more plausible, given the size of the collection and the high cost of photography at the time.

This hypothesis was tested by reviewing the summer 1956 issues of the Groene Kruis association's journal – with positive results. The July 1956 issue explicitly states:

> Two activities have occupied our attention in recent weeks:
>
> A. The handover of Swiss buildings in Zeeland, South Holland, and North Brabant;
>
> B. The New Guinea campaign.
>
> As for the first, it involved a few exhausting but very successful days. The goal of showing the Swiss what we did with their money and expressing our gratitude was completely achieved. We will elaborate on this in the next issue.[14]

Figure 9: "Group by bus on dike", July 1956 (photographer unknown). Source: Dutch Museum for Nursing, photo G1583.

The August 1956 issue provided the missing piece of the puzzle. Not only were several of the 49 photos published with location labels (Stavenisse, Sint-Annaland, Sint Philipsland, Nieuwe Tonge, and Herkingen), but it also confirmed that the two-day trip began by bus in Rotterdam and continued on the second day by police boat, made available by the province.[15] The article describes the itinerary and the speeches, interwoven with memorable moments:

> It was difficult to time these expressions of gratitude properly, which meant we were running late and arrived about an hour behind schedule in Sint-Maartensdijk. [...] The story may seem monotonous, but the reality was anything but; each place had its own unique atmosphere. A number of women wore traditional costumes from Thole [one of the Zeeland islands] and treated the delegation to all kinds of delicacies, including sausage buns [worstenbroodjes], a Zeeland specialty. For Mr. Bastiaanse, who played a major role in the realization of this building, it was a great satisfaction to be present, after consulting his doctor.[16]

Descriptions of the weather and anecdotal details about the group dynamics bring the story of the visit further to life: "Apart from the hazy sky and lack of sunshine, this was an impressive journey, one that was particularly beautiful for the Swiss visitors; a trip through the mouth of the Eastern Scheldt is

[14] Hulpverlening 1956.
[15] Inauguratie Zwitserse gebouwen 1956.
[16] Inauguratie Zwitserse gebouwen 1956, p. 134.
[17] Inauguratie Zwitserse gebouwen 1956, p. 135.

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certainly worthwhile", and "Along the way, some of the Swiss guests took turns driving [the bus], which caused much hilarity".[17]

It was possible to identify some of the individuals in the photos from the newspaper articles. However, the article in the Het Groene en Witte Kruis journal resulted in several corrections to earlier assumptions. Specific individuals could be definitively identified through this piece. For example, the man holding a microphone turned out to be a member of the Swiss delegation and one of the original radio broadcasters from Chaîne de Bonheur, not a Dutch journalist, as previously assumed.

Figure 10: "Group visiting district building", July 1956 (photographer unknown). Source: Dutch Museum for Nursing, photo G1551.

The speeches (partially reproduced in the article) reveal that the plan to build the 32 district buildings originated in consultation with Swiss donors to ensure a purposeful use of the money. In 1956, 20 buildings had been completed in the province of Zeeland, eight in the province of South Holland, and one in the province of North Brabant (in Klundert). The opportunity was used to improve the facilities: while the land for construction had been donated by local municipalities, the inclusion of public bathhouses in many of the buildings was a novelty that was strongly encouraged.[18]

All in all, the article demonstrates that the Swiss felt their money had been well spent, and the Zeeland community and the Groene Kruis organization expressed their gratitude in every possible way. Many of these buildings continued serving their purpose for decades and in some villages they are still maintained and are in use today.

[18] Toespraak prof. Dr. J.H. Tuntler 1956, pp. 137.

5 CONCLUSION

Managing a heritage collection can be done in many ways and is never static. By studying objects more closely and adding (sometimes newly discovered) context, a new story can emerge that helps legitimize the significance of an object. This is no different for collections relating to the history of (district) nursing. The question of what constitutes a (nursing) object, and how this changes over time, is one historians ask themselves every day.

A good example is this photo series on the opening of district buildings (health centers) in 1956. At first glance, the photos are difficult to interpret in terms of time and context. Only the awarding of the honorary medal or the presence of a commemorative plaque offers a partial glimpse of the backstory. However, when additional material is consulted, in this case, relevant newspaper articles, a relatively unknown story emerges about the Swiss radio broadcasters, their campaign for Belgium, the Netherlands, and England, the solidarity fund Chaîne de Bonheur, and the enormous sum of money that led to the construction of 20 new district buildings in Zeeland.

It is particularly notable that 20 of the 32 planned district buildings were built and operational within three years. This took place only a few years after World War II, at a time when (construction) materials were scarce. The decision to allocate the funds to district health centers also sends a message about the role of district nursing in local health care.

The photo series as a whole can thus be seen as a form of documentary photography with considerable historical value. Although several newspapers wrote about the events, neither newspapers nor magazines published any photographs of the visit; only the Groene Kruis's own journal featured these images. In producing this report, the national association of the Groene Kruis effectively deployed a powerful corporate identity tool to promote itself. The photos were not forgotten in storage; they have been well preserved to this day, but their interpretation and contextualization within the collection could have been better. This reinterpretation provides an opportunity to reposition all 49 photos and link them to the broader narrative of the North Sea flood of 1953.

In short, even within an existing collection, there are still many discoveries and (re)interpretations to be made in order to fully understand the story. New methods and insights continue to emerge and therefore these photos are a nice example of nursing history for Lost & Found. In this particular case, it would be possible to add international perspectives to obtain a full understanding of the historical encounter in 1956 between Dutch and Swiss authorities and representatives of health care organizations, like the Swiss Red Cross and the Dutch Groene Kruis. For this article, only the Dutch side of the story behind this photo collection was researched. For an exhibition or presentation online or on site to mark the 70th commemoration of the official opening in July 2026, the next step would be to explore Swiss archives for additional documentation of the event that took place in the province of Zeeland in 1956, so as to share these new insights into the founding of the district offices, some of which are still in place today.

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