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Nursing Care in Times of Epidemics and Pandemics. Historical and Ethical Issues

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Editorial – Nursing Care in Times of Epidemics and Pandemics. Historical and Ethical Issues

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1 Introduction

Applauded as "silent heroes" on balconies at the beginning of the COVID-19 pandemic, nurses in various European countries spoke out as the pandemic progressed to highlight their precarious working conditions and their importance in combating the pandemic. A number of nursing ethics problems arose from the lack of sufficiently qualified nursing staff in intensive care, the lack of material equipment in hospitals and the inadequate working conditions in long-term care: How can a fair distribution of resources be ensured under pandemic conditions? How do nursing professionals deal with the fact that they were unable to meet the demands for professional and, in this sense, good nursing care? (The keywords "missed nursing care" and "moral distress" may be mentioned here.) How can nursing care do justice to vulnerable and elderly people under pandemic conditions (and, in the future, also in the event of epidemically occurring, dangerous infectious diseases), when their liberties must be restricted for their own protection?

The current pandemic experience has rekindled interest in epidemic history. Revisiting historical research on pandemics and epidemics, one thing in particular stands out: good nursing care is crucial for the survival and recovery of infectious patients whose disease cannot be treated causally. Even though bacterial infectious diseases such as cholera, tuberculosis and typhoid fever have been easily treatable with antibiotics since the 1940s, it is still true today that, for pandemics caused by viruses, professional nursing care plays a key role in the course of the disease and in the prognosis of patients. Unlike the importance of nursing in pandemic control, the role of nurses and their daily work in past pandemics and epidemics has been little studied.

An epidemic history that puts nursing and nurses at the centre of interest examines not only concrete nursing practices but also the knowledge that was necessary to prevent the spread of dangerous infectious diseases. Knowledge of hygiene can still be considered a core competence of nurses today, and it was also evident in the current pandemic.

The fourth issue of the European Journal for Nursing History and Ethics focusses on how nurses have dealt with epidemics and endemic diseases in specific – historical as well as current – political and social settings. The contributions in the themed section range from the experiences of Bulgarian nurses in the typhoid epidemic of the 1930s, discussed by Kristina Popova, to the fight against epidemics in immigration camps for Holocaust survivors, analysed by Dorit Weiss and Hava Golander, to the most recent experiences in the context of the COVID-19 pandemic. The historical contributions are complemented in the open section by an article by Hall et al. on the transfer of the Danish deaconess model to the Faroe Islands.

The cover of this issue already refers to the mask as an iconographic object of the COVID-19 pandemic. The photo is from the first wave of the pandemic in Lombardy, Italy, and is part of

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a collection of narratives about everyday life during the pandemic shared by nurses and midwives across Europe in 2020.[1] The question of how this new materiality of "COVIDwear" has changed nursing practice is explored by Benoît Majerus using the example of Luxembourg. Sabine Wöhlke and Gisela Ruwe examine the specific experiences of nursing students in the hospital setting during the initial period of the pandemic, which was characterised by a high degree of uncertainty. Astrid Eich-Krohm et al. turn to the nursing home setting, analysing the impact of COVID-19 regulations on the relationship between nurses and residents in nursing homes in Germany.

The historical and ethical contributions to this special issue have emerged in light of the researchers' direct experience with the COVID-19 pandemic. In the future, there will probably be a large number of historical studies on this pandemic in which the contribution of nurses can also be addressed, as a large number of documents have been collected that present the experiences of nurses in their own voices.

Bibliography

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[1] European Association for the History of Nursing 2020.

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"…I was thinking, when doing this scrubbing, of Miss Florence Nightingale's barracks…": A Local Typhoid Epidemic in the Correspondence between a Bulgarian and an American Nurse in 1932 (Nevena Sendova and Clara Noyes)

Kristina Popova

Abstract

One of the most important epidemics in Bulgaria in the 1930s was typhoid fever. The research focuses on the description of this disease in a small town in Southern Bulgaria in 1932 in a letter written by a leading Bulgarian nurse, the Director of the Sofia School of Nursing, Nevena Sendova (1895–1987), to Clara Noyes (1869–1936), National Director Nursing Service of the Red Cross in the USA. Together with two of her colleagues and four students from the School of Nursing in Sofia, Nevena Sendova came to the small town of Bratsigovo in order to support local hygiene and anti-epidemic measures and to teach the accompanying students. At that time, the number of professional nurses in Bulgaria was small and there were no local nurses in this town. The letter is a rare egodocument about a local epidemic from the point of view of a nurse. It is part of a large regular correspondence between the directors of the Sofia School of Nursing and the leading nurses of the American Red Cross. These exchanges continued for about 15 years after American Red Cross nurses supported the reform of the Sofia School of Nursing in the 1920s along the same lines as the American education model. While describing the nurses' activities in the two hospitals of the small town during the typhoid epidemic, Nevena Sendova also described the poverty of the local population, its hygiene habits, and the local beliefs and superstitions. Moreover, she recounted what local people were saying about the illness, a topic she considered she ought to bring to Clara Noyes' attention.

Keywords: Typhoid fever, Sofia School of Nursing, Clara Noyes, Nevena Sendova

1 The Reorganization of Nursing Education in Bulgaria after World War I

Professional nursing education in Bulgaria was started by the Bulgarian Red Cross Society in 1900, following several discussions in the 1890s. The Red Cross invited some nurses from Russia – from the Holy Trinity Society (Svetotroizka obshtina), led by Russian nurse Sister Efrosina. A Holy Trinity Society was set up in Sofia, affiliated to the Red Cross Society. It followed the Russian nursing practice of learning, working and living together, which was similar to the German "motherhouse" model. A small hospital with eight beds was opened for the practical training. The course lasted one year, followed by a year of hospital practice, during which the nurses' skills, qualities and abilities were evaluated by the head doctors on

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an attestation form. Qualities like obedience, accuracy and diligence were evaluated. In 1904, a Public Health Law passed by the Bulgarian Parliament formulated the general obligations of nurses: caring for and consoling patients, encouraging their hopes for improvement, and other activities connected to their status of "sisters of mercy".

About 100 nurses graduated from the courses before the Balkan Wars of 1912–1913. Almost all of them served in the hospitals during these conflicts and later in World War I (WWI). Another 1,500 or so voluntary nurses who were trained in short courses also worked as sanitary staff. Many of them served in the military hospital wards for cholera, typhus, dysentery, and other infectious diseases. Many of them became ill and some of the nurses died.[1] A large number of nurses took part in the struggle against cholera and typhus epidemics during the Balkan Wars and WWI. They were appointed to care for typhus cases in the military hospitals. Unfortunately, the scarce documents detailing their activities are insufficient to reconstruct the work and contribution of nurses during this wave of epidemics.

On the initiative of Queen Eleonore of Bulgaria (1908–1917), nursing education in the country was reorganized after 1913. Eleonore von Reuss zu Koestritz was a skilled nurse, who studied in Kaiserswerth in her youth, and managed a sanitary train in the Far East during the Russo-Japanese War (1904–1905). Afterwards, she had a leading position in the nursing institution in Luebben.[2] Eleonore intended to reform nursing education in Bulgaria in line with the American model: a longer course of study with more disciplines, introduction of regular working time and salaries, and more independence in their personal life. For this purpose, she contacted Jean Delano[3] in the USA. After the organizational troubles caused by the war, two American nurses, Helen Scott Hay[4] and Rachel Torrance[5], reached Sofia and the new School of Nursing was started at the Alexander Hospital, run by graduates of the American colleges in the Bulgarian towns of Lovech and Samokov.

After the death of Eleonore in September 1917, work on the new School of Nursing in Sofia was interrupted. Jean Delano also died during a trip to Europe in 1919. But in August 1920, the new National Director of the American Red Cross Nursing Service, Clara D. Noyes[6] visited Bulgaria with Helen Scott Hay to explore possibilities for restarting the school. In October 1922, Rachel Torrance, who assisted Helen Scott Hay in 1915–1916, was appointed Director

1 Popova 2013.

2 In Luebben, Eleonore held an honorary position on the Board of Nurses (Kuratorium der Schwesternschaft) which she gave up in 1907 immediately before her marriage to Bulgarian King Ferdinand.

3 Jean Delano (1862–1919), President of the American Nurses Association and founder of the American Red Cross Nursing Service.

4 Helen Scott Hay (1869–1932), founder of the Queen Eleonore School of Nursing in Sofia in 1916, Chief Nurse of the Balkans Commission of the American Red Cross.

5 Rachel Torrance (1886–1937) was an assistant to Helen Scott Hay and Director of the Sofia School of Nursing 1923–1927.

6 Clara Noyes (1869–1936) was appointed Director of the Nursing Division of the American Red Cross in 1919. More about Clara Noyes, Noyes 2017.

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of the School of Nursing in Sofia. She arrived in the Bulgarian capital accompanied by her assistant, Theodora LeGros[7]. In 1924, Rachel Torrance was replaced by a new Director, Hazel Avis Goff[8], who stayed until 1927. During the early years of the school, some Bulgarian nurses were trained at the Teachers College in New York to take up leading positions in Sofia. The first was Nevena Sendova[9], followed by Krustanka Pachedjieva[10] and many others. Another young nurse, Boyana Christova, participated in the first international course for public health in London. She returned as the first nurse in Bulgaria specialized in public health.[11] Maria Nikolova[12] also graduated from the Bedford School in London.

In her book, Making the World Safe: The American Red Cross and a Nation's Humanitarian Awakening, Julia Irwin researches the politics of the American Red Cross in Europe after WWI.[13] This activity is embedded in the context of the "Progressive Era" in the USA – a time of major sociopolitical reforms in public health and education, the rise of feminism and the expansion of women's public participation. Julia Irwin believes that this was the time when, on the one hand, the American government discovered the value of foreign aid as a means of influence and as part of diplomacy. On the other hand, however, it became part of the self -understanding of Americans during WWI and in its aftermath.

The reorganization in Bulgaria was similar to processes in other European countries after WWI (Czechoslovakia, Poland, Yugoslavia, France etc.). There too, American concepts of nursing education and work were introduced, as experts sought to convince the local authorities that the American standards of the profession were the highest in the world.[14] The profession was defined in a universalist way.[15]

Special attention was paid to the educational level and qualities of the individuals who entered the school. The educational qualifications of the applicants had to "connote sufficient maturity of years and mind to safeguard the school against the extremely youthful persons of unformed character and unstable ambitions." "Nursing," Clara Noyes wrote, "is one of the noblest of vocations and as such not to be entered into lightly or as a stopgap

7 Clara Noyes wrote about Theodora LeGros: "Theodora C. LeGros, a graduate of the General Hospital in Minneapolis, Minnesota, U.S.A [….]. Miss LeGros had served as an Army Nurse with the American Expeditionary Forces, had done medical social service work in Bellevue and from 1919 to 1922 had been assigned to nursing duty under the Red Cross in Romania and Poland."

8 Hazel Avis Goff (1892–1973). Clara Noyes wrote about her: "…a nurse of superior professional attainments and a specialist in school administration".

9 Nevena Sendova (1895–1987) graduated from Teachers College in New York, Director of the Sofia School of Nursing 1929–1934.

10 Krustanka Pachedjieva (1895–), graduated from New York, Director of the Sofia School of Nursing 1934–1940.

11 Boyana Christova organized the first children's ward in Sofia in 1924.

12 Maria Nikolova (1897–1985) graduated from Bedford School. She was a lecturer at the School of Nursing in Sofia, Vice-Director of the school 1934–1935 and the head nurse inspector at the Public Health Department of the Ministry of Health 1935–1944.

13 Irwin 2013.

14 Noyes 1923, p. 3.

15 Lapeyre 2013; Irwin 2013.

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between school and marriage."[16] The curriculum was enriched by the addition of more specialist subjects. Hazel Goff prepared some new textbooks. Boyana Christova prepared a course in public health, and Maria Nikolova taught the new subject of ethics, a topic that Krustanka Pachedjieva also lectured on.

Soon after the school relaunched, a Florence Nightingale Society of nursing was organized, which started taking part in international meetings and congresses of nurses. The Florence Nightingale Society joined the Bulgarian Women's Union, which was the main such organization in the country and led the struggle for women's rights. A newspaper called Sestra ("Nurse") was also launched. It commented on professional topics as well as on the social and cultural life of nurses, and covered international news regarding the profession. Additionally, it described the activity of the School of Nursing.

As a result of the school's reorganization by the American nurses and their Bulgarian students, a new type of nurse with a different professional habitus appeared. The new situation was described by Maria Nikolova, who later wrote a history of nursing in Bulgaria. She distinguished the "new nurse" from the "old type", while also emphasizing continuities:

> Since 1923, another image of the nurse emerged, quite different from the previous one, established in the period 1900–1922. The two differed in their intelligence, professional and general knowledge, methods of work, personal interests, attitudes toward social life, level of culture and social views. The new type of nurse preserved for a long time the qualities and her devotion to the patient, without regarding direct service to the patient as humiliating her – the intelligent nurse. She preserved this attitude which was characteristic of the nurse of the old school, who had less knowledge, but a rich practical experience drawn from her work.[17]

In the 1930s, vocational training for nurses became a more attractive profession and its status in Bulgarian society changed. The field still had to overcome the traditionalist attitudes of local Red Cross authorities and of officials at the Health Ministry. The Red Cross tried to keep the traditional image of nurses as symbolic figures of compassion and charity work.[18] This corresponded also to the traditionalistic and neo-patriarchal tendencies in Bulgaria. Only at the end of the decade did women win the right to vote.

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16 Noyes 1923, p. 3.

17 Nikolova (without year).

18 In 1936, the Red Cross Society prepared a calendar with an image of a nurse on the cover. The president of the society described it as follows: "On the right side, almost in the full part of the calendar the true image of compassion is presented: the fine image of a nurse in white with a red cross on her breast and with eyes looking forward piercing through the troubles of the suffering people, alleviating them through her warm simpathy as well as through the tools that science has created". Circular letter N 5664 from December 5, 1936, Central State Archive, F. 156k, op.1, a.e. 71, p. 127.

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2 The Correspondence

The communication between American and Bulgarian nurses included collaboration in Sofia as well as regular correspondence between the Americans (Rachel Torrance, Hazel Goff, and Clara Noyes) and senior Bulgarian nurses Nevena Sendova and Krustanka Pachedjieva, both during the Bulgarians' apprenticeships and when they became directors of the School of Nursing. Other regular letters maintained the social and professional network: between Clara Noyes in New York and the Americans in Sofia (Rachel Torrance and Hazel Goff), between students sent abroad and the directors etc. This exchange created a network of communication that helped establish and internalize personal contacts and loyalty, develop professional standards, and create female role models. The correspondence was very important in maintaining the women's network of individuals who traveled a lot and often changed their place of work.

Power relationships were part of this communication and they were reflected in the letters. These differences were more obvious in the beginning because the Bulgarians were still students and the Americans were their teachers and leaders, and also decided on the future leadership of the School of Nursing. Writing letters to their American teachers in the initial period, Bulgarians became familiar with professional standards and learned to evaluate new situations and professional challenges according to these standards. The correspondence was also a way to maintain control over the school's activities. In the second period, during the 1930s, once Bulgarians were in charge of the School of Nursing in Sofia, the communication with the American nurses continued and new forms of collaboration were found.[19] Bulgarian nurses stressed in their letters that the school was a "grandchild" of the American Red Cross.[20] Using the same kind of family metaphor, Clara Noyes regarded the Bulgarian school as "a daughter" of the American Red Cross.[21] She was proud "that the work that was done there by our American nurses has borne such good fruit."[22] Such maternalistic discourse was typical of the relationship between "Western" and East European women in international communication in the women's movement at that time, and was supported by both sides. In the correspondence with Clara Noyes, this metaphor continued throughout the years of Nevena Sendova's directorship, which ended in 1934. Krustanka Pachedjieva deployed the same metaphor of "the American Red Cross's daughter" when she took over as Director.[23]

The letters written by Nevena Sendova and Krustanka Pachedjieva to Clara Noyes contain reports on the school's work. They also contain personal information, jokes, and memories of their shared past, meetings, friends and colleagues. The documents comprise a mix of

[19] One of the most interesting forms of collaboration was the Rural Health Center in Golemo Konare Village, which was started by Hazel Goff with Todorina Petrova as her assistant in 1933 to prepare public health nurses for the rural areas. It was also intended to be an institution for international collaboration. The Center was supported by the Rockefeller Foundation.

[20] Letter from Nevena Sendova to Clara Noyes, October 13, 1931, p. 76, State Archive Sofia, Fond 360k.

[21] Letter from Clara Noyes to Krustanka Pachedjieva, January 18, 1935, State Archive Sofia, Fond 360k.

[22] Letter from Clara Noyes to Krustanla Pachedjieva, May 23, 1936, p. 60–61, State Archive Sofia, Fond 360k.

[23] Letter from Krustanka Pachedjieva to Clara Noyes, February 12, 1935, State Archive Sofia, Fond 360k.

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institutional and private narratives that helped maintain not only professional but also personal ties between the Americans and the Bulgarians.

3 Typhoid Fever, 1932

In September 1932, a typhoid epidemic broke out in the southern regions of the country. According to the Director of the Sofia School of Nursing, Nevena Sendova, the Red Cross Society in Bulgaria decided to send four third-year students, led by Todorina Petrova[24] (at that time head nurse at the Red Cross Hospital in Sofia), to help the patients in the small town of Bratsigovo, where they stayed and worked for 40 days.[25]

Typhoid fever was a widespread infectious disease in Bulgaria well into the 1940s:

Diphtheria	Poliomyelitis	Typhoid fever	Typhus	Malaria
60.5	20.8	10.8	2.4	943.6

Rates of the most widespread infections per 100,000 population in 1942[26]

Between 1930 and 1934, typhoid epidemics exploded in Sofia, Plovdiv, Pazardjik, Kyustendil, Haskovo and other towns. The main causes of this situation were the lack of hygiene and especially the insufficient clean water supply for the population.[27] In some regions of Bulgaria, schools were closed. In the small town of Bratsigovo near Plovdiv, about 400 people fell ill in 1932, out of a population of 3,200.[28]

The situation remained critical in other towns too, despite the beginning of immunization campaigns.

Nurses played a key role in the struggle against typhoid fever: They cared for patients in hospitals and assisted with prevention measures as public health workers.[29] Their contribution was very important, especially in the case of sick children: Mary Walton and Cynthia Connolly wrote that "Research on nurses' work at Children's Hospital of Philadelphia

[24] After graduating from Bedford School in London, Todorina Petrova was a teacher at the School of Nursing in Sofia. She was assistant to Hazel Goff. In Golemo Konare Village, she initiated a model health center in 1933 to train public health nurses in rural areas. After Hazel Goff left in 1936 to go to Istanbul, Todorina Petrova became head of the health center. From 1942 to 1944 she was Director of the School for Public Health Nurses in Skopje.
[25] Nevena Sendova to Clara Noyes, the same letter.
[26] Dikov 2012. About 30 years later these diseases had almost disappeared.
[27] Dikov 2012.
[28] Letter from Nevena Sendova to Clara Noyes, December 6, 1932, State Archive Sofia, Fond 360k.
[29] For the important role of nurses in typhoid fever epidemics see Walton/Connolly 2005.

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in the late 19th and early 20th centuries shows that nurses were crucial in the treatment of pediatric victims of the typhoid fever epidemics."[30]

The work of nurses during the epidemics in Bulgaria is underrepresented in historical sources as well as in the historiography. The correspondence between nurses is an important source that can break this invisibility of the past because it reflects the nurses' experiences but also indicates the expectations of the recipients.

Nevena Sendova described the nurses' work in her letters to Clara Noyes. She continued writing letters during the epidemics and was able to provide direct information to Clara Noyes as part of her reports on the work of the School of Nursing in 1932. She took the opportunity to present the growing importance of nurses in Bulgaria.

Nevena Sendova, as Director of the school, together with her colleague Maria Nikolova, joined the students to help and to observe the nurses' work in Bratsigovo. They stayed for eight days. Maria Nikolova visited 40 homes of the sick. Home visits were not only needed to help the patients, but were also established as an important public health measure at that time. The aim was to study, control and advise people (primarily mothers) on how to improve the living conditions and the social situation of their families according to scientific hygienic standards. During their visits, the nurses were confronted not only with the health situation and bad hygiene conditions, but also with the poverty and the living conditions of the local people and with their habits, superstitions and prejudices.[31]

Nevena Sendova described for Clara Noyes the desperate situation that she found in Bratsigovo, where the schools had been turned into hospitals during the epidemic:

> The two school buildings in Bratsigovo were the only suitable places for hospitals. Patients were brought in with their own beds and bedding. You can imagine the sight of a hospital with beds and bedding of all sizes and colors. The people of the town, 3,200 in total (1,800 households), are extremely poor. In most cases, the bedding they possess consists, with very few exceptions, of a faded red, green or brown. There are very few white sheets or pillowcases. Many of the patients lay in bed in their everyday clothes. They were all asked to bring a chair from home (some had to borrow one, because they had none) to serve as a bedside table. Until we got out our own enamel bedpans and dishes, they had dozens of jugs and pots around their beds. There is a big hole in the school yard today where we have buried hundreds of those infected jugs and pots. There is no other way to disinfect them.[32]

In this situation, the nurses from Sofia – Sendova, Nikolova and Petrova – organized work both to help the sick local people and to train their students. Their intervention therefore also had a pedagogical character. The letter emphasizes that some of the people's household belongings – the infected objects – were publicly burned. This is presented as a

[30] Walton/Connolly 2005.
[31] Letter from Nevena Sendova to Clara Noyes, December 6, 1932, State Archive Sofia, Fond 360k.
[32] Letter from Nevena Sendova to Clara Noyes, December 6, 1932, State Archive Sofia, Fond 360k.

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necessary civilizing activity, and as something of which Clara Noyes is expected to approve. Nevena Sendova points out that people needed the nurses' explanations and demonstrations because doctors did not discuss the situation properly with their patients.

At the same time, the nurses presented their work in a symbolical way, both to their patients and to their former American teachers:

> When Miss Petrova and I helped to scrub the floor in the hospital, people looked upon us with great curiosity. They said that what they learned from us in this short time they would remember for many, many years. They were criticizing their teachers and doctors for not having taught them to live more hygienically. I was thinking, when doing this scrubbing, of Miss Florence Nightingale's barracks, and of how she helped to reduce the mortality of the soldiers by cleanliness and I thought also of Miss Hey, who taught me how to do it.[33]

Even when doing the most menial physical work, scrubbing the floor in the hospital, Nevena Sendova relied in her thoughts on the authority of two symbolic figures of nursing: Florence Nightingale, a symbolic figure for all nurses, and Helen Scott Hey, her personal teacher and educator for all Bulgarian nurses. Helen Scott Hey had recently died. Nevena Sendova wrote of her that she was "a friend, a good teacher and a hero nurse, the organizer of modern nursing in Bulgaria".[34]

In her descriptions, Nevena Sendova maintained a cultural distance from the population of Bratsigovo. People were presented in their unhygienic conditions and their ignorance about the etiology of the typhoid epidemic. In contrast, nurses were able to explain the true reasons for their illness and teach them how to live in a more hygienic way. Their actions were enlightened and rational, in contrast to the irrational views of the population concerning the epidemic.

> Miss Nikolova took charge of the patients in their homes. She visited 40 houses and she helped 56 patients. People were very pleased to have her in their homes, where she helped them to follow the doctors' orders and taught the people the cause of the epidemic. They had very erroneous ideas about the disease: They blamed their doctor for it and God too for He had sent the epidemic to them as repayment for the rich crops He had given them this year.[35]

In Sendova's account of the "Bratsigovo case", Bulgarian nurses belonged to a symbolic professional community emulating its leading figures from the past. Those examples helped the Director of the Nursing School to do the work of cleaning without experiencing it as humiliating, and to burn people's belongings in the school yard. Guided by their foreign teachers, nurses managed to "normalize" the situation in the town: the "faded red, green or brown" sheets were removed, the infectious pots were buried. Death rates in the town were

[33] Letter from Nevena Sendova to Clara Noyes, December 6, 1932, State Archive Sofia, Fond 360k.
[34] Letter from Nevena Sendova to Clara Noyes, December 6, 1932, State Archive Sofia, Fond 360k.
[35] Letter from Nevena Sendova to Clara Noyes, December 6, 1932, State Archive Sofia, Fond 360k.

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minimized and Nevena Sendova hoped that in the future "the people will appreciate better the laws of personal hygiene."[36]

The Bulgarian Nurses Association sought to use these achievements and "the psychological moment" of the struggle against the epidemic for public demonstrations and information about caring for typhoid patients. Their activity in Bratsigovo was also invoked at a meeting with the Bulgarian Women's Council (of the Bulgarian Women's Union) to enlighten its members about the profession.[37]

In this way, Nevena Sendova hoped to convince Clara Noyes that Bulgarian nurses were ready to fulfill their duty and serve society. She showed that they had reacted properly in the time of disaster and had managed to make the right decisions. Nurses had internalized the professional norms that they had been instructed in through their study of the American model. Doctors, nurses and midwives often described local hygienic habits as something strange, irrational and "dark". This "othering" of their native people was a tool to strengthen their professional status. Nevena Sendova also observed this distance in her letters. She did not support the image of "the picturesque Bulgarian towns" that Clara Noyes knew from her short visits to Bulgaria, and did not hesitate to present Bratsigovo as an unhygienic place with citizens who believed in strange superstitions.

4 "We are healthy, we see only full days of work before us and even forgot that tomorrow is Sunday…" Typhoid in the Hospital in Haskovo, January 1934

In 1933 and 1934, typhoid epidemics spread again in the southern regions of Bulgaria. Two of the most experienced nurses – Zafira Christova[38] and Maria Lazarova, who were lecturers at the school in Sofia – were sent by the Red Cross to the hospital in Haskovo to assist the struggling local medical staff of 12 doctors, two nurses and two unskilled nurses (Samaritan nurses).

Christova and Lazarova shared their experiences with the school Director, Nevena Sendova. In their letters to Nevena Sendova they described the hospital situation during the typhoid

[36] Letter from Nevena Sendova to Clara Noyes, December 6, 1932, State Archive Sofia, Fond 360k.

[37] Letter from Nevena Sendova to Clara Noyes, December 6, 1932, State Archive Sofia, Fond 360k.

[38] Zafira Christova studied in London in 1930–31 and after returning to Sofia she taught nursing techniques at the School of Nursing. She became Vice-Director of the school at the end of 1934, when Nevena Sendova got married and left the school, and Krustanka Pachedjieva took up the directorship. Zafira Christova replaced Pachedjieva in 1940 and remained Director until 1944.

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epidemic, their work there and their living conditions during their stay.[39] Power relationships with the doctor who was head of the hospital were also discussed in the letters. As Director of the School of Nursing in Sofia, Nevena Sendova was in a position to send reports about the activities during the typhoid epidemic in Bratsigovo in 1932 (to Clara Noyes) and in 1934 found herself receiving reports (from Zafira Christova) during the epidemic in Haskovo. In both situations, she was responsible for maintaining professional standards and the nurses' personal networks.

The town of Haskovo had at that time a population of about 26,000 citizens. Like other towns in Southern Bulgaria, it had problems with its clean water supply. Doctors and other medical professionals considered the lack of clean water the main reason for the typhoid outbreak.

The hospital buildings in Haskovo had been destroyed by a strong earthquake that hit the region in 1928. In the following years, new buildings were erected and in 1936 the number of beds in the wards increased to 300. Because of the lack of financial support, furnishing the new buildings proved very difficult. According to the annual reports of the hospital, supplies of food and medicines for patients were also irregular in the 1930s.[40]

The two nurses, Christova and Lazarova, arrived in Haskovo by train on January 25, 1934, and were met at the train station by the hospital administrator and a local nurse. Without having the possibility to see the town, they were taken straight to the hospital. They wished to have a separate room to live in there, but there was no space and they were accommodated together with a midwife in a hospital room described by them as a store for physiotherapy devices. They could not rest properly because the room-mate's shifts were different from theirs:

> The room we have is in a nice, hygienic building, sunny all day but, as soon as we manage to sleep, the midwife is called – at 11.30 at night, or at 3 o'clock in the morning – because of a birth.[41]

They also described the low quality of the food ("horror", "indescribable", "I bristle thinking about it") and water.

In the beginning, there was some disagreement about the division of work with the hospital head doctor, who said that he "didn't want generals in his hospital".[42] The matter was resolved and the two parties reached an agreement on the organization of medical services. Discipline in the hospital was very strong: "The hospital is like a military zone," they wrote. "Nobody is allowed to leave ."[43]

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39 Here their second letter is cited. Their first letter from Haskovo is not preserved in the archive but it is mentioned in the second letter.

40 Haskovo State Archive, Fond 27k.

41 Letter from M. Lazarova and Z. Christova to Nevena Sendova, January 27, 1934, State Archive Sofia, Fond 360k.

42 Letter from Lazarova and Christova to Nevena Sendova, January 27, 1934.

43 Letter from Lazarova and Christova to Nevena Sendova, January 27, 1934.

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The two Sofia nurses were responsible for the severe cases ward with 45 children, and they alternated night and day shifts, each lasting 12 hours. The child morbidity and infant mortality rates in Bulgaria were still very high in the 1930s. The educational programs of the Sofia School of Nursing placed emphasis on measures for improving children's health and the need to train public health nurses for the children's wards.

When they arrived at the Haskovo hospital, the two nurses noted the poor conditions in the children's ward. There were no sheets for the children's beds and young patients were lying on "bare tarpaulin".[44] The nurses asked the hospital at least for "short sheets" for the children's beds so that they could be changed regularly but there were none available, so they asked Nevena Sendova and the Red Cross to send some old sheets for the Haskovo hospital.

Zafira Christova expressed in the letter her concerns about the hospital conditions for sick children: "It is poverty, poverty, a horror!"[45] The connection to the school in Sofia was very important to Christova and helped her solve many practical problems: She asked Sendova for nurses' apron dresses and slippers. However, what she sought above all was professional understanding and support.

Like other letters in the communication with the School of Nursing, these letters were a mix of informal and professional information. Nevena Sendova (the Director), Maria Nikolova, Todorina Petrova, Zafira Christova, and Maria Lazarova were young women from the same generation; they were friends and colleagues, but their letters were primarily about the service they had been sent to perform.

Their aim was not only to help in the hospital, but to initiate improvements in the way the institution's activities were organized. Zafira Christova wrote:

> What we did: We took the ward into our own hands, we mobilized, organized the shelves: syringes, thermometers, mouth instruments, laboratory devices; the common making beds, removing every paper cover, designating responsibilities for certain services: all day, from 6 to 19.30 with a little break after lunch… The work is too much, hindered by many obstacles and with little help to motivate us.[46]

The nurses described the cleaning of the children's mouths as especially exhausting. Typhoid disease caused changes in the digestive functions and system and was characterized by, among other symptoms, dry, cracked or swollen lips, with a brown or gray crust, which was painful for the patients, especially for children. This crust had to be regularly removed. Christova wrote: "When I am getting up from a child whose mouth I have cleaned, it is very hard to straighten my waist. And there are so many of them!"[47]

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44 Letter from Lazarova and Christova to Nevena Sendova, January 27, 1934.
45 Letter from Lazarova and Christova to Nevena Sendova, January 27, 1934.
46 Letter from Lazarova and Christova to Nevena Sendova, January 27, 1934.
47 Letter from Lazarova and Christova to Nevena Sendova, January 27, 1934.

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Fatigue was also part of the hospital work during the epidemic. The nurses were tired and suffered from headaches. But the hard work was something they found young nurses had to get used to. Lazarova and Christova missed their students who could learn to work in extraordinary situations: "How I regret that the probationary class is not here to see how to clean mouths, how to do dozens of injections."[48]

During their service in Haskovo, both nurses demonstrated to their Director, Nevena Sendova, that they had not lost their optimism. Despite the 12 to 13-hour shifts, the lack of rest and sleep, and the poor living conditions, they expressed a positive attitude toward their stay. Zafira Christova summarized their everyday life in the hospital: "I and Sister Lazarova are healthy, we eat more bread, drink tasteless water and laugh from time to time."[49] At the end of the letter she adds: "I repeat, for now we are healthy, we see only full days of work and even forgot that tomorrow is Sunday."[50]

Laughing "from time to time", the two nurses kept their distance from the troubles in the hospital.

5 Conclusion

The two letters present important moments in the nurses' experience during the typhoid fever epidemics between 1932 and 1934, and give us the opportunity to hear their own voices. These are voices of elite nurses in leading positions at the Red Cross School in Sofia, who represented the "new type" of educated "intelligent nurse". The documents provide information about the trends in the nursing profession in Bulgaria at that time. Nevena Sendova, Todorina Petrova, Maria Nikolova, Zafira Christova, and Maria Lazarova did their best to represent the Red Cross Society's School of Nursing through their work. Their descriptions present hard work: how they scrubbed hospital floors, cleaned rooms, organized instruments, gave hundreds of injections, cleaned children's mouths, changed bed sheets etc. without proper rest. They also exercised their power: visiting patient homes and checking hygiene conditions, instructing local people, and burning infected pots in the school yard. They did not see their service as "humiliating" them. They also defended their independence to take decisions and plan their work. Feeling that they were part of a wider nurses' society was also an important source of their positive attitude.

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48 Letter from Lazarova and Christova to Nevena Sendova, January 27, 1934.
49 Letter from Lazarova and Christova to Nevena Sendova, January 27, 1934.
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Nurses from Here – Epidemics from There. The Encounter between Nurses from Eretz Israel and Holocaust Survivors Abroad, in an Effort to Eradicate Epidemics and Morbidity 1945–1948

Dorit Weiss and Hava Golander

Abstract

Throughout history, wars and epidemics have been interrelated, as are *immigration* and *health problems*. At the end of the Second World War (WWII), Jewish survivors of the Holocaust wandered across European countries hoping to find living relatives. Many of them were gathered in temporary displaced persons camps operated by the Allied forces and humanitarian organizations. The survivors were in poor health, exhausted physically, emotionally, and morally, and suffered from a variety of contagious diseases. The purpose of this article is to shed light on the roles, experiences, and contributions of the nurses "from here" – Eretz Israel – who volunteered as emissaries to care for their Jewish brothers and sisters wherever needed.

Our study followed the nurses through three different immigration camps between 1945 and 1948. First, in the displaced persons camps (DP camps) for Holocaust survivors in Germany ("over there"). Next, in the detention camps in Cyprus, where the British held refugees caught trying to enter Eretz Israel without the correct immigration papers ("over there"). Lastly, a short glimpse into the complex reality the nurses faced within the absorption camps for new immigrants in Israel ("back here"). The nurses' ingenuity and resourcefulness made up for the lack of means and infrastructure in eradicating epidemics and caring for the immigrants. In the light of the current trends of mass immigration and global pandemics, the discussion focuses on potential lessons that can be learned from the unique Israeli experience of integrating immigrants and overcoming epidemics.

Keywords: Nursing History, Immigration, Epidemics, Israel, Eretz Israel, Holocaust Survivors

1 Introduction

1.1 Background and Rationale

Throughout history, *wars* and *epidemics* have been interrelated, as are *immigration* and *health problems*. Israel is a relatively young state, established in 1948, which already has a long, unique and impressive record in absorbing mass waves of immigration, and overcoming a variety of imported and endemic epidemics. In fact, the essence of the Zionist movement was to fulfill the old dream of the ingathering of exiles and the return of the children of Israel to their homeland.[1]

At the end of the Second World War (1945), Jewish survivors of the Holocaust wandered across European countries hoping to find living relatives. Many of them (around 250,000) were concentrated in temporary displaced persons camps (DP camps) and other residential arrangements in the American and British Occupation Zones in Austria and Italy, and particularly in Germany. The camps were operated by the Allied

[1] Jeremiah, 31:16.

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forces and humanitarian organizations.[2] The survivors were in poor health, exhausted physically, emotionally, and morally after years of hunger, torture and forced labor in concentration camps, or ghettos, or from constantly hiding and fleeing from Nazi persecution.

In addition to the poor hygienic conditions, the survivors suffered from a variety of contagious diseases (TB, typhoid, scabies etc.), extreme malnutrition, and post-traumatic stress disorders.[3] They were not welcome in their previous neighborhoods, nor did they have homes to return to. Furthermore, they were not allowed to start a new life in a different country. They could not go to Israel, as Palestine/Eretz Israel[4] at that time was still under the British Mandate and operated a closed-border policy. The United States also operated an immigration restriction policy.

The survivors were imprisoned again in an impossible dead-end situation. They pleaded for help in despair: "We were saved, but have not become liberated as of yet."[5] The pre-statehood Jewish community in Israel (the *Yishuv*) felt they had a duty to rescue, cure and rehabilitate their fellow surviving brothers and sisters, but actually had very little to offer apart from good will gestures, as they themselves were under British restrictions. Nevertheless, between 1945 and 1948, the Yishuv sent about 400 emissaries *(Shelichim)*, men and women, to prepare the survivors for their future life in Israel while also providing humanitarian help.[6]

The purpose of this article is to shed light on the roles, experiences and contributions of the nurses who volunteered to leave their families for a period of about two years to care for their Jewish brothers and sisters wherever needed. We describe the nurses' experiences in eradicating epidemics within the camps and helping the Holocaust survivors at three different sites on their long and draining voyage to Israel: first, right after the war in the DP camps in Germany; then, after being caught as illegal immigrants, back in the detained immigration camps in Cyprus, and finally – after Israel's independence – shedding some light on the condition of immigrants' health within the newcomers' absorption camps in Israel. We will discuss the dilemmas and the long-term effects that the treatment of epidemics had on the immigrants, the care providers, and the nursing profession, and offer some insights and suggestions for dealing with the current interaction of global pandemics and mass migration of refugees.

1.2 Methods

Documenting the historiography of nursing practice in general presents methodological difficulties, especially when it is practiced in unstructured, dynamic circumstances, as in the topic under study. First and foremost, it is generally agreed that nurses are better doers than writers; secondly, because of the transient nature of the camps the

2 Rosenberg-Friedman 2007, pp. 121–155.
3 Schein 2010, pp. 10–11.
4 Israel was called Eretz Israel (or Palestine) during the British Mandate of 1917–1948.
5 The pleas of the imprisoned survivors in the camps: "Allow us to reach to the last corner of hope – Israel". In: "Davar" newspaper, September 3, 1945.
6 Schaary 1981, pp. 28–35.

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documentation of the events is incomplete, not kept in one place, unorganized and difficult to access. Thirdly, little has been previously written about the role of the Eretz Israel nurses in helping the Holocaust survivors, so we focused our studies on exploring, documenting, and publishing their unique contribution to nursing and to the history of the country. Fourthly, most of the existing literature sources are in Hebrew and not accessible to an international audience. This paper is therefore the first exposure of the original testimony of nurses dealing with the extreme reality of immigrants, epidemics and distress, providing lessons which are also relevant to the present global situation.

In searching for relevant information, we relied on a variety of sources, including our own previous extensive historical research.[7] The additional relevant materials included official texts, letters, official reports, protocols, press cuttings, and journals. The study is also reliant on written memoirs and oral history interviews. The use of oral testimonies is vital in providing support for issues described in other sources and for shedding light on subjects not documented in writing.[8]

2 The Nurses in Service of the Holocaust Survivors within the DP Camps

Before 1912, there was not even one registered nurse in Eretz Israel. It was Hadassah, a voluntary organization of Jewish American women, which established the first nursing school in Jerusalem in 1918 and developed progressive public health services. Toward the end of 1943, the Jewish community in Eretz Israel (the *Yishuv*) started to understand the shocking magnitude of the Holocaust in Europe. During the graduation ceremony at the Hadassah Nursing School, Ms. Kantor, the director, referred to the sacred mission that nurses would face after the war:

> Do not forget how much work we'll have when our brothers and sisters, the remains of the victims and saints, will begin their arrival in masses. A lot of the responsibility for their absorption will be placed on our shoulders.[9]

In a nursing journal, Ms. Mohliver anticipated the complexity of the forthcoming challenge. She wrote:

> The expected absorption of our brothers will be bloody – they are refugees of sword and starvation, injured in their bodies and souls. For such immigration, we nurses need to prepare and train ourselves to bring remedy to the souls and bodies of these tortured brothers.[10]

7 Weiss 2022; Golander/Brick 2008.
8 Rosenberg-Friedman 2008.
9 Speech by Ms Kantor at the Hadassah graduation ceremony, December 21, 1944, The Central Zionist Archives, 5/II165.
10 Ms Sara Mohliver, The Building of Eeretz Israel. In: The Nurse, December 22, 1943, The Central Zionist Archives, J117/282.

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Shortly after the war ended in Europe (1945), several humanitarian organizations volunteered to help the Allied military forces, which evidently did not have a clear policy as to what to do with the growing numbers of refugees, or how to handle the disastrous sanitation and personal hygiene, the overcrowded housing, the need to feed, manage, and care for these "walking dead people".[11]

Among these organizations were the United Nations Relief and Rehabilitation Administration (UNRRA), and several Jewish bodies were involved in the American Jewish Joint Distribution (JDC) and the "Welfare Platoon" *(Ploogot Hasaahad*) formed in 1944 by the Jewish Agency.[12] The first Eretz Israeli nurses who volunteered to treat the Holocaust survivors in the DP camps belonged to the two latter organizations. They were well experienced in public health thinking and techniques. They dealt with comprehensive urgent problems, performed health screenings, improved the survivors' living conditions, treated typical common diseases (TB, ringworm, scabies, etc.), and improved the survivors' health and welfare.[13] We will elaborate on three significant nurse figures representing two different aid organizations.

2.1 Nurses as Emissaries of Care: Ms. Rebecca Lyons

Ms. Rebecca Lyons, later better known as Prof. Beccy (Rebecca) Bergman, was nominated to be the Chief Nurse for the American JDC in the American Zone of Germany (1946–1948). The JDC, commonly called the Joint, was established in the United States in 1914 by a small group of wealthy Jewish philanthropists, and later became the largest and most effective Jewish relief organization, capable of managing several projects simultaneously around the globe. The JDC's ideology is to respond to distress and the emerging needs of Jewish people wherever needed. Its motto – "rescue, relief, and reconstruction" – was expressed in various ways: establishing soup kitchens during WWI, distributing food packages and helping refugees escape from Nazi regimes during WWII. The Joint's strategy has always been to cooperate with and help local communities, with the agreement of the relevant governments. The Joint financed infrastructure and the operation of services inside and outside the DP camps, and provided food, medication, transportation, professional services, and training as needed.[14]

Prof. Rebecca Bergman (1919–2015) was chosen for the position in Germany due to her previous experiences of caring for refugees in the British detainee camp in Atlit, where illegal immigrants who arrived by ship were held. In 1944, Prof. Bergman joined the Middle East Relief and Refugee Administration (MERRA), a British aid organization which set up temporary tent cities in the Sinai Desert in Egypt to care for 40,000 Yugoslavian and Greek war refugees, mainly children, women, and the elderly. The combination of the desert heat, a lack of sanitation, and overcrowding led to outbreaks of disease and epidemics. Prof. Bergman successfully stopped the spread of measles by transforming an abandoned aircraft hangar into a children's hospital for isolation.

11 Keynan 1996, p. 11.
12 Yahil 2016, pp. 30–31.
13 Rosenberg-Friedman 2007.
14 Golander/Brick 2008, pp. 1–12.

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Without speaking their languages, she demonstrated to the sick children's relatives how to treat them effectively.[15]

Prof. Bergman demonstrated the same creativity, sensitivity, and flexible thinking in the Atlit detainee camp that she had exhibited in finding efficient and versatile solutions for endless deficiencies and complications in Germany when she was barely 27 years old. Within the chaotic atmosphere that prevailed in Germany after the war, she succeeded in creating "something out of nothing". Prof. Bergman and her driver searched for and found essential valuable medical equipment in deserted warehouses, and converted empty buildings into equipped medical and dental clinics. She cooperated with local Jewish communities to trace and take in orphan children and the sick and infirm. She translated pamphlets and essential information into Yiddish and encouraged the survivors to take advantage of the new network of medical and relief services that had been opened for them. In order to overcome the manpower shortage and the survivors' idleness and apathy, she organized a short training course for nurses' assistants and recruited physicians and nurses from among the survivors. During the two years she spent in Germany, she set up and assembled a range of essential health services that treated thousands of survivors and prepared them for their arrival in Israel.

Prof. Bergman shared her experiences and published her letters concerning her work with the Holocaust survivors in Israeli journals.[16] In her memoirs she specifically mentioned accompanying a group of tuberculosis survivors on a trip from Munich to the sanatorium in Davos, Switzerland. Another memorable experience was the month she spent with the people of the Exodus after they were shipped back to Germany. She was impressed by their strength and determination and treasured the Exodus membership card of honor she was awarded by their leader.[17] She also documented tough memories, the emotional distress, the voices of joy and/or devastation when the survivors found out what had happened to their loved ones during the war. "There was so much tragedy that it almost became the norm."[18]

In 1948, she left her post in Germany to take on another challenging assignment in Israel. When the War of Independence broke out, she was drafted and assigned to open and head a frontline military hospital in Jerusalem. Later on, she became the chief nurse of Malben-Joint, a philanthropic organization that cared for elderly, disabled and infirm newcomers across Israel. She initiated and led the academization of nursing education and chaired the first nursing department at Tel Aviv University. Prof. Bergman became an international leader and carried out official roles as the second Vice-President of the International Council of Nurses (ICN) and as a World Health Organization (WHO) consultant for developing countries. She was presented with many prestigious prizes and awards. Prof. Bergman is the first and only nurse to be

15 Bergman 2000, pp. 5–6; Golander 2009.
16 Lyons 1946, pp. 12-14.
17 Bergman 2000, p. 11.
18 Bergman 2000, p. 8.

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awarded the nation's highest honor, the Israel Prize, for her life-long contribution to society and the nation.

As mentioned above, the pre-state administration in Eretz Israel, the Jewish Agency, responded willingly to the survivors' plea for help and organized the Welfare Platoon. Between 1945 and 1948, a total of about 400 emissaries, men and women, volunteered to serve for a minimum period of one year in the DP camps, most of them in the American Occupation Zone in Germany. The camps were under the authority of the Allied forces, while UNRRA provided the everyday necessities and the relief services for the survivors.

After seven months of bureaucratic barriers, it was finally agreed that the Welfare Platoon's emissaries would function independently but within the framework of UNRRA and would wear UNRRA uniforms. The emissaries' official role was to prepare the survivors for their future lives in Eretz Israel, while also providing humanitarian aid. In practice, each emissary carried out his/her assignment differently according to their understanding, abilities, and circumstances.

Of the 132 identified emissaries reported by Keynan (1996), about half were women, equally divided between mothers and those without children. A breakdown by profession showed that they were mostly educators and people with experience in childcare. Very few came from the health care system. These included four nurses, one psychologist, one physician and six social workers.[19] We were able to trace three out of the four nurses, all of whom came from *kibbutzim* (communal settlements in Israel, typically agricultural).

The first known nurse to be sent for the missions in Austria and Germany was Rebecca Linkovski. However, we chose to report the work of Zvia Lahar and Tzila Rosen, as their experiences were better documented, supported by memoirs, letters, oral interviews, and some personal acquaintances. Their narratives reflected the major concerns and challenges they faced in caring for Holocaust survivors and the emotional burden they experienced.

2.2 Mrs. Tzila Rosen

Tzila Rosen (1903–1972) was born in Bukovina, Romania, came to Israel as a young pioneer in 1926, and was one of the founders of Kibbutz Sarid. She was trained in childcare and development and later completed her professional education in nursing. She specialized in pediatric nursing. The kibbutz ideology was the influencing spirit in those days and children's welfare and socialization was of the utmost importance.

According to the kibbutz doctrines of those days, the collective interest of the group and the nation took precedence over individual preferences. Therefore, to free up the parents for their communal chores, and to provide the children with the best possible care and socialization, the kibbutz children were raised together with their age group in communal children's homes within the kibbutz. Every afternoon, after work, the

[19] Keynan 1996, p. 132.

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children spent several hours of quality time with their parents, but most of their daily care was provided by a trained childcare worker (nanny). She cared for them, watched them when they were sick, and monitored their vaccinations.

Tzila headed the health and development activities of all the children's homes in her kibbutz, guided the childcare workers and cooperated with other health agencies on behalf of the children. Because of her expertise, she was called in to participate in relevant national assignments: She cared for the "Children of Tehran" – a special group of about 700 children, mostly orphans who escaped from Poland during the war and who were finally brought to Israel through Tehran in 1943 with the help of the British army. These children were cared for in the Atlit detainee camp and Tzila was called to head the nursery and children's homes of this fragile group.[20]

In 1947, when she was 44 years old, and already a mother of three children, she joined the Welfare Platoon and was sent to Germany to open mother and child clinics in coordination with UNRRA in the DP camps. In her ongoing reports and letters, she reported special actions and events, together with her impressions from her mission. Her writings reflect the fragile complexity of the mission and the encounter between the two different world views.[21] She describes, with deep sympathy, the significance that children had for the lives of the survivors. Many of them had lost their babies during the war and were eager to rebuild new families and a new life for themselves. She pointed out the very high birth rate in the camps, as well as the difficulties that arose in raising these precious children within those circumstances. At the same time, she was critical of the behavior of the mothers. In her diary she wrote (May 2, 1947):

> Today 12 mothers visited the mother and child clinic. The main problems are their bad practices that need to be uprooted, mainly concerning nutrition: All children are breastfed without any regulated schedule. The mothers keep the babies by their breast during the whole night. They continue breast feeding even beyond the age of 1½ years. Artificial food is given against all the accepted wisdom of modern medicine. Vegetables and fruits are rarely given to the kids. People are suspicious and don't trust the things they're "given." There's so much that needs explaining to these mothers. They need tutoring even in basic and general things about nutrition, how to hold the baby, personal hygiene [...].

She also added: "Today we finally received a baby's weighing scale. It is a huge progress."[22]

Toward the end of her assignment, she proudly wrote to her friend in the kibbutz (March 14, 1948) from the city of Kassel:

> So far, I've set up six mother and child clinics [...]. I've mentored nurses both at work and through lectures [...]. We employ German doctors and this is itself an issue [...]. We have many cases of rickets, the most difficult

[20] A Mother and a Nurse 1973, p. 44.
[21] A Mother and a Nurse 1973, p. 44.
[22] A Mother and a Nurse 1973, pp. 45–46.

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> cases are among the children of Romanian Jews, who have wandered for many months from place to place. Among the older kids there are a lot of rotten teeth, lice, itching and skin problems [...]. Among the survivors in Germany, we have about 8,000 disabled people, invalids and people with chronic disabilities. They will not be accepted as emigrants in any other country. We will be obliged to bring them to Eretz Israel, but first they must be cured here and taught a vocation according to their capabilities [...].[23]

Upon her return to Israel, Tzila Rosen continued to hold leadership positions and initiated new national projects. She founded the national Health Committee for the kibbutzim, whose goal was to formulate a unified health policy for the kibbutzim and serve as a platform for information exchange and mutual learning. In 1949, she founded the Nursing School of the Kibbutz Movement.[24]

2.3 Mrs. Zvia Lahar-Hershkovits

Another emissary nurse who played a crucial role was Zvia Lahar-Hershkovits (1915–2011). Zvia was born in Bialystok (Russia/Poland) and emigrated to Eretz Israel with her family at the age of 8 (1923). She later joined the Jewish defense organization (*Haganah*) which was a paramilitary organization (1920–1948). Zvia had a long and impressive record of participating in various operations and was wounded in one of them. She joined the Kibbutz Giv'at Brenner and graduated from the Hadassah Nursing School. After the death of her husband, a soldier in the Jewish Brigade within the British forces, she volunteered to serve in the DP camps. In the light of her previous achievements, she was assigned to head a DP camp in Germany (1945–1948).

A collection of her letters was published in a book entitled "Buds of Hope" (2002). In her letters she described the complexity of the survivors' lives. The longer they stayed in the camps, the more ambivalent they became towards the emissaries from Eretz Israel. On her arrival in the DP camps, it seems that both sides held high expectations: "They (the survivors) waited for us to bring the gospel of *aliyah* (emigrating to Eretz Israel),"[25] while she herself wrote that she was thrilled with the honor and the responsibility of serving the survivors as a manager of the camp. However, the reality she faced was gloomy and disappointing. On September 2, 1947 she wrote from Ulm, Germany:

> The food supply was cut in half, it is extremely cold, the black market is booming. They exchange everything bought or stolen. It is hard to blame the survivors. These people are hungry. They are cold in their body and soul. Our promises have not been fulfilled. There are no permits (to enter Eretz Israel). There is no work. The only thing they can do is to trade with each other [...].[26]

[23] A Mother and a Nurse 1973, p. 44.
[24] A Mother and a Nurse 1973, pp. 31–32.
[25] Lahar-Hershkovits 2002, p. 20.
[26] Keynan 1996, p. 154.

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Zvia was also especially concerned with the Romanian Jews' situation:

> The pressure from the Romanian Jews is seriously mounting. They came with nothing on them. They suffer from many acute and chronic illnesses, pulmonary and intestinal diseases. Their transport to Germany was a disaster [...] endless walking, no one to lead them. Someone threw the people on the trucks, including the babies [...] they were driven around almost aimlessly [...] they changed their route with every rumor about Russia closing its borders.[27]

Zvia played an important role in the "escape operation" (*Habricha*), the organization of illegal emigration to Israel, mainly by sea. On her return to Israel, she continued to serve in meaningful leadership positions within the national Health Committee for the kibbutzim and the Israeli Nurses' Union.[28]

3 The Nurses in the British Detention Camps in Cyprus

The detention camps in Atlit (in Eretz Israel), Mauritius, and Cyprus were transit camps which were opened by the British Mandate authorities to imprison the 85,000 immigrants who attempted to enter Eretz Israel without permits. For political and diplomatic reasons, the British authorities had limited the number of immigration certificates for Jewish applicants to Eretz Israel during 1920–1948. The situation worsened still further when the sixth updated version of the White Paper (1939) restricted the number of permits to only 15,000 a year for five years. As the persecution of Jews dramatically intensified in German-occupied Europe during the Nazi era, the urgency driving the immigration became more acute.

This limited supply of legal permits was nowhere near enough to meet the rising demand, especially after the war. Several Zionist organizations worked together to facilitate the immigration of refugees even without permits. During the post-war era (1945–1948), the collectively organized Habricha escape efforts succeeded in shipping 70,000 Holocaust survivors from different ports in Europe to Eretz Israel on 66 ships. Altogether, by the time the state was established, about 120,000 emigrants had entered the country this way. Over half of the shipments were stopped by the British patrols. Most of the intercepted immigrants were sent to detention camps, first in Atlit, and Mauritius (1940–1945) and, when these became overcrowded in 1946, they were shipped to Cyprus (1946–1949).[29]

Weiss (2002) studied the nursing care in these detention camps. The study describes the organization and the practice of nursing in each camp, and compares the camps in Mauritius, Cyprus, and Aden (British camp for Yemeni Jews).[30] As most of the European immigrants were deported to Cyprus, we will present a short description of the

[27] Lahar-Hershkovits personal letter from Munich, November 30, 1947, Ghetto Fighters' House Archive, RM 23306.
[28] Lahar-Hershkovits 2002, p. 79.
[29] Naor 1991, pp. 110–118; Bogner 1991, pp. 13–15, 36–40.
[30] Weiss 2002.

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health challenges faced by the team of nurses from Eretz Israel who served in the Cyprus camps.

Overall, about 52,000 deportees were sent to Cyprus on 39 ships. Most of the deportees were born in Poland and Romania, some came from Bulgaria and North Africa. They were settled in temporary camps that had previously been used by the British army. The "summer camp" mainly consisted of a group of tents surrounded by barbed wire. The "winter camps" had tin cabins and were therefore considered to afford somewhat improved living conditions. The British army provided the essential supply of water, food, basic daily needs and medical care. However, the provisions were insufficient, and the conditions were harsh and not suitable for a civilian population. One can only imagine the depth of the survivors' despair and frustration when their dreams of a new life in their new homeland were shattered, and they were forced to adjust again to life in a detention camp.

3.1 The Medical Condition and Treatment of the Detainees

Most of the Cyprus deportees were young and relatively healthy, as they had previously been medically screened for the voyage. Yet, right from the beginning, 15 cases of open tuberculosis were detected and a similar number of old tuberculosis. There were also cases of typhoid fever, and diarrhea was common, as were scabies and pediculosis. Most of the health problems stemmed from the poor conditions in the camps: no running water, few toilets, overcrowding, and poor nutrition.[31]

Following an official visit by the medical delegations of the JDC and the Yishuv, management of the medical service in the camps was transferred to the JDC. Gradually and systematically, the JDC financed and directed its effort towards improving the poor living conditions, expanding the health services, and enriching the psycho-social wellbeing of the deportees. The delegates from Eretz Israel played a significant part in these operations. They set up children's homes and youth camps, taught them Hebrew and music, provided vocational training, and exposed them to Judaism and the modern Israeli culture and spirit.

3.2 Nurses and Nursing within the Detention Camps

The very first medical delegation sent to the camps included two nurses from Hadassah Hospital: Ms. Ahuva Goldfarb and Ms. Gotha Gostinski. The initial idea was that they would not replace the British team, but rather focus on medical examinations and screening of the refugees, in a manner similar to that operating in the DP camps. But in the light of the devastating conditions, the neglect, and the high incidence of wounds and abscesses, they changed their original plan completely.[32] They adapted barracks into clinics, and tents into small hospitals (patients' rooms). They rearranged the medical supplies and equipment, allocated suitable places for the nursery and the kitchen, as well as for the health staff's housing. They trained nurses from among the

[31] Schaary 1981, p. 138.
[32] Weiss 2002, p. 216.

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deportees to work in the hospital. The need for proper nutritional food was identified as an urgent concern as it was insufficient and unappetizing. On the recommendation of the Hadassah hospital staff, the JDC began providing food supplements.[33]

The nurses played a comprehensive and pivotal role in the refugees' lives in sickness and in health (2,200 babies were born on the island). They felt pride in their contribution to the assistance provided to the detainees, and sympathized with their hardships. In their letters, they described the unbearable conditions on the island.

Ms. Ahuva Goldfarb was a public health nurse. She had previous professional experience with refugees in the Atlit camp. She served two terms in Cyprus and later volunteered to work in the temporary refugee camp in Aden. She described the depressing visual and spiritual atmosphere that prevailed in Cyprus upon their arrival.

> Wooden cabins without a floor. There is not a single tree to be seen. Everything is colored gray and brown. Masses of people are wandering aimlessly around the camp, doing nothing. They wear worn shirts, and short pants supported by rope belts. They walked barefoot, and a state of degenerate indifference overcame all.[34]

Another senior nurse sent to Cyprus was Ms. Ida Wissotzky. She received her diploma in nursing from Warsaw. Almost everyone in her family perished in the Holocaust. She saw the mission to Cyprus as a fulfillment of a dream, the first front line of Zionism. She was especially sensitive to the resilience of the orphaned children.[35] She summarized her thoughts and experiences from Cyprus in a newspaper article in January 1979:

> Almost every one of them had spent six years in a German concentration camp and/or a British camp, and did not know that somewhere there is a life in which death and terror are not found [...]. These children who were born in the ghettos or European refugee camps had never seen a field, a tree, a life [...].[36]

In general, aside from several expert and influential nurses, most of the nurses who served in Cyprus were young and new to nursing or childcare. They went straight from the protective environment of the school in Eretz Israel to the demanding constraints of the camp. They faced young people the same age as themselves – but with long and tragic life experiences. They argued that even though they had been thoroughly prepared for their work, no one could foresee the reality that they would have to face in the camps.[37] Almost immediately upon their arrival, they had to act resourcefully, improvise, and find creative solutions. The set of difficulties which piled up in front of the nurses was almost discouraging in its severity. Yet they continued to pursue their

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33 Weiss 2002, p. 217.
34 Nurses Tell 1968, p. 49.
35 An article by Ida Wissotzky "Winter – Cyprus 1947", published in: Al Hamishmar newspaper, Hotam supplement 1979, quoted in: Henigman 1983, pp. 16–17.
36 Henigman 1983, p. 21.
37 Weiss 2002, p. 324.

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mission even under these almost impossible conditions. Something of what they faced can be learned from nurses' memoirs published in a booklet of Hadassah graduates. One of the nurses wrote:

> From August to November of 1946, I worked in Cyprus. Behind a barbed wire fence, I saw poor human skeletons wandering around with dissatisfied faces from inaction. Many of them are bereaved parents and orphaned children who have not yet experienced the meaning of a family. The weather is bad. It is humid, hot and stuffy in the summer, and cold and very wet in the winter. There is no electricity, nor flashlights. The people are living in tents, several families share one tent. Drinking water is rationed, five liters per person.

She added that they opened a “humble” nursery in an old building. Washing the diapers in the salty sea water caused severe irritations for “these feeble babies”. They asked for an extra amount of sugar water, which the nurses kept in special locked boilers. The food was limited and dull. The nurses supplemented the families with egg powder, soaps and combs. She concluded that even in such tough circumstances the refugees made special efforts to restore normalcy as much as possible.[38]

In conclusion, the major health problems presented by the deportees resulted from poor sanitation and hygiene. Wounds, skin rashes, widespread furunculosis, and burns were all treated by dressings and medication. Scabies and pediculosis resulted from the combination of poor living conditions and the difficulty of washing clothes and blankets. Spraying with DDT was an essential and common treatment in the camps. Tuberculosis patients were quarantined in the island’s hospital. Heart disease, diabetes, and digestive problems were related to nutritional deficiencies, and were also treated through various diets and vitamins. The young neophyte nurses implemented principles of public health nursing, preventive medicine, community and emergency nursing in their practice.

3.3 Back to the Homeland to Face New Challenges

On their return to Israel, many of the nurses from Cyprus followed the newcomers and worked at the absorption camps in Israel. Others returned to their previous workplaces. The former chief nurses of the Cyprus camps, who had been carefully screened and chosen for their demanding position in the detention camps, grew to assume top leadership positions following their mission in the camps. Several refugees, who were care assistants on the island, continued their professional training in one of Israel’s schools of nursing. As for the refugees, with the final evacuation of the camps in February 1949, the detention chapter of their lives finally ended, but the next chapter saw them enduring the absorption camps in Israel.

[38] Nurses Tell 1968, pp. 50–51.

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4 Epilogue – Nursing in the Absorption Camps in Israel

With the termination of thirty years of the British Mandate, and the declaration of the State of Israel (May 14, 1948), the new state had to face two formidable tasks simultaneously: fighting the War of Independence while absorbing masses of new immigrants. During the second half of 1948, in the midst of difficult battles, Israel absorbed 102,000 new immigrants, a sixth of its entire Jewish population, in 20 improvised absorption camps.[39]

At the end of the War of Independence (July 20, 1949), the young state addressed the urgent task of assuring free Jewish immigration. Within three and a half years the population of Israel doubled: 650,000 people absorbed nearly 700,000 new immigrants from dozens of places in the diaspora – a rate of absorption unprecedented in the world.[40]

The ingathering of the Holocaust survivors and the evacuation of the DP camps was a promissory note that had to be redeemed. To a great extent, the distress and danger to which Jews were subjected in their native countries dictated the order of priority followed when selecting waves of immigration ("immigration of distress" vs "immigration of rescue"). Challenges included addressing the unique personal and cultural characteristics of the immigrants. The majority of the first newcomers were very poor, in ill health, with high morbidity rates due largely to infectious diseases. A large proportion of the children and older persons, especially from Yemen, suffered from extreme malnutrition and dehydration. The percentage of disabled people, those with mental illness and chronic illness, was relatively high. About 10% of the immigrants suffered from a disease which necessitated immediate hospitalization. In addition, in 1949 a polio epidemic broke out throughout the country and lasted for a decade.[41]

Furthermore, during the early years of immigration, Israel did not have sufficient manpower, resources or hospital beds to treat and isolate patients with contagious diseases. The immigrants' health issues became a focus of political and social debates. The division was between those who called for a reduction in the rate of immigration from countries with high morbidity, and those who demanded first the improvement of their health in one of the transit camps located in France, Italy and Germany. Those camps were operated by the JDC and other relief organizations. In contrast, others sided with those who wanted to bring in as many immigrants as possible, for fear that the window of opportunity would close.

The full account of how Israel managed to eradicate the epidemics and absorb the newcomers from diverse cultural backgrounds into the "Israeli melting pot" is beyond the scope of this paper. Nonetheless, there is an important lesson to learn from Israel's multicultural experience.[42]

39 Sicron 1986, pp. 32–52.
40 Golander/Brick 2008, pp. 4–5.
41 Stoler-Liss/Shvarts/Shani 2016, pp. 11–12.
42 Stoler-Liss/Shvarts/Shani 2016, p. 14 (Ben Gurion diary, citation no. 13).

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Providing proper care to these selected groups presented a huge challenge for several reasons: First, their illnesses demanded special expertise, which the Israeli doctors and nurses did not possess. Second, in contrast with other refugee groups, there were some from developing countries who lacked their own health personnel to lead them and mediate their needs to the establishment and provide support. Third, language differences, communication barriers and women's literacy seriously affected health education and social interactions. Fourth, vast cultural differences and modern health illiteracy posed barriers to treatment. Fifth, the idea of providing health care in the absorption camps using the total care model ("efficient kibbutz model" as in Cyprus), was foreign to the immigrants and often undesired.[43] The nurses played a pivotal role in overcoming these barriers. They were committed, creative and skillful soldiers in the battle to eradicate epidemics and improve the immigrants' health.

Most of the nurses who worked in the camps were young and inexperienced and either volunteered or were sent by their health agencies. During their interviews, they described the creative solutions they used to facilitate communication and enlist the immigrants' cooperation (using gestures and demonstrations, compiling a dictionary of useful terms in different languages, using an intermediary, etc.). They had painful memories of their experiences of holding a dying baby in their arms, and not being able to help. Another nurse remembered the screams of a sick child while she gave him the painful known treatment for ringworm. Living in the absorption camps, they shared the same difficult living conditions, and were often infected with the same contagious diseases. Despite their difficulties, they took enormous satisfaction and pride in their mission. In fact, following our interviews, several of the nurses are writing their memoirs.[44]

5 Discussion and Implications

What can be learned, in retrospect, from this unique Israeli experience of integrating immigrants and overcoming epidemics during the early years of the post-WWII era? Furthermore, what is the relevance of these experiences to the current trends of immigration and pandemics? And finally, how is nursing related to these two interrelated phenomena?

Our study followed the practice of nurses "from here" (Eretz Israel) through three different immigration camps during the short period between 1945 and 1948. First, in the DP camps for Holocaust survivors in Germany ("over there"). Next, in the detention camps in Cyprus, where the British held refugees who attempted to enter Eretz Israel without the correct papers ("over there"). Lastly, a note about challenges faced by both the health care providers and the new immigrants within the absorption camps in Israel, ("back here"). We argue that – in spite of the immense differences between the camps, the diversity of the residents' characteristics and the health needs that the

[43] Stoler-Liss/Shvarts/Shani 2016, pp. 150 (citation no. 2, 3); HaCohen 1994, p. 200.
[44] Personal interview: Malka Grebler, 2019, 2022 (Pardes Hana), Yael Gilad, 2019, 2022 (Hod Hasaron).

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nurses faced – there are many similarities between the essential approaches and strategies they followed.

5.1 Nurses' Contributions

Nursing has a social mandate and a proven historical record of eradicating epidemics and achieving remarkable outcomes by applying a preventive medicine philosophy and health promotion techniques.[45] Styles (1982) believes in the critical importance of the *sense of social significance*, both for the personal development of nurses and for the profession.[46]

In that spirit, the nurses from Eretz Israel demonstrated the utmost confidence in the nation's task of ingathering its fellow brothers and sisters from exile and establishing a homeland in Israel. They volunteered to be sent on extremely demanding missions abroad and/or at home, while paying a high personal price. Often their health was affected, their personal safety endangered, and their own families' needs were neglected. They were totally committed to accomplishing their assignments. Referring to nurses and physicians,[47] two major interrelated goals were identified in their "battle for the nation's health":

1. To participate in the national effort of helping the immigrants become Israelis. In accordance with the "melting pot" dogma and the public health principles, the care providers encouraged the immigrants to adopt Israeli patterns of behavior and thinking. The intent was not cultural extinction but a desire to build a nation and a healthy young new generation (the social mandate).

2. To save lives, prevent the spread of epidemics, lower infant mortality etc. (the curing mandate).

In retrospect, the nurses helped to successfully achieve both the social mandate and the health mandate. Indeed, toward the end of Israel's first decade, most of the serious health problems that endangered the country were treated and resolved. Tuberculosis, malaria, polio, and syphilis almost completely disappeared. Polio vaccinations (Salk and Sabin) eradicated the polio virus. The incidence of ringworm, trachoma and gonorrhea dropped drastically with the development of new antifungal ointments and antibiotics. The rate of infant mortality decreased due to mother and child clinics, which were successful in assimilating health education techniques, increasing the hospital birth rate, and providing nutritional and health services in schools.[48]

5.2 Strengths and Pitfalls

There is a general lesson that can be learned from analyzing both the strengths and the weaknesses of the accumulated Israeli experiences of integrating immigrants and

45 Crowan Novak 1988, pp. 80–87.
46 Styles 1982, p. 123.
47 Stoler-Liss/Shvarts/Shani 2016, p. 265.
48 Stoler-Liss/Shvarts/Shani 2016, p. 291.

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fighting epidemics. We will refer to the organization of care services, the perspectives of the recipients of care, and the development of the nursing profession.

Considering the harsh conditions, in which the health personnel had to react swiftly to complex situations, their ability to find creative solutions, improvise, and get organized quickly were critical for achieving their goals. However, although these intuitive successful techniques could be effective and appropriate in resolving sporadic and local problems, they were not sufficient as a general plan to rely on. In effect, successful solutions and insights which were formulated in one camp were not necessarily passed on to another camp, nor were the recommendations translated into a deliberate policy of action.

Another characteristic of the camps' organization of services was the multiplicity of voluntary and philanthropic organizations that took part in the provision of a wide range of essential health and welfare services. The advantages of multiple organizations cooperating and complementing each other are obvious, yet this situation could also lead to deficiencies, duplications, and the absence of a leading plan of action. In fact, one could argue that an over-reliance on philanthropic organizations to provide full-scale services is undesirable as it could lead to reducing the state's responsibility.

The very fact that an entire country is enthusiastic about absorbing and assimilating masses of immigrants in its territory is a rare phenomenon in itself. Nurses and other health providers devoted considerable effort and thought to finding the best possible means to cure the immigrants and help them become independent and productive citizens. Given the lack of infrastructure resources and the harsh living conditions within the different camps, the centralized model of providing care, which was common and somewhat similar to the one practiced in the kibbutzim, seemed to be the best model for medical and financial effectiveness. Babies were treated and cared for in nurseries, tuberculosis patients were sent to temporary sanitariums, and children with ringworm to designated care centers. Care was basically regimented and centralized.

During those stormy days, little attention was given to the care recipients' traditions, feelings, or preferences. Mistakes were certainly made – but mainly from a lack of knowledge and with good intentions. It was only years later that some of the immigrants' voices of frustration were heard and documented, describing what they perceived as paternalism and poor cultural considerations.[49]

Nurses, both as individuals and as a profession, made a significant and unique contribution to the achievement of overcoming epidemics and absorbing the newcomers. Undoubtedly, the days of great immigration increased the recognition and prestige of the nursing profession, especially in the light of the shortage of physicians. The number of nurses increased dramatically through the recruitment of immigrant nurses and by opening new programs and nursing schools to train licensed practical nurses and registered nurses.

[49] Sternberg 1973, pp. 161–164; Alfi 2018.

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The increase in the supply of nurses came at the expense of the profession's composition. In 1949 the majority of nurses (71%) were Registered Nurses (RNs), but by 1963 only 41% were RNs, compared with 59% Licensed Practical Nurses (LPNs).[50] The nurses' place in public health improved, but the academization of nursing weakened.[51] This goal of academizing nursing, which was raised as early as 1922, was finally achieved in 1968, when Prof. Rebecca Bergman opened the first department of nursing at Tel Aviv University. It took that long to be implemented "because there was always something more pressing on the agenda".[52]

5.3 Migration, Pandemics and Global Implications

The links between epidemics and mass immigration are not only of historic interest, but have currently become a global burning issue.[53] In fact, since 2005, and especially in the last decade, the number of refugees and economic migrants in the world has jumped by 100% to reach 80 million people globally, according to UNHCR[54] or 40 million according to Eyal.[55] A great deal of the increase relates to refugees who have escaped war zones, yet the majority are undocumented migrant workers who arrive from developing countries to seek a better life in modern welfare states.

With globalization, transferable diseases can easily develop into epidemics and pandemics. Immigrants, especially asylum seekers, are often particularly vulnerable to contagious infections, both as spreaders and as victims, due to pre- and post-migration risk factors.[56] Pre-migration factors include torture and refugee trauma, which may result in mental and physical illness. The refugees often come from conflict areas, with inadequate access to health services. Post-migration factors include detention, length of asylum procedure, language barriers, and a lack of knowledge about the new health care system. Prevalent physical problems include tuberculosis, HIV/AIDS, hepatitis A and B, parasitic diseases, and non-specific body pains. Mental health problems include depression and post-traumatic stress disorder (PTSD).[57]

Migrants are especially at risk in the current COVID-19 pandemic. Many live in densely packed quarters and rely on low-income jobs where it is impossible to implement social distancing. They may have limited access to personal protective equipment and healthcare and have higher rates of conditions that contribute to COVID-19 complications.[58] In light of the pre-migration difficulties and the many barriers to vaccination rooted in their unique status, it is crucial to solve this problem globally. Teerawattananon and his group report on their experience in vaccinating undocumented mi-

50 "Nursing in Israel." Ministry of Health: Report of 1963.
51 Weiss/Boretz-Peles 2014; Miller 1996, p. 12.
52 Zwanger 1995, p. 13. And also The Council for Higher Education, 11 March 1985, pp. 39–42.
53 Teerawattananon et al. 2021.
54 United Nations High Commissioner for Refugees (UNHCR) 2020.
55 Eyal 2018, pp. 193–195.
56 Norredam/Mygind/Krasnik 2005, pp. 285–286.
57 Norredam/Mygind/Krasnik 2005, p. 285.
58 International Organization for Migration (IOM) 2019.

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grants in Singapore and Thailand. They call for a collective effort for a global vaccination alliance, as well as for each country to be accountable for vaccinating those living within its borders, including undocumented migrants.

> […] this is a challenging task. However, all nations must work together to protect the vulnerable and extend healthcare to everyone, for "no one is safe, until everyone is safe".[59]

Shallish (2020) actually proposed a conceptual-practice model for coping with outbreaks of infectious diseases in waves of immigration like those that the world is currently facing. Her model is based on lessons learned from her historical research on the eradication of tuberculosis in Israel.[60] The model refers mainly to the immigrant as a potential spreader of infectious diseases. The "four arms model" (meaning helping hands) is an organizational outline which consists of four consecutive and complementary stages/directions that governments are advised to follow:

1. Preliminary actions to *prevent* the outbreak of the disease, which should be taken *before* entering the country (i.e. medical screening, isolation and treatment).

2. Taking essential *preventive* measures immediately on arrival and *before* immigrants are *assimilated* into the general population. This includes maintenance of strict hygiene conditions, social distancing, digital registration and data sets, medical treatment and vaccination, culturally sensitive health education and instruction, and centralized management of care.

3. Recruiting and training of suitable personnel, knowledgeable about and responsive to the immigrants' specific needs and culture.

4. Actions to *assimilate* immigrants in the general population. This final stage translates into providing counseling and support services to avoid the segregation of migrants and facilitate their genuine integration into society.

The encounter between mass immigration and epidemics is not just a medical problem, but rather a complex combination of political, social, economic, cultural and health phenomena, with significant potential implications that can be either positive or harmful. Nurses are in a unique position to make a difference to the health of immigrants and the wellbeing of society. In fact, there is a growing need to develop refugee health nursing as a specialty. Desmyth and her friends, employed by various Australian agencies for refugee health programs and services, refer specifically in their editorial article to refugees, but their descriptions also fit other categories of immigrants.[61] The authors believe that the key roles of this specialty are providing primary care that is culturally responsive, promoting health literacy and empowerment, and advocacy for these patients within healthcare systems. They state that such a specialty

[59] Teerawattananon et al. 2021.
[60] Shallish 2020, pp. 190–199.
[61] Desmyth et al. 2021.

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demands a vast extent of specific knowledge, understanding and skills, including immunization, oral health, nutrition, infectious diseases and parasitology, family planning and mental health.

Looking back on the practice of the young and dedicated nurses who cared for the Jewish immigrants in the different types of camps – the obvious conclusion is that they did in fact perform the actions proposed by the model.[62] They intuitively fulfilled most of the desired key roles expected of an advanced nursing specialist.[63] Their heroic practice should be unveiled, their story should be told, and their contributions should be cherished in the history of nursing and the Israeli nation.

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[62] Shallish 2020, pp. 190–199.
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"COVIDwear" and Health Care Workers. How Has the New Materiality of Clothing Affected Care Practices?

Benoît Majerus

Abstract

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

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

1 Introduction

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

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

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

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1 Strasser/Schlich 2020.

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

3 Sandelowski 2000; Atzl and Artner 2019.

4 Labrum 2012.

5 Bates 2012.

6 Buse/Twigg 2018.

7 Lamont/Molnár 2002.

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

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

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

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

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

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

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

Biographies of interviewees used in this article[15]

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

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

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

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

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

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

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

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

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

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

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

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

2 Boundary Objects

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

14 Lair-Hillion 2019.

15 The interviewees choose if they wanted their identity to be anonymised or not; names with an asterisk have been anonymised.

16 Jacobs/Richtel/Baker 2020.

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

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

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

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

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

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

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

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17 Belorgey 2016.
18 Arborio 2012.

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

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

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

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

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

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

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

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

[19] Thießen 2021, pp. 75–80.

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

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

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

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

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

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

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

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

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

3 Sensory landscapes

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

3.1 Seeing and Hearing

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

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

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

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

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

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

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

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

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

3.2 Time

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

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

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

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

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

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[20] Torresani/Liefgen 2010.

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3.3 Bodily Marks

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[24] Savage 1995.

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

4 Conclusion

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

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

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

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

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

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

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Uncertainties and Coping Strategies among Nurses During the First Wave of Covid-19 in Germany – Nursing Students' Use of Diary Entries to Document their Experiences during the First Wave of Infections in the Covid-19 Pandemic

Sabine Wöhlke and Gisela Ruwe

Abstract

Background: In March 2020, German hospitals were preparing for the first major wave of Covid-19 infections, implementing crisis management procedures without precedent or prior testing. At this time, we asked student nurses in their eighth semester of study to complete a nursing diary for a period of four weeks. The aim of this research was to ascertain students' perceptions of the constantly evolving crisis and retrace their reflections on the situation on the basis of the knowledge they had at the time.

Methods: Eleven students completed a nursing diary, which entailed writing entries on the care they provided on the wards to which they were assigned. They added images such as pictures, screenshots and drawings to their diary entries. We analysed the data using ethnographic methods as follows: a) categorisation of the entries in accordance with general thematic similarities; b) comparison of the entries with published nursing literature from this time period, with the aim of identifying possible gaps in the content of our data.

Results: The student nurses worked on different wards; some volunteered to staff the newly established Covid-19 wards. Nursing students felt the unfolding crisis to be defined by a sense of uncertainty and potential threat, associated with various fears. The students described their own actions and behaviour in specific situations and outlined observations of others. We categorised our findings in four sub-topics: a) crisis management; b) the invisible crisis; c) a sense of crisis; and d) coping with the crisis.

Discussion: In giving insights into the day-to-day work of nurses under extreme conditions, the diaries collected and analysed for this study highlight experiences of ambivalence and uncertainty during the first wave of Covid-19 infections. Specifically, the students' reflections on professional responsibility point to this principle's importance within the system of values espoused by members of the nursing profession.

Keywords: 1st Wave of COVID-19 Pandemic, Student Nurses, Experience, Qualitative Empirical Research, Germany

1 Introduction

The impact of the Covid-19 pandemic on medicine, nursing, policy, the economy, cultural life and ethical reflection has been a dramatic one.[1] In March of 2020, Germany, like other countries, found itself facing a level of crisis not seen since the end of the Second World War. Task forces came into being at local, regional and national level, charged with drawing up emergency and infection control plans for in- and outpatient healthcare.[2] Preparatory action in-

1 Coronavirus Disease (COVID-19) Pandemic, https://www.who.int/emergencies/diseases/novel-coronavirus-2019.

2 Giese 2020, pp. 103–105; Petkovic 2020, pp. 41–43.

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cluded arrangements for the distribution of personal protective equipment (PPE) and the conversion of hospital wards into 'Covid wards'[3], on which, at this stage of the pandemic, nursing staff volunteered to work.[4] During this period, it was impossible to predict the effects of this first wave of Covid-19 infections on the working situation for nursing staff in Germany, or the potential risks to them.[5]

The serious, long-term staff shortage in the nursing and care sectors exacerbated the pandemic's impact on these areas in Germany.[6] The country's hospitals attempted to respond using crisis management procedures never previously put into practice.[7] As the pandemic gathered pace, reports of PPE shortages, a lack of psychological support for hospital staff, and incidents including the theft of disinfectant and sanitiser fed into significant levels of uncertainty and anxiety among those working in these settings.[8] Social media served as a catalyst for the frustration experienced by numerous nurses at this time, and the increasing severity of staff shortages in all areas of care for seriously ill Covid patients engendered a sense of overwork and overwhelm.[9] Recruiting staff for Covid wards proved no easy task; financial incentives were unable to resolve this issue in areas where staffing levels were already strained.[10] Ward teams were split up or their composition changed, losing the cohesion they had maintained up to this point.[11] The pandemic highlighted a notable lack of support for nursing staff in Germany as they sought to manage the risk of collapse in the health sector, conscious of the severe shortage of nursing staff. It further demonstrated and considerably amplified the urgent need for reform in the German healthcare system.[12]

Notwithstanding structural problems in hospitals, the ethical challenge of 'stepping up' in uncertain times such as a pandemic situation remains one faced ultimately by nurses themselves; moral stress may ensue if they find themselves unable to take on this responsibility. This phenomenon remains observable despite the social change continuously in progress since the 1980s, with its concomitant crises and corresponding impact on the societal handling of risk.[13] Crises of all kinds carry a threat to the structures underlying the societies that undergo them. Failure to manage such exceptional situations will deplete public trust in the ability of institutions to solve problems that arise, an effect in which the Covid-19 pandemic has provided an object lesson.

The status of the nursing profession as a distinct group in its own right[14] is a necessary aspect of its professional identity and entails the exercise of responsibility in a number of contexts

3 Garbe 2020, pp. 32–34.
4 Fromm 2020, pp. 106–108.
5 Hellige 2020, pp. 15–17; Giese 2020, pp. 103–105.
6 Fatke et al. 2020, pp. 675–681; Stetzenbach et al. 2020, pp. 4–7.
7 Hunlede et al. 2020, pp. 10–14.
8 Ernst et al. 2020, pp. 57–59.
9 Wöhlke/Hartwig 2020, pp. 123–126.
10 Jansen 2020, pp. 53–56; Gundolf 2020, pp. 27–32.
11 Garbe 2020, pp. 32–34; Fatke et al. 2020, pp. 675–681; Begerow/Gaidys 2020, pp. 33–37.
12 Giese 2020, pp. 103–105; Klie et al. 2021; Ullrich 2020, pp. 8–11.
13 Beck 1986; Ullrich 2020, pp. 8–11; Pelz et al. 2020, pp. 38–40.
14 For the purposes of this article, we define 'nurses' as nursing professionals who have completed either a course of vocational nursing training lasting at least three years (as remains the most frequent case among qualified nurses currently working in Germany) or a nursing degree.

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and arenas.[15] This responsibility stems from the nursing profession's collective commitment to and adherence to a specific set of values, enshrined in the ICN Code of Ethics, which govern nurses' actions at work and which require nurses to uphold, simultaneously, the principles of empathy and professional distance; altruism and self-care; and critical reflection on their work, alongside efficiency. The high standards inscribed in these demands find explicit expression in legislation, regulations and guidelines and take implicit form in the particular trust people place in the work nurses do. Such professional values, of course, form only part of what the nurse's role entails; a further core component thereof is the increasing expectation on nurses to possess, apply and reflect on up-to-the-minute specialist knowledge in their field.[16] 'Responsibility', in the sense of accountability, thus attaches fundamentally to all nurses; its facets encompass causal responsibility (i.e. who has caused a particular problem), responsibility for the consequences (whose 'fault' it is), the attribution of responsibility (who is made accountable for what has happened), and distributed, organisational responsibility (how responsibility is shared among the actors involved).[17]

Responsibility, of course, also has a moral aspect; it references concepts such as commitment and duty, as well as engaging the process of arriving at a moral decision. Professional responsibility, thus conceived, incorporates a duty to care for oneself and others, yet extends far beyond this intra- and interpersonal level, encompassing an obligation to other professions to account for one's actions. Professional responsibility, then, rests on the basis of a collective and organisational responsibility.[18] In light of the situation in which nurses found themselves during the first wave of Covid-19 in Germany, the moral decision to acknowledge professional responsibility and act accordingly raises issues around how we conceive of what is morally 'good', around how we define the principles which we set to govern our actions, and around the extent of our – or specifically, nurses' – freedom to take our (their) own decisions, which, even prior to the pandemic, had been subject to severe limitations imposed by structural conditions. This article will explore nurses' perspectives on the principles affecting their professional radius of self-determined action in their care for acute Covid-19 patients. In an exploratory study that took place at the outset of the first wave of Covid-19 infections, we sought to ascertain the extent of practising hospital nurses' preparedness to work in the extreme conditions presented by the pandemic situation; specifically, we were interested in nurses' reflections on their professional responsibility in this context and setting. Our work has an expressly experimental character, having taken place during a period of time unlike anything we have seen since the last major pandemics of the 1950s and 1960s. Viewed from today's vantage point, our approach reveals limitations in the depth of the data our participants generated and, ultimately, in their capacity to stand as representative of the situation at the time. Our intent in this article is therefore not so much to present a definitive portrait of nurses' experience in this period, but rather to cast light on the promising potential of a participatory, stakeholder-based methodological approach to empirical research around matters of ethics.

15 Ulrich et al. 2010, pp. 2510–2519.
16 Wöhlke/Leinweber 2022, pp. 117–131.
17 Tronto 1993.
18 Responsibility thus defined entails a professional's awareness of their own spheres of responsibility, including their boundaries and limits, in clinical interaction with members of other professions and within hierarchically defined distributions of tasks and roles. Cf. Gastmans 2006, pp. 135–148.

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2 Methods

At the outset of the first wave of Covid-19 cases in March 2020, we asked students in the eighth semester of a cooperative degree course in nursing, who were taking a course module on 'extended reflective practice', to complete a nursing diary over a period of four weeks.[19] The purpose of this task was for students to document their experience of the emerging crisis situation, which at that time was evolving daily. The use of diaries for data collection is currently on the rise in empirical research on health, most typically for recording information on working practices.[20] Asking research subjects to complete diaries is a method that has found little use in nursing research to date; it is nevertheless, in our view, eminently suitable for collecting information on participants' views, subjective emotional states, and experiences of specific situations. Diaries, as qualitative data, can serve to record people's thoughts and feelings, particularly in highly personal, emotionally charged, or challenging situations. Recent work taking a phenomenological approach provides exemplars of the capacity of diary writing to generate substantial and illuminating insights on the relationship between emotion and self-reflection.[21] Potential drawbacks of the method include its dependence on participants completing the diaries regularly and comprehensively, and variance in subjects' ability to express themselves in writing.

We employed this method in the context of structured reflection conducted over a four-week period, with the aim of documenting and exploring the incipient first wave of Covid-19 in March 2020 and the response to it in terms of infection control. Eleven students on a cooperative nursing degree programme[22] completed a nursing diary over a period of four weeks, from mid-March to mid-April 2020. We asked them to make an entry daily, specifically from a nursing perspective, and set no maximum or minimum length for entries.[23] The diaries constituted a requirement for successful completion of the module.[24] Students submitted them to us at the end of the four-week journalling period, enabling us to review the data and devise a rough set of thematic categories. We observed considerable variation as regarded the length of the diaries (between 12 and 68 pages of A4) and the depth of reflection in evidence. In the final session of term, we discussed and evaluated our pre-analysis with the students. All participants gave written informed consent to the publication of their diary entries under pseudonyms. This exploratory study has not been through an ethics committee approval process.

19 Diary writing as a method of collecting empirical data should not be confused with the 'care diary' (*Pflegetagebuch*) completed by people requiring care and their relatives for the purpose of documenting their needs, as provided for in Book XI of the German Social Code.

20 Jones 2000, pp. 555–567.

21 Bedwell et al. 2012.

22 At the time of data collection, the student body of this cooperative degree course comprised both those taking the degree to complete their initial nursing training and vocationally qualified nurses studying for the degree alongside their position as a nurse.

23 Ross et al. 1994, pp. 414–425.

24 The module was assessed through a number of different types of assessed task. One of them entailed completing the diary and giving a brief presentation to the class on its content. We were aware of this study's experimental character and of the fact that participants were simultaneously completing an assessed part of a course module. We communicated all this candidly to students at the outset and permitted anyone who did not wish to participate to complete a written paper for their assessment instead. The institution was likewise aware of these arrangements.

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The phenomenological analysis of the diaries, in line with the nursing-based methodological approach taken, centred the participants' lived experience and their perceptions of the situations in which they found themselves.[25] We sought above all to identify and ascertain the reality of the Covid crisis as our participants viewed it during this period, with the ultimate aim of recording their experience of the events, objects and phenomena that comprised their professional lifeworld.[26]

The initial stage of the analysis entailed us reading each of the eleven diaries. During this, we identified common factors and divergences, which a second reading subsequently examined more closely and critically in the context of nurses' reports[27] from this period, with the aim of revealing any aspects of the crisis which the diaries omitted.[28] Four central thematic categories for analysis emerged from this stage of the work: 1. Crisis management in the hospital setting; 2. The 'invisible' crisis: the unknown threat posed by the pandemic; 3. A sense of crisis: how participants perceived people around them (colleagues, patients, relatives) in the changed clinical setting; 4. Coping with the crisis. The participants further described a variety of ways in which they relaxed and decompressed outside of work. Following this stage of the work, we set out these initial findings to the students and engaged in a critical discussion of them. Each participant chose an excerpt from their diary to read to the group and assigned it to one of the four categories, with help and advice from us, where required. The findings we will discuss below consist largely of participants' descriptions of their experiences and perceptions.

The open approach required by our method of phenomenological observation, and our commitment to deriving our categories from the empirical data, debarred us from including the concept of responsibility as a distinct category in the analysis. To do justice to the centrality of responsibility to nursing ethics,[29] we incorporated the concept into our considerations via Joan Tronto's work (1993) on responsibility and the ethics of care, on which we drew for our ethical and empirical analysis[30] of the participants' experiences and views.[31]

3 Results

The nursing profession is inextricably intertwined with the principle of care work. Nurses' experiences of the pandemic's early stages, as set out in our participants' nursing diaries, point to aspects of this period, and of its significance, that the rapid pace of events makes it difficult to access retrospectively. The diaries detail nurses' reflections on the value of nursing as providing various forms of care and caring in times marked by profound uncertainty, in which it seemed almost impossible to maintain authentic relationships of caring in the day-to-day provision of nursing care. Further, the diaries uncover the ethical considerations that nurses view as having relevance to healthcare. The participants' sense of being in a situation where 'care' was regaining its core, now somewhat archaic, meaning of worry and concern, left them

25 Schütz/Luckmann 2003; Raab et al. 2008.
26 Thomas/Pollio 2002, pp. 183–184.
27 These reports related exclusively to nurses' experiences in Germany; an example of their sources is the journal *Pflegewissenschaft*, which has published special issues on the pandemic (2020).
28 Van Manen 2022, pp. 77–79.
29 ICN Code of Ethics 2021.
30 Wöhlke/Schicktanz 2019, pp. 424–427.
31 Vosman/Nortvedt 2020.

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feeling, at the outset of the Covid-19 pandemic's first wave, that their lives consisted in a complex moral and emotional relationship with their professional responsibility.

In March 2020, the students were working on various wards in a large acute hospital. Some of them volunteered to staff the newly established Covid wards, while others remained where they were. The participants described numerous situations that were new to them and frequently associated with uncertainty and a sense of potential threat. The diaries consisted of descriptions of their own behaviour and actions and those of others, reflections on events, fragmented thoughts; they had a collage-like character, incorporating visual means of communication such as pictures, screenshots and drawings alongside text.

Our analysis of the diary entries identified four key themes, which we have outlined above and which we will refer to, in short form, as 'crisis management', 'the "invisible" crisis', 'a sense of crisis', and 'coping with the crisis'. In the period from mid-March to mid-April of 2020, nurses, including our participants, found themselves on unprecedented alert for a degree of threat not experienced since the major pandemics of the 1950s and 1960s, although Germany was ultimately spared the feared worst-case scenario – the collapse of its health system due to factors such as overwhelming patient numbers entering hospitals.

3.1 Crisis Management: The Unsettling Disruption of Routine Work on the Wards

The category of entry most frequently in evidence in our participants' diaries is that of 'crisis management'. The students recorded an 'inside view' of life in the hospital as it struggled to contain an unknown virus. In the period between 15 and 30 March 2020, the entries principally describe an atmosphere of teams trying to 'keep it together' (as the structures around them changed, dissolved or fell away). The previously established principles of order and structure on the wards, such as working routines, rotas, hospital hierarchies, care procedures and assigned areas of work, were disrupted. Rotas could no longer be relied on, exposing nurses with children to a particular level of additional emotional strain. Patients were transferred to other wards; planned admissions did not take place. Wards were rearranged and rededicated; tasks redistributed; the offer of risk supplements to wages sought to motivate nurses to work on the new Covid wards. One entry describes a conflict between the nurse's family responsibilities and the professional responsibility of someone working in the healthcare system:

> A lot of nurses are staying at home for safety, for fear of putting themselves at risk. On the one hand it's understandable, but on the other it's a systemic and attitude problem. After 4 nightshifts, I'm sitting here today logging straight back into my online lectures. I'd been looking forward to a sunny weekend to decompress. But no, yesterday already I got the call to say that I had to go in. Of course I thought briefly about saying no. But I can't, my responsibility to my patients and colleagues wins. (9FN)

A nurse at the beginning of her career described leaving the children's wards and starting in intensive care:

> "We'll train you up this Monday and Tuesday and then you can start – don't worry, it'll all be fine." [words of the charge nurse to the diarist] I think, yeah, sure, of

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> course it'll all be fine. Like everything has to be fine in hospitals. I wrote down every part of every task on a piece of paper I had with me. Hoping I hadn't forgotten anything important. Am I ready now? No; I knew full well that I actually hadn't a clue. (7FN)

Further uncertainties arose from working in newly formed or rearranged teams whose members' roles and remits were not clearly defined:

> On late shift today (…) 2 staff from theatre, 1 staff member from dermatology, and a nursing assistant [from another different ward]. Nobody on the late shift has had [the new documentation system] explained to them (…) I have to show 3 colleagues how to use the telemetry system. (1FE)

As the diaries indicate and our students confirmed in reflection sessions in class, 'keeping it together' includes maintaining emotional composure and resisting the urge to run away. The diary entries on this topic are ambivalent in character, revealing a mixture of astonishment at what is happening to the diarists' familiar working environment before their eyes and a mounting sense of unease at the 'invisible' threat facing them. One entry notes:

> Now there's security at all the entrances to the hospital, and they're only letting members of staff in, who show their ID. The hospital's closed off to everyone else. (11FE)

Signs and notices appearing daily on the ward detailed the infection control requirements: "There's info up everywhere" (11FE). By the end of March, masks had become mandatory for all staff and patients at the hospital; the lack of adequate amounts of PPE to cover all areas and wards posed a fundamental threat to the nursing staff. Issues and dilemmas arose in the matter of interactions with patients, with nurses experiencing the continuous mask-wearing as highly limiting in this regard. They report constantly weighing up whether to break the rules and conduct specific nursing interactions without a mask:

> I even have time to wash a patient's hair, and I think about wearing a mouth and nose covering, because I'm working so close to her… but I don't want to unsettle her and decide not to [wear one]. (11FE)

This lack of structure that characterised the pandemic's initial stages was likewise evident in the logistics surrounding resources, provisions and procedures for infection control. At this time, alongside insufficient numbers of masks for staff and patients, a shortage of sanitiser was making itself felt: "There's a spate of sanitiser thefts; I heard that security even had to intervene." (6FE)

Adding to these structural deficits that the crisis inflicted on the running of the hospital, a shift in workloads was in evidence, with a greater burden falling on wards and units that were in place pre-pandemic:

> The ward is full to bursting with patients. One patient is dying, and there's another who we'll probably have to transfer to intensive care. This shift's nothing but rushing around; I haven't had breakfast, I haven't been able to go to the toilet. I can't even say right now whether it's because of the Covid situation or because of the high levels of staff sickness and how frightened some staff members are. It'll soon be over and the late shift will come on. I hope! (9FN)

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The nursing management in the hospital had delegated medical students to the wards to help relieve the staff shortages caused by sickness and quarantining. The newly established Covid wards were not full at this point, giving rise to various different perceptions among our diarists:

> Nightshift. There are three patients. And there are two of us working. There's nothing to do. Weird phenomenon: I look at the clock every 15 minutes, and each time only 2 minutes have passed… I'm too tired to think about it any more, I just hope that this night will be over soon. Thursday, 26.3.2020. There are only two patients tonight. I think of my colleagues on my usual ward, who can hardly manage their workload. I'm ashamed of feeling bored. (4ME)

Another entry notes:

> I'm on a non-Covid ward looking after a post-operative patient who is due to be transferred at some point during the shift. Rarely have I been able to give a patient such extensive care in accordance with what he wanted, and during this I also had time to have discussions with my colleagues – their experience is the same. The care that people on my ward are getting has rarely been as good as it is now. (3FN)

The uncertainty intensified in the first week of April, with the emergent sense of threat filtering through from media reports about the virus. Up until this point, the latent risk of infection had stemmed from patients; now, however, numbers of staff with proven or suspected Covid were on the rise:

> Today I'm disinfecting handles of doors and other things, my blood pressure monitor and the phone receiver especially often; I remind the doctors to [do the same] – they hadn't thought of it before… . (11FE)

The participants experienced having a suspected Covid infection as shaming and stigmatising; they sought to avoid this stigma by not telling anyone they had done a test until the result was available. Alongside shame towards colleagues for supposedly having infringed infection control procedures stood the potential exposure of nurses' families and friends to stigma or even discrimination. This was a period in which the immense level of flexibility required of nurses had an invasive impact on their personal lives. Participants became increasingly concerned about catching the virus: "When I get home from work, I go and take a shower before hugging my children. The worry about passing the virus to them is always with me." (11FE)

Amid evaluation of the infection control procedures that had been in place up to this point, residents of care homes were arriving in the hospital, being admitted to Covid wards and tested. The rapid spread of the virus permeated all areas of life in the hospital. During all this, some diarists noted exhaustion among their colleagues, one indicator of which was an increase in verbal disagreements around crisis management matters. Some of these incidents took place in interactions with patients' relatives:

> A nurse 'bites a relative's head off', [saying] how did that happen – a relative accompanying a patient. There was no need for [the nurse] to speak [to the relative] like that. The relative doesn't even get asked about the situation. While this goes on, I personally feel sort of ashamed for my colleague. I resolve to mention this, perhaps, at an appropriate moment. (6FE)

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Alongside this, disillusionment and discouragement were beginning to weigh on the participants:

> I have to admit that at the moment, it's not the Covid crisis that's my main stress factor, but the sickness absences on my ward. It's the conditions in which we nurses do our jobs that push us to our limits, and that was the way it was before Covid too. (9FN).

Our findings in the category of 'crisis management' point to a sense of uncertainty affecting nurses during this period, an uncertainty in matters organisational and staffing-related, but also in their personal lives. Amid this uncertainty, the participants attempted to do justice to their professional commitment to being a source of stability and security for patients, while enduring the chaotic conditions engendered by the pandemic's advancing first wave. Here we note the emergence, as indicated above, of a sense of 'care' as worry or concern, with participants seeking to establish their boundaries and to work out for themselves whether and when they can, are allowed to, or indeed have to 'be strong for' their patients despite their own uncertainty.

3.2 The 'Invisible Crisis': The Strained Intimacy of the Caring Relationship with Patients and their Families

This second category of our analysis encompasses data that points to the day-to-day impact of the loss of routine outlined in the previous subsection. The participants found themselves facing situations that placed them under moral stress. Similar perceptions emerge from their reflection around their self-care, particularly in relation to their own families. During this period, the aspect of nursing that gives patients stability and provides a consistent and calm presence and support in their suffering appeared to be impacted, to have itself declined in stability and security, in consequence of the falling away of familiar routines.

Nurses' interactions with patients rely on direct physical contact, facial expressions, and other non-verbal and verbal communication. One student diarist observed, in relation to the care he provided for the handful of patients infected with the SARS-CoV-2 virus at this time, that "my PPE has the additional effect of making it considerably harder for me to form a relationship with the patient" (4ME). One of his entries relates to a Covid-positive dementia patient:

> I'm with the patient again. [Her] symptoms are still only mild ones. However, the isolation is taking its toll. She barely speaks any more, and is increasingly withdrawing from interaction. The thing that's occupying my thoughts most of all is that this doesn't seem to be important at all in this situation. But I can't see that I have any way of bringing about change here, and this is making me more and more frustrated. (4ME)

Some days subsequently, he stopped writing about this particular patient: "Suffice to say the case is still on my mind." (4ME)

Our participants appeared to expect and wait for the hospital to present solutions to the difficulties encountered, which they could try out and put in place. The use of a vocabulary typical of crisis situations, redolent with the imagery of disaster and war, has the effect of amplifying the impression of this cautious, reticent behaviour: "In the last few days, I've been hearing

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[people using] these metaphors: 'Calm before the storm'; 'it's like waiting in the trenches [to go over the top]'; 'the tsunami is ebbing away'." (11FE)

Participants kept a close eye on themselves and the risks they were exposed to, alongside the concomitant potential harm to themselves and their families:

> At home, the children want to hug me. I keep them at arm's length until I've been for a shower; I feel dirty somehow. We – the nursing staff – should really be being tested as well [as patients]... I'm worried about my children; would they perhaps be better off in key worker childcare? Are they more likely to get infected at home? (11FE)

The first week of April brought an increase in the frequency of entries revolving around the students' fears about becoming infected with the virus themselves and the associated risk of long-term sequelae. The diarists attempted to pay close attention to themselves and their physical state, with the aim of identifying a Covid-19 infection at an early stage:

> This morning, I had this feeling of not being able to breathe freely again; I needed to cough; it felt as if I'd done a sprint... I'm glad to have the day off, think, what if I have Covid. Always had these thoughts when this weird feeling came back. It feels a bit like asthma...before going to bed, I check my emails again, the result is negative...phew...all the strange feelings are gone at once. (6FE)

3.3 'A Sense of Crisis': Public Perceptions of the Pandemic

Mass media reporting, social media, and the daily case figures from Germany's core epidemiological organisation, the Robert Koch Institute (RKI), powerfully influenced people's experience of the Covid-19 pandemic. Panic buying of flour and toilet paper illustrated the level of public fear at its outset. In March 2020, the media in Germany, as elsewhere, were showing images of exhausted medical and nursing staff in neighbouring European countries whose health systems had collapsed under the pressure of the pandemic. German hospitals were only just beginning to draw up their emergency plans at this time. This notwithstanding, nurses in Germany felt safe and were glad to be working where they were, a sense of relief that served briefly as consolation for poor pay and chronic staff shortages.

Participants in our research noted their unease with the praise and applause showered on nurses at this point in the pandemic:

> So how believable is all the talk about the great importance of nursing ... especially in the media? (5ME) But what'll happen when the crisis is over? Will nurses still be as important as everyone is writing that they are right now? (...) It would be a good idea to [talk] about adequate pay for nurses in the near future. At the moment, almost every politician is lamenting how badly paid nurses and carers are. Well, yes! Even so, I don't believe that this insight will be followed by an improvement of any kind. (5ME)

On 23 March, unprecedented legislation in Germany partially banned physical meetings between people from different households. These restrictions on people's personal freedoms exacerbated nurses' sense of uncertainty. Entries made by our participants indicated agreement with the enforcement of these rules: „A police car stops ahead of me. In my rear view

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mirror I see three police officers walking towards a group. They haven't kept the minimum distance and there's a ban on gatherings; they have their ID checked… good." (11FE)

During the second week of April, we observe a degree of 'pandemic fatigue' towards media reporting on the situation. At this point in time, the pandemic's development and the associated debates around freedom, autonomy and their loss were inescapable parts of public discourse in Germany. One diarist observes:

> I avoided the news today. (…) Yes, OK, I just can't take any more of it. The death rate is going down in Italy. Germany had almost 260 deaths today and the figures are going through the roof in America. There's a 'Covid special' on every TV channel. I've had enough for today and don't want to hear another word about it. (9FN)

3.4 'Living with the Crisis': Strategies for Managing the Unseen Threat

Participants recorded their strategies for recuperating from the strain they were under at work. These included spending time with their families or engaging in solitary hobbies; „being in nature" appeared to be particularly highly valued. Participants still found, however, that the pandemic, with all its associated issues, permeated all areas of life, adding to the stress they experienced. One entry describes the jarring moment of re-realising the situation:

> Sometimes I feel like everything's normal, the atmosphere around me feels that way, the sun's shining, the trees are in blossom, the birds are singing – then I think, who could I go and see after work - and I remember that I can't. Can't sit with friends or go out in the evening after work. (All the stuff we can't have at the moment). (6FE)

Alongside the changes in the once-familiar structures at work, participants faced the challenge of reorganising their home lives, with particular difficulties for nurses with children:

> I'm sending the children to key worker childcare, (structure is important…) the [childcare] workers know that I'm not scheduled to work today and am studying alongside my job. They're happy to have any children in at all (today: 5/40 from two groups). (11FE)

Some participants attempted to use the experience of spending time in nature as a positive counterpoint to the emotional strain and difficult situations at work and the events that are the subject of media reporting:

> Mowed the lawn today. I never knew how relaxing mowing the lawn can be … (4ME). Today I spent the day in the garden, planting flowers. I avoided switching the news on or clicking on articles about Covid online. (5ME) (…) the weather is amazing, so off I go into the woods, away from people, to enjoy nature. I have the feeling that nature is recovering and I am seeing and feeling the landscape, the weather and the air differently from how I used to. I'm taking more notice of what's in bloom, how animals are behaving, and rediscovering the world. (9FN)

Germany's first Covid lockdown, which commenced on 22 March 2022, imposed numerous restrictions on people's movements and interactions in public. It is imperative to read our diarists' comments in the context of the exceptional and, as far as their generation goes, entirely

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unprecedented situation that prevailed at that time. The strict limits on travelling that were in force left the students compelled to focus on home and the natural world, a reorientation we can regard as a self-care strategy and therefore as an assumption of responsibility for their wellbeing.

3.5 Discussion

The diaries completed by our study participants provide us with multifaceted insights into nurses' experience of the first wave of the Covid-19 pandemic in Germany. The entries, documenting day-to-day work and life in conditions far beyond the ordinary, reveal ambivalent and paradoxical emotions and views, states of uncertainty and a sense of confusion and disarray. Nurses found themselves facing feelings of overwhelm as predictions of a first wave of Covid infections with a rapid rise in cases precipitated a range of infection control rules and procedures. As the threatened tsunami of cases failed to materialise to the extent feared, nurses were left with a sense of emptiness and deflation; their responses to the potential for worse to come included uncertainty and, in some cases, a feeling of resignation.[32]

In their diary entries, the student nurses in our sample explored various facets of their moral responsibility as nurses. We will discuss three examples in this context: professional responsibility specific to the work of nursing; the responsibility of the hospital in which they work; and societal responsibility.

Nursing-specific responsibility: The diaries strikingly illustrate the intensity of the workload faced by nursing staff in all areas of acute care, with the general exception of the Covid wards newly set up at the time of data collection. Covid permeated the nurses' view of their patients, raising a fear that the patients might infect them and they might subsequently pass the infection on to others, with the concomitant risk that these 'others' could include the nurses' own families and especially vulnerable family members. The participants were simultaneously aware that, in the conditions that were in force at that point in the pandemic, the PPE they were required to wear, such as masks, represented a serious barrier to the process of forming a relationship with the patient. The ensuing conflict between the distancing that was an integral part of 'correct' infection control procedures and the value nurses place on creating a positive nurse–patient relationship was, at this point in time, irresolvable, leaving nurses forced to essentially suppress it and placing them under moral stress. An ambivalent perspective emerges in relation to the hospital's clinical management of the crisis. As well as giving rise to uncertainty, the emergency procedures, which were evolving day by day, provided nurses with guidance on the standards required of them at this time, bolstering their professional role in the setting. The participants valued rules for the new routines and procedures that entered their working lives, finding that they helped guide their work and supplied a new, albeit initially unfamiliar, structure in what had suddenly become an unstructured space. Their focus was on doing everything right within the newly prescribed structures and strictures, on being able to resolve instances of ambivalence, and on reducing the moral stress to which they were exposed. Some nurses took and defended decisions to prioritise the nurse–patient relationship over the infection control procedures in place,[33] thus successfully resisting the dominance and authority

[32] Petkovic 2020, pp. 41–43.

[33] Mask mandates in hospitals were coming into force during the data collection period; it took some time for full compliance to be established. Many people were wearing cloth masks (for instance) at this time.

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asserted by medics on the basis of a biomedical perspective encapsulated in the so-called 'AHA' rules,[34] predicted case numbers, and physical distancing requirements.[35] Our findings indicate that, in the four weeks commencing the initial wave of Covid-19 infections in Germany, nurses found themselves confronted with the task of restoring an order that had been severely disrupted as the pandemic began to unfold. The complex landscape of rules, regulations and information around the virus presented a severe challenge to the practice of empathetic and compassionate nursing care. The fear and the all-encompassing sense of unease felt by many during this period left nurses in various settings unable or struggling to find creative ways of continuing to provide such care, to improvise and identify alternative paths to restoring to themselves the stability they had lost at work.[36] None of our participants' diaries recorded an instance of a problem solved in such a way; this crisis situation appeared instead to cause people to fall back on conventional, inflexible ways of handling the issues arising in their day-to-day working practices. The attempt to create the impression that the desperately struggling health system was coping with the pandemic certainly had the purpose of managing societal fears. This optimistic view evidently also had a part in the rigidity with which actors within the system sought to regulate their own fears and worries by relying on tried-and-tested approaches amenable to a hierarchical implementation and thus generating a sense of security amid the crisis.

Our diarists reflected on various dilemmas they encountered during this period, one example being considerations around whether to wear a mask when interacting with a patient and accept the barrier to relationship that it presented. With regard to this aspect of professional responsibility, participants apparently considered the risk of infection with Covid-19 as justified in view of the principle of providing empathetic care. This perspective emphasised the vulnerability of the other party to the relationship more strongly than the risk to the nurses themselves. Nurses seeking to assess the implications of a distanced nurse–patient relationship regarded infection control procedures with a critical eye, revealing a distinct and marked professional ethos.

Our findings suggest that nurses approached the pandemic situation from a point of view that placed the vulnerability of the other and their own vulnerability centre stage – a perspective of care as concern. Underlying their actions was the knowledge that, while Covid-19 had the capacity to kill, a comparable level of potential harm could arise from nurses' inability to provide patients and their relatives with compassionate, empathetic care, and from the obstacles to their professional practice of caring presented by the lack of supportive resources that was a consequence of policy-level decisions at that time.

The responsibility of hospitals: Nursing takes place within spaces structured and defined by fixed roles and accompanying responsibilities, and undergirded by a specific system of values. During these early weeks of the pandemic, as existing structures fell apart and actors within the hospital system attempted to restore order in a context newly marked by uncertainty,

[34] 'AHA', an acronym targeted at the general public in Germany and representing rules intended to limit the spread of SARS-CoV-2, stands for Abstand (distancing), Hygiene (hygiene; infection control) and the wearing of an Alltagsmaske (that is, a face mask, which at this point was not required to be medical grade). Cf. https://www.bundesregierung.de/breg-en/news/meeting-with-state-premiers-1792296; https://www.bundesregierung.de/breg-de/themen/coronavirus/aha-a-formel-1774474

[35] Klie et al. 2021, p. 12.

[36] van Heerden 2021.

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nurses sought to provide their patients with compassionate care in accordance with the values and ethos of their profession. What also emerges from our data, however, is that this focus on care was very closely intertwined with direct, individual relationships, blocking nurses' potential to come together to assert their personal and professional interests within the hospital. None of our diaries contained first- or second-hand accounts of nurses' involvement in working groups or emergency task forces. The hospital setting is a highly complex sphere of nursing work whose facets and implications extend far beyond the responsibility to the patient within the nurse–patient relationship. Knowledge of how pandemics unfold and advance was crucial to the ability of those working on the 'front line' of the Covid crisis to cooperate multiprofessionally in finding ways of meeting infection control stipulations that did not infringe patients' dignity. In this light, a nurse's professional responsibility appears as an ambivalent space of care-driven relationships, attitudes and values; one example of this from our data is the diary entry, cited in our analysis above, made by a nurse noting the tedium of a nightshift on the Covid ward, earning a supplement, but without any Covid patients to care for. This nurse found himself feeling ashamed of having left his colleagues on his usual ward coping with a heavy workload. In view of these conflicts of responsibility and ethos, we consider it vital to encourage nurses to engage with and act in accordance with their professional responsibility in the sense of protecting the interests of their patients alongside their own. Professional supervision, to this end, needs to extend beyond its use for theoretical 'reflective practice' and find a firmly rooted place in nurses' working lives.

Hospitals, as complex organisational systems, are sites of divergent sets of values, where biomedical conceptions continue to predominate, and economic notions of value have come to attain an equal influence. In this preponderant, scientifically-driven system, the values underlying the nursing profession exist within a niche that shrinks in direct proportion to the emergence of crisis within the healthcare system. This situation leaves a professional ethos of nursing care without the ability to flourish.[37] We are of the view that urgent action is required to enable nurses to establish and protect their professional system of values, allowing space for answers to questions such as "What shall/can I do with my newly acquired knowledge and skills?" and "What career paths, or routes to greater responsibility and control of my work, are available or can become available to me in my department/profession?" and thus uncovering scope for autonomous action as nursing professionals.[38]

Societal responsibility: News headlines are a pervasive presence in our participants' diary entries. The diaries often included screenshots, primarily showing graphs and charts issued by the Robert Koch Institute. During this period, the media frequently featured members of the public applauding nurses and other workers – in Germany as elsewhere. Nurses and carers expressed vehement criticism of this gesture on social media. We would note at this point the importance of distinguishing between the self-sacrificing ethos that society ascribes to nurses and members of other caring professions, alongside correspondingly high expectations of these workers, and the perceptions and positions which members of these professions ascribe to themselves – encompassing structural altruism, but not necessarily implying a heroic willingness to lay down their own lives. Our participants reflected on these issues in their diaries, without engaging critically with the actual or desired role of the nursing profession's representatives in the policy sphere, particularly after the designation of nurses as 'key workers'

37 Isfort et al. 2018; Aiken et al. 2013, pp. 143–153.
38 Giese 2020, pp. 103–105; Stemmer et al. 2020, pp. 116–117.

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(the German term is *systemrelevant*, meaning 'relevant/vital to the system [of society]') at national level.[39] We are of the view that empowering nurses to represent their interests to national policymakers is a task for society at large. The pandemic, on top of exacerbating existing difficult conditions on hospital wards, has left nurses struggling to gain appropriate recognition for their adherence to their distinct professional system of values.[40] As the first wave of Covid-19 infections ebbed away, large numbers of nurses, driven by frustration over the demands placed on their profession and the perceived lack of genuine societal support underlying them, left their roles in Germany's hospitals. It has historically been, and remains, the case that few in society, at individual level, are willing to enter into a profession such as nursing, with its tendency to impose workloads far beyond the contractual, and few, at collective level, are prepared to support pay, conditions and societal appreciation that would do justice to this commitment. Genuine recognition of nursing as a 'key' profession would require extensive redistribution of financial and human resources.[41]

The Covid pandemic was an object lesson for our societies in the vulnerability of their reliance upon mutual solidarity. Those working in healthcare received insufficient recognition and appreciation for their professional contribution to the stability and security of our society in times defined by uncertainty. The nursing and medical professions are responsible for caring for the sick and bearing witness to vulnerability, old age, and death, and they fulfil this responsibility. During the pandemic situation, however, members of these professions found themselves compelled to deliver ritualised forms of care, distanced from people in life-or-death crisis, if they were to cope with the levels of suffering they encountered in their day-to-day work. Nurses in Germany are in urgent need of greater understanding of their present situation, which many of them experience as a diffuse sense of powerlessness. The extreme staff shortages and inadequate working conditions plaguing the profession are the result, in part, of its limited political power and influence in German society – power and influence which nurses need if they are to make the point that societal assumptions and ascriptions around them, far from reflecting the reality of their work, effectively promote professional identities which are unhelpful in the practical discharge of their duties.[42]

4 A Look Ahead

In this exploratory study, conducted at the outset of the first wave of Covid-19 infections in March 2020, nursing students on a cooperative degree programme kept diaries in which they described a variety of new situations, procedures and events that engendered a profound sense of uncertainty, fear and threat. The crisis took a marked toll on their sphere of professional action, characterised hitherto by care- and compassion-driven nurse–patient relationships, established routines, and nursing-specific values. These student nurses found themselves required to refigure and reconfigure their professional responsibilities in accordance with the dual interests of their patients and their own physical and mental wellbeing.

In our view, the study has shown that professional and ethical reflection, by means of keeping a diary of day-to-day life on the wards, is a promising method through which nursing research

39 Hunlede et al. 2020, pp. 10–14; Fromm 2020, 106–108; Roigk 2020, pp. 47–48.
40 Edward 2011, pp. 184–191.
41 Reiber et al. 2021, pp. 197–208.
42 Giese 2020, pp. 103–105.

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can bring practitioners on board in participatory designs and encourage them to take a more active role in interpreting their experiences. We further believe that this method may provide a new approach for ethics advice and support for nurses, in formats such as regular ethics discussion groups. This practice could empower nurses to articulate both their experience of incapacity to effect change and the authenticity and integrity of a successful, caring and empathetic nurse–patient relationship in day-to-day nursing, and to reflect on these considerations in the teams they work with. During the first and second waves of the Covid pandemic, it became apparent that nurses did not engage with the ethical and psychological support which numerous settings put in place rapidly and in extremely easy-to-access formats; it therefore seems imperative to identify ways of providing this support that work for nurses in the current structures of their roles.

As a final thought, we would suggest that our findings call for fair and just participation for nurses in hospital structures – participation that goes beyond a putative 'equity' and enables nurses to engage fully in shaping their working conditions. Achieving this will entail forging new paths in the organisational structures of hospital wards and creating ways to help nurses understand and maintain their resilience and attain the skills they require to manage the situations they face today.[43]

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[43] Giese 2019, p. 321.

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Too Close for Comfort? The Social Health of Geriatric Nurses During the COVID-19 Pandemic in Germany

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Abstract

Background: The first COVID-19 lockdown in spring 2020 had detrimental effects on both the residents and staff of long-term care facilities in Germany. Regulations to prevent the spread of the virus closed off facilities to visitors, creating social and physical distancing of residents and changing the daily routines of residents and nursing staff alike. Using a grounded theory approach, this study explores the impact of COVID-19 regulations on the social health of geriatric nurses in long-term care facilities in Saxony-Anhalt, Germany.

Methods: We conducted semi-structured interviews after the first lockdown (June/July 2020) and during the second lockdown (November 2020–March 2021) with 13 nurses, primarily those in management positions.

Results: We found that COVID-19 regulations changed the relationship between nurses and residents in important ways. First, nurses became primary caregivers and proxies for the relatives and professionals (e.g. hairdressers, physiotherapists) with whom residents typically interact. Second, strict regulations regarding hygiene, physical and social distancing, and visitors contrasted sharply with nursing as a holistic practice and profession. Third, although nurses had to remain distanced from residents, they simultaneously developed greater emotional closeness. This dynamic affected the social health of both groups, raising important ethical questions about nursing responsibilities and emotional capacities in geriatric care during times of extended crisis such as the pandemic.

Keywords: COVID-19 Pandemic, Social Health, Long-Term Care, Nursing Ethics, Role of Nursing

1 Introduction

In March 2020, with the beginning of the COVID-19 pandemic, the work of nurses came into focus and nursing was named a critical occupation. In Germany and other countries, members of the public and politicians applauded nurses for their important work during the pandemic.[1] With growing concern about residents in long-term care institutions, geriatric nurses also received increased attention. Older adults were quickly referred to as a "high risk group" in need of specific precautionary measures, particularly in terms of interpersonal contact.[2] Although adults above the age of 65 represent a highly heterogeneous group,[3] it was true that age was associated with an increased risk of severe COVID-19.[4] In Germany, 70% of hospitalized patients and 95% of those who died from COVID were aged 60 or older.[5] Since the beginning of the pandemic, 293,461 cases of COVID-19 have been reported in care homes in Germany. Of these, 209,434 affected people aged 60 or older, and the median age of COVID-related death is 81 years.[6] Residents in long-term care facilities comprised a large share of hospitalizations

1 Koebe et al. 2020.
2 Ayalon et al. 2021.
3 Ehni/Wahl 2020.
4 Gaertner et al. 2021.
5 Schilling et al. 2020.
6 Robert Koch-Institut (RKI) 2022.

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and deaths, both of which increased dramatically between March and May 2020.[7] According to a comparative international analysis, the death rate relating to COVID-19 in long-term care had reached 28% in Germany in January 2021, despite strict regulations to prevent infections in nursing homes.[8]

In spring 2020, the German government established regulations to contain the spread of the novel coronavirus. Federal states were responsible for implementing these provisions regionally, while accounting for local needs and circumstances. Thus, Saxony-Anhalt established social distancing in long-term care facilities in April 2020, when it officially stopped all visits. With the exception of palliative care staff, everyone else (including relatives, friends, therapists, hairdressers, and other nonessential professionals) were forbidden from entering nursing homes.[9] In addition, nursing staff and residents were required to practice physical distancing by wearing face masks and observing strict protocols for hygiene and disinfection.[10] As there is still uncertainty concerning successful treatment options, especially for immunocompromised and older people with chronic diseases, the threat of COVID-19 transmission via increasingly asymptomatic vectors remains high for the residents and nurses in long-term care facilities, and for their families.[11]

Despite the desire to contain the virus and reduce risk to the most vulnerable, the long-term impact of social and physical distancing on the residents and staff of closed facilities such as nursing homes is difficult to ascertain.[12] First, social and physical distancing are not clearly defined concepts and tend to be used interchangeably.[13] Second, empirical studies on the effects of distancing are rare. Most studies fall within the category of gray literature or policy recommendations, as shown in an international review.[14] What is clear is that the visiting restrictions (particularly complete bans) place a high toll on residents, for whom digital social interaction may not be suitable or available.[15] The toll on nursing staff, though unclear, is also likely to be high.

Altintas and colleagues argue that emotional exhaustion was a key factor affecting the nursing profession in France during the pandemic as the workload (a) increased considerably and (b) shifted toward medical care, leaving less time to spend with residents in terminal stages.[16] The situation was similar in Germany with regard to workload, along with challenges relating to information about pandemic-specific rules, and being left out of the decision-making process.[17] International and German studies show that many nurses expressed a desire to leave the profession during the pandemic,[18] but there are no solid statistics on how many did so.

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7 Kohl et al. 2021, p. 4.
8 Comas-Herrera et al. 2021.
9 Landesregierung Sachsen-Anhalt April 2, 2020.
10 Landesregierung Sachsen-Anhalt April 2, 2020; RKI 2020.
11 Fine/Tronto 2020.
12 Sims et al. 2022.
13 Sims et al. 2022.
14 Sims et al. 2022.
15 Barnett/Grabowski 2020.
16 Altintas et al. 2022.
17 Hering et al. 2022.
18 Schulze et al. 2022; Falatah 2021; Phelan et al. 2022.

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The German federal employment agency offers some clues in its statistics relating to nursing vacancies (as recorded by employers) compared to the number of nurses who registered for unemployment benefits. Although the agency identified a nursing shortage prior to the onset of the pandemic (i.e. many more vacancies than unemployed nurses), the nursing sector in Germany grew more than other professions during this period.[19]

1.1 Professional Nursing Education in Germany

Prior to the pandemic, German professional nursing consisted of three independent educational tracks based on a three-year vocational program combining theory and practice in (1) pediatrics, (2) gerontology, or (3) general nursing.[20] To make the profession more competitive and attract more nursing apprenticeships, Germany (in 2020) combined the three tracks into one generalist program spanning the whole of life. The new degree program was viewed as a success.[21] In 2021 alone there was a 5% increase in nursing apprenticeships.[22] In an effort to support staff salaries and other provisions for long-term care services, German legislation has been enacted to provide financial support at federal and state levels. Differences in salaries between hospitals and long-term care were a particular concern.[23] Nursing homes feared that the generalist nursing program would lead to nurses applying for jobs in hospitals instead of in long-term care. For this reason, from September 1, 2022, geriatric nurses will be paid the same wages negotiated for hospital nurses.[24]

1.2 Financing of Long-term Care and its Relevance for Nursing Care

An important change in long-term care provisions was the transition from a "deficit" model to determine the level of care (such as, acute or long-term medical care) (*Pflegestufen*) to a "degrees of care" model (*Pflegegrade*) that takes into account factors such as cognition and psychological resources of older people.[25] Federal nursing care insurance covers the costs of nursing and care based on the degrees of care an older person needs. There are five degrees of care, with degree one being the lowest and five the highest amount of care needed by an individual. The financial support increases with every degree of care. However, nursing home costs are higher than the payments from the nursing care insurance cover and this gap is financed by contributions from the insured resident.[26] This financial contribution is the same for all residents, regardless of the degree of care required.[27]

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19 Bundesagentur für Arbeit 2022.
20 Bundesministerium für Familie, Senioren, Frauen und Jugend (BMFSFJ) 2017.
21 BMFSFJ 2022.
22 Statistisches Bundesamt 2022.
23 Statistisches Bundesamt 2021.
24 Bundesministerium für Arbeit und Soziales 2022.
25 Klie 2016, p. 130.
26 Neubert/Neubert 2022, pp. 39–48.
27 Neubert/Neubert 2022, pp. 39–48.

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The paradigm shift to degrees of care reflects, in some ways, the holistic and person-centered ethics of professional nursing in Germany. An important nursing task is to understand the individual circumstances of each resident to determine their specific care needs.[28] To understand patients' needs, proximity between caregiver and care-receiver is vital.

To better understand the importance of proximity in the long-term care setting, we turn to Malone's differentiation between "proximal" and "distal" nursing.[29] Proximal nursing recognizes nursing care in terms of a shared practice of meaning and values between patients (in our case residents) and nurses. Distal nursing understands nursing care as the management and execution of technical tasks aligned with objective measures, such as medical diagnoses and treatments.[30] Distal nursing cannot be reconciled with more holistic forms of care, often leading to a form of functional care guided by the principle of efficiency and expressed by means of rationing and prioritization (such as providing care with fewer nursing staff).[31] In practice, nursing care is proximal and relies on proximity, yet close physical and social/emotional contact was difficult to maintain under pandemic regulations.[32] Measures to contain the virus called for either maintaining adequate distance or engaging in close contact only when using protective gear. The no-visitors policies in place at long-term care facilities transformed nurses into residents' most important social contacts. As proximity between nurses and residents increased in daily routines, so the social health of nurses declined.

1.3 The Concept of Social Health

When considering social health, it is critical to understand that the concept refers to all social relationships a person engages in personally and professionally.[33] According to Huber and colleagues, social health involves "people's capacity to fulfil their potential and obligations, the ability to manage their life with some degree of independence despite a medical condition, and the ability to participate in social activities including work".[34] More than in other professions, the relationship between residents and nurses uniquely relies on close bonds (social and physical) between the person being cared for and the person providing care.[35] This relationship is not equal. Residents depend on nursing staff to take care of them and support them in their daily activities (such as bathing, eating, dressing, maintaining relationships, and so forth). Many residents are unable to make autonomous decisions or communicate their wishes and needs adequately.[36] Nursing in long-term care facilities therefore entails a special responsibility among nurses to ensure residents' well-being. Prior to the pandemic, this responsibility was shared with family and friends of residents and other professions. The pandemic changed all this, in addition to making nurses a risk (to residents) as a potential carrier

28 Bobbert 2002; Senghaas-Knobloch/Kumbruck 2006; Kleinman 2013.
29 Malone 2003.
30 Malone 2003.
31 Primc 2020.
32 Halek et al. 2020; Lob-Hüdepohl 2021.
33 Paul et al. 2021.
34 Huber et al. 2011, p. 2.
35 Paul et al. 2021.
36 Birnbacher 2020.

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of contagion, and placing them at risk from residents, who were already more susceptible to infection.[37]

This paper analyzes the impact and unintended consequences of the pandemic's containment measures on the social health of nurses in long-term care facilities. By highlighting the nuances of geriatric care during times of crisis (such as the COVID-19 pandemic), we offer deeper insights into ethical and practical challenges facing the nursing profession.

2 Context of the Study

The study is part of a larger project, "CoronaCare", that investigates the impact of the COVID-19 pandemic on social health in the unique context of nursing staff and residents in long-term care facilities in Germany.[38] In cooperation with the Institute of Social Medicine and Epidemiology at the Brandenburg Medical School Theodor Fontane and the Institute of Social Medicine and Health Systems Research at the Otto von Guericke University Magdeburg, CoronaCare is funded by the Federal Ministry of Education and Research (BMBF No. 01KI20117).

The Magdeburg research team conducted seven semi-structured interviews in long-term care facilities with nursing staff and residents from November 2020 to March 2021. The HeiCo study (Pflegeheime in der COVID-19 Pandemie: Nursing Homes during the COVID-19 Pandemic)[39] conducted six semi-structured interviews in July/August 2020.[40] A semi-structured approach allowed participants to speak freely and without interruption.

Both studies were approved by their respective ethics committees (CoronaCare: Ethics Committee of the Brandenburg Medical School Theodore Fontane, No. E-01-20200605; HeiCo Study: Ethics Committee of University Hospital Halle an der Saale, No. 2019-006, and both in cooperation with the trust office of the Faculty of Medicine at Otto von Guericke University Magdeburg).

Using a grounded theory approach[41] to the shifting meaning(s) of social health during the pandemic, we draw on these two corresponding datasets (n=13) (HeiCo and CoronaCare).

2.1 Recruitment and Data Collection

The research team recruited participants from prior contacts and nursing home websites in Saxony-Anhalt. We contacted nursing home directors to request participation. Although some declined due to pandemic-related time constraints, others agreed to be interviewed or recommended other members of the nursing staff. Those who expressed interest received detailed information about the study and a consent form. Interviews were scheduled only after participants returned signed consent forms. The trust office of the Otto von Guericke University Magdeburg stores all signed forms securely. As pandemic regulations made it impossible to conduct the interviews face-to-face, we conducted them via telephone. Interviews lasted

37 Paul et al. 2021.
38 Paul et al. 2021.
39 HEICO-Pflegeheime in der COVID-19 Pandemie 2020.
40 Bieber et al. 2022.
41 Corbin/Strauss 2008; Charmaz 2006.

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20–60 minutes (mean: 35 minutes). All interviews were audio recorded, transcribed, and pseudonymized. Data was then transferred to the management program, MAXQDA. To facilitate comparative analysis of data from the HeiCo and CoronaCare studies, questions about the social dimensions of care from the HeiCo study were integrated into the interview guide of the CoronaCare study. The authors analyzed the data and translated quotes from German into English.

2.2 Sample Description

The 13 interviewees in this analysis include eleven women and two men, primarily in management positions. Nursing home directors may have geared our recruitment efforts toward those in supervisory roles, and away from the wards, out of concern for reputation management. Some nursing homes had already been criticized for resident deaths due to COVID-19, despite implementation of protocols to contain the virus. Even those in management positions were in close contact with the wards and often engaged in care work due to the shortage of nurses.

German nursing homes are organized by size (number of residents), space (housing structure: one building or smaller buildings such as a campus structure), and organizational structure (not-for-profit, private or public). Our aim was to recruit a sample of nursing homes in rural and urban areas, with differences in size and type of organization. Half of the nursing homes were located in rural areas and half in an urban setting. Only one nursing home was publicly funded; the others were equally divided between not-for-profit and private organizations. Seven nursing homes had between 50 and 100 residents, five had 100 to 150 residents, and only one had fewer than 50 residents. Whereas the nursing homes in rural areas consisted of groups of smaller buildings in a campus structure, the urban ones were housed in one building with different sections or wards.

Seven participants in this study were nursing home directors (NHDs). Nursing managers (NMs) are responsible either for a number of wards or specific areas, such as a group of residents in a nursing home. Five participants were nursing managers and one participant was a geriatric nurse (GN) without management duties. Most of the staff were either general nurses or gerontology nurses and averaged 20 years in the profession. Only one participant was not a nurse, but a manager of activities (MA) for residents who had extensive engagement with residents.

2.3 Methodological Approach and Data Analysis

Grounded theory facilitates analysis of qualitative data to discover and describe social phenomena.[42] To develop a grounded theory of nurses' social health during the pandemic, we analyzed how actors make sense of and assign specific meaning(s) to their social world. During

[42] Corbin/Strauss 2008; Charmaz 2006.

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the initial analysis, an open coding process explored the data without preconceived assumptions, so as to remain open to meanings that emerged.[43] Emergent themes were then classified in terms of their properties and analyzed more closely. We reviewed the interview data line by line to detect the deeper meaning participants give to their actions and to understand the processes involved.[44] As analytical categories (codes) emerged, we reflected on the initial themes and impressions.[45] Finally, the properties, categories, and subcategories were fully defined (via axial coding) to structure and refine the overall analysis.

For example, one of the themes that emerged quickly was the end to visiting. It had a bearing on all policies that had to be implemented by nursing homes shortly after the beginning of the COVID-19 pandemic, so it was often used as a point of reference to describe changes in the work and responsibilities of the nursing staff (example property: residents developing feelings of loneliness and sadness). Whereas the properties use original phrases from the participants (in parentheses), the codes are analytical (example: nursing staff as proxies for family and friends). The category (example: impact on social health) presents the different outcomes for nurses (example: emotional support for residents increased). The table presents parts of the analysis for this article.

Table 1. Impact on social health for nursing staff in long-term care

Themes	**Properties**	**Codes**	**Category: Impact on Social Health**
End to visiting	Time for chores (It got so quiet)	Change in the experience of time	Fewer work interruptions
	Residents developed feelings of loneliness and sadness	Nursing staff as proxies for family and friends	Emotional support for residents increased
	Questioning social distancing of residents (It was like a prison)	Restriction of residents' autonomy	Suffering with residents increased
	Self-help (Using private smartphones)	Less contact between residents and family & friends	Finding solutions to increase social contacts for residents
	Residents need more attention (How to pass time)	Nursing has to substitute for professional and voluntary services	Spending more time with residents
	Continued explanation of regulations (Everything takes longer)	Special case: residents with dementia	More time for residents with cognitive decline

[43] Charmaz 2006.
[44] Charmaz 2006.
[45] Charmaz 2006.

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Hygiene measures	Face masks, keeping a distance	Becoming unrecognizable	Continuous explanation of regulations
	Change in how nursing tasks are performed	Questioning policies to accommodate difficult care situations	Suffering with residents

3 Results

Although the COVID-19 pandemic was framed in epidemiological and biomedical terms, especially at the onset, the consequences of containment measures were manifest in everyday social life.[46] When nursing homes were closed to visitors during two pandemic lockdowns in March 2020 and from November 2020 to March 2021, the regulations caused considerable uncertainty for the residents and nursing staff in Saxony-Anhalt. No one knew how long the prohibition would last, and physical distancing confined residents to their rooms without the usual distractions of time spent with other residents or visitors, and with no access to the variety of social spaces throughout the facility. With passing time, physical distancing turned into social isolation for some residents.

For nursing staff, the nature of time itself changed. Once busy with daily routines, the lockdown led to massive slowdowns because, at first, no one from the outside disrupted the nurses' work. Chores that were long overdue could finally be accomplished. At that point, no one knew how long the regulations would last. What is more, the relationship between nursing staff and residents changed as staff became the only people with whom residents could interact. At first, nurses appreciated the emotional closeness they developed with residents. However, as they came to terms with the reality that they could not fulfill residents' needs for sociality and intimacy, the management of residents' social health became a detriment to nurses' well-being. In the following we will show the challenges that geriatric nurses were confronted with during the pandemic: the impact of the regulations on the individual autonomy of residents, the physical and social isolation inside the nursing homes, supporting contact between residents and families, and caring for residents with dementia who did not understand the regulations.

3.1 A Break From Routines: Time to De-stress and Connect With Residents

During the first pandemic lockdown in March 2020, it seemed that the world came to a halt. Everyone who could, worked from home, and all social venues, such as concert halls, theaters, and restaurants, closed. No one knew how long this situation would last and nurses initially found solace in the sudden tranquility of the nursing homes. Without visitors, nurses finally had time to work through their long to-do lists of unfinished chores. A nurse manager compared the new slower-paced setting to their usual work environment:

[46] Paul et al. 2021.

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> In the beginning it got so quiet. Sometimes it's crazy, when three therapists come at once and you have to get the residents ready for therapy. They might need to use the bathroom first, and for other residents you have to search (for them if they are not in their rooms). In the beginning (of the pandemic), everyone (nursing staff) was enjoying the fact that no relatives and visitors would come. It was less stress. (NM_02_F_HeiCo)

The new situation highlighted that visits were stressful events that disrupted nurses' work and took time away from other important tasks. In addition to the initial stress reduction, nurses enjoyed the closeness they developed with residents. A nurse manager explained:

> During the first lockdown [...] it wasn't as difficult for the residents. We did connect with them. I would say it was a good togetherness. We were all in the same situation, and no resident could receive visitors. The nursing staff and residents became close because they had to spend time with each other. (NM_01_F_CC)

During the first lockdown, the once busy nursing home slowed down and social connection between residents and nurses seemed to grow. This intimacy with residents underscores a holistic understanding of care that was difficult to achieve prior to the pandemic.

3.2 Residents' Autonomy in Question: "It Was Like a Prison"

Long-term care facilities varied in how they enforced pandemic protocols. Some were stricter than others, depending on the cost/benefit analysis of curbing viral transmission weighed against the potentially negative impact of lockdown measures on the social health of residents and staff. One nurse manager compared the pandemic setting to a prison:

> The house was completely closed off. No one (visitors) was supposed to get in, and no one (residents) was supposed to get out [...]. It was like a prison; you know, when they have yard exercise. The administrative staff work until 4 o'clock in the afternoon; and then, it was our (nurses') turn to attend to the doorbell. It is a two-story house, so every time the bell rang, one of us had to go downstairs. It was a lot more work than before. Before (the "no visitors" rule) people would just come and go. (NM_02_F_HeiCo)

The nurse understood that the restrictions were in place because of the dangers posed by the virus, but she questioned whether the prison-like response was the best way to handle it. In addition to nursing care, support for the activities of daily living came to include strict management of contact between residents and the outside world, including running to the door to receive the onslaught of packages, flowers, and mail for residents as friends and family members did their best to maintain contact.

Confinement was another component of the prison-like ethos. Residents were not only confined to the facility, but they were also confined to their rooms. The constraint on movement from one area to another for meals, activities, or socializing meant that the social connection among residents was radically diminished. A nursing home director explained the effect on residents and nursing staff:

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> It wasn't that they (the residents) couldn't go to the meals, it was that they missed the socializing, the contacts with the others. Usually at breakfast, they chat with each other; that didn't happen anymore. The group activities got canceled. The therapists and the volunteers for daily activities didn't come. […] The effect (of the lockdown) on the residents was that they constantly asked for their relatives. It was very stressful for us (nurses) after a while. (03_M_NHD_CC)

Pandemic restrictions resulted in a significant increase in nurses' obligations to support residents' social health all day, every day. Helping residents to maintain some degree of contact among each other and with their family and others was crucial for residents' well-being, and an added stressor for nurses.

3.3 Beyond the Call of Duty: Nurses Innovate to (Digitally) Connect Residents With Family and Friends

Nursing home residents communicated with relatives and friends in a variety of ways during the pandemic. During good weather, some residents went outdoors to meet up with friends or relatives at a gate or through a fence. Such options were more limited in the winter months and for residents who were less mobile. For the most part, communication options for residents relied upon the ability of nursing staff to access digital devices, such as cell phones, tablets, and laptops. If these were not available in the facility (and often they were not, or the facility lacked a reliable internet connection), nurses sometimes shared their own cell phones. However, for residents with dementia, digital devices were confusing because they could not grasp the concept behind them. For some residents, the telephone in the room was the only lifeline to the outside world. Residents who did not have phones in their rooms had to rely on nurses to bring them a phone if someone called the home for them. A manager of activities for residents explained some of the difficulty:

> In the spring (2020), the residents met their relatives outside; that worked because of the warm weather. Right now, it's different (winter 2020); no one wants to sit outside for a chat drinking a coffee. It makes everything more complicated. We hope that we can keep it so that one person (a relative) can come twice per week, of course with advance notification. (5_F_MA_CC)

Helping residents and their families and friends to maintain contact during the pandemic required continuous effort and innovation. Some nursing staff recounted how relatives would constantly call the nursing home to speak with their loved ones. A nursing home director described how some nursing staff took matters into their own hands to make the processes more efficient:

> During the first lockdown, we implemented video chats with relatives so that they could see each other and chat a little. It was an initiative by the nursing staff, and they used their private cell phones with Face Time and WhatsApp chat to make it possible. They made appointments with the relatives for the calls. That's how we made it through. (7_M_NHD_CC)

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This example demonstrates how nursing staff responded to the social needs of residents and their relatives.

3.4 An Added Stressor: Supporting Residents With Cognitive Impairment: "Everything Takes Longer"

Nurses often commented on the specific needs of residents with different stages of cognitive impairment. Residents with varying stages of dementia needed the most time and support from nurses to handle the stress of masking, distancing, and lockdown measures. At times, nursing homes deviated from pandemic regulations to make special accommodations, such as requesting an exception to the "no visitor" rule during times of crisis. Unfortunately, this subpopulation of residents often experienced heightened anxiety and an increase in cognitive decline after visitors were banned. Nurses observed with empathy and concern and tried to help them to feel more at ease.

A nursing home director described how the mask mandate affected some residents:

> It is difficult for our residents with dementia to recognize the faces of the nursing staff behind the mask. Many knew the names of the nursing staff (before the pandemic), but now (with masks on) they orient themselves by the hairdo, voice, body length, and so forth. I am tall and easily recognized around the house, but residents in the later stages of dementia don't even recognize their relatives anymore. I am surprised that they trust us. No one can tell what they think when someone with a mask who looks different from before is standing in front of them. That's difficult in a caretaking situation. (7_M_NHD_CC)

Trust is important in a caring relationship. Not knowing if the resident trusts a nurse adds stress to daily nursing tasks such as administering injections or medication or helping with taking a shower. The resident might refuse the injection or might fall in the bathroom. Residents can injure themselves or the nurses.

When verbal communication fails, nonverbal communication is paramount. A nurse manager explained: "With the dementia residents, much (of the communication) is touch, to caress someone's arm and to put one's arm around them." (1_F_NM_CC)

Residents with cognitive impairment needed more time and attention from nurses to help them feel secure. In fact, these residents needed additional time for everything that involved COVID-19 precautions, in part because they did not understand the regulations (wearing masks and respecting social distancing), the lockdown, why they had to be separated from other residents, why their family members were not visiting them, and the testing that started in fall 2020. A geriatric nurse explained a typical testing scenario:

> The residents participated in testing. It's complicated testing residents with dementia because they don't understand. […] You explain and clarify, and they say *yes, yes*, but when you put the test swab in their nose it becomes uncomfortable, that's very complicated for them. (19_F_GN_CC)

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The emotion management involved in caring for residents with dementia and implementing pandemic measures that confuse them and cause discomfort requires calm, a trusting relationship, and patience on the part of the nurses. This emotion management was time consuming and became more difficult the longer the pandemic lasted.

Many residents with cognitive impairment either did not respond in the same way to their relatives after the lockdown as they had before, or did not recognize them at all. Some participants explained that the residents' dementia seemed to progress faster without social contact. For some residents, the impact of the visitor stoppage had dire consequences. In fact, some residents refused food and fluids when their relatives were no longer allowed to visit. This was the gravest consequence told by two members of the nursing staff from different nursing homes:

> We had one resident with dementia who stopped eating and drinking after a while. Quickly we got an exception to the visitor regulations. The son and the daughter came for a visit, and we could see in the mother's face that she was happy. She didn't recognize her son, but she knew that he belonged to her and from that day she started eating again. […] She had visits twice a week before (the pandemic) and she felt that something was different. The residents recognized that (the differences). They suffered, and we did too. I had a lot of anguish, and we were all tense. We were asking ourselves: How long will it last? (NM_02_F_HeiCo)

This excerpt shows the huge emotional stress that residents and nurses alike endured during the COVID-19 lockdowns. For residents, social connection with family and other loved ones is so important that without it, a life-threatening situation can develop. For nurses, the emotional consequences were that their relationships with the residents became too close and they could not fulfill the residents' social needs. The regulations on social and physical distancing during the pandemic were the factor that caused the social needs of residents to grow enormously and nurses were not able to compensate for other social contacts. On the one hand, the pandemic forced a closer and more holistic care relationship between residents and nurses. On the other hand, nurses were overwhelmed by the social demands of residents, and the conflict of not being able to satisfy those demands led to a decline in nurses' social health.

Limitations

Study limitations include the small sample size, the self-selection of participants, who primarily represent managerial roles rather than nurses in wards, and data collection via phone interviews as these necessarily could not provide comprehensive insights into the lived experiences of nurses in their everyday setting.

4 Discussion

In addition to medical uncertainty, the COVID-19 pandemic brought with it sudden and far-reaching changes to everyday life across social institutions. Nursing homes, in particular, were not well prepared to manage the developing and ongoing crisis.[47] At the start of the pandemic, German nursing homes lacked basic personal protective equipment (masks and gowns) to

[47] Phelan et al. 2022.

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minimize transmission.[48] The initial political response was to isolate nursing homes by stopping visits and introduce physical distancing for residents.[49] For residents, this meant physical separation from each other and from family, friends, and volunteers and professionals who routinely entered the home for therapy and other activities. For nurses, it meant continuing to care for residents as before, while also tending to residents' social health in new and encompassing ways. Nurses tried to make up for residents' social losses caused by the absence of visitors and social activities, while adhering to regulations aimed at limiting their own and residents' exposure to the virus. Within the closed environment of the nursing home, nurses and other staff were at high risk of infection.[50]

At the start of the pandemic, the break in normal routines gave nurses an opportunity to work without disruption from visitors. This meant that long lists of unfinished tasks could be completed, suggesting that the pre-pandemic workload for nurses had been too high. The serenity that initially offered a reprieve to nurses soon gave way to a new set of responsibilities designed to manage the unintended consequences of residents' social isolation. Nurses' daily routines now included communication and relationship management to compensate for the lack of social services and interactions with relatives that previously ensured residents' engagement in social life.[51]

As the pandemic continued, residents needed more time and attention from nurses. Unable to replace the familiar social bonds created throughout life with family and friends, nurses suffered alongside the residents as their own social health declined. Social health as we defined it encompasses all social relationships, both personal and professional. The pandemic situation exposed the issues detrimental to the social health of nurses in long-term care institutions. In particular, ethical considerations, a higher workload due to COVID-19 regulations, and being fully responsible for the social contacts of residents had implications for nurses' understanding of their work and for their social health.

Nursing staff had to make far-reaching ethical decisions, for example applying for an exception to the visitor ban and risking letting the virus into the nursing home. The German Ethical Council (Deutscher Ethikrat, DER) states that such decisions should hold human rights in high regard and always consider the rights of the individual to be as important as the rights of others to avoid infection. In other words, measures to contain the virus should not overturn human rights.[52] However, the regulations at the beginning of the pandemic led to social isolation of residents, with negative consequences for their psychological and mental well-being.[53] All the regulations in nursing homes severely restricted older adults in their last years of life.[54]

The nurse who compared the nursing home during the ban on visitors to a prison questioned the ethical foundations of pandemic regulations in nursing homes. Her perspective on how nursing home residents should live (including who they see, where they spend time, and what

48 Dichter et al. 2020; Deutscher Pflegerat 2022.
49 Landesregierung Sachsen-Anhalt April 2, 2020.
50 Schweickert et al. 2021.
51 Kohl et al. 2021.
52 Deutscher Ethikrat 2020.
53 Deutscher Ethikrat 2022.
54 Elsbernd et al. 2021.

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they do) differed greatly from what occurred during the pandemic. It showed a high degree of empathy and, at the same time, revealed the limitations of nurses' work. Decision-making by nursing staff is a complex process and moral concerns about care ethics lead to burnout[55] and can call into question nurses' professionalism.[56] As a result, the increased physical and emotional workload led to higher rates of sick leave during the first visitor ban.[57]

By the summer of 2020, when the visitor ban was lifted, new visitor regulations were developed that required more work. Visitors had to be tested, special visiting rooms prepared, personal protective equipment provided, along with other protocols specific to each facility. When infection rates decreased, residents and staff still had to abide by strict containment protocols.[58]

Nurses tried to connect residents with their families and friends as best they could during the pandemic. Nursing homes in urban areas were better able to use digital services to promote social interaction, but this was not the case for most of the facilities in rural parts of Saxony-Anhalt, highlighting the ongoing digital divide in Germany. With few other options, some nurses used their personal smartphones to help keep residents "socially close" to their relatives and friends. Despite being innovative and pragmatic, this approach was questionable in terms of data protection laws and ethical considerations. Now nurses had contact numbers of residents on their personal phones and relatives of residents had the personal phone numbers of nurses. The use of personal smartphones as a way of supporting residents' social contacts could have expanded nurses' working hours to a 24/7 shift. Additionally, digital solutions were not at all useful for residents with high cognitive decline.

Nursing home residents with cognitive decline posed the greatest challenge for nurses during the pandemic. This subpopulation of residents required the most time and patience from nurses to feel secure and cared for. Without the usual intimacy with friends and relatives, those with dementia suffered severe emotional losses that nurses could not adequately replace, especially over an extended period. There was some evidence to suggest that residents with dementia may have benefited from the sense of calm and quiet that resulted from the ban on visitors.[59] However, our data revealed that for some, the total isolation from loved ones (even those they no longer recognized) resulted in apathy, further decline, and a refusal to eat or drink. Compared to prior years in Germany, the death rate increased significantly during the first lockdown for nursing home residents with dementia.[60]

Recognizing that self-determination and quality of life for residents are the most important goals of long-term care, some argue that measures to control the spread of infections should protect residents but not lead to their isolation.[61] With this aim in mind, residents' participation

55 Goethals et al. 2010.
56 Jones et al. 2022.
57 Drupp et al. 2021.
58 Kohl et al. 2021; Deutscher Ethikrat 2022.
59 Sporket 2020.
60 Kohl et al. 2021.
61 Deutscher Pflegerat 2022.

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in individual and group activities should be possible throughout times of pandemic, and nursing homes should remain open to visitors.[62] The nurses we interviewed were deeply affected by the suffering and discomfort they observed in their patients during the pandemic. As caregivers who rely on empathy to anticipate and act upon the needs of their patients, the nurses we interviewed felt emotionally exhausted. Although emotional exhaustion among caregivers was evident during the first lockdown,[63] the second lockdown lasted longer and resulted in increased workload due to testing responsibilities, vaccinations, and ongoing visiting issues as nurses continued to be the primary social support for residents.

The difficulties arising from a nursing shortage that predated the pandemic were magnified by COVID-19 and the ripple effect it caused.[64] The ever-increasing workload, high burnout, emotional exhaustion, and daily stress of nursing care during the pandemic describe the experiences of many nurses, especially those in long-term care facilities. We argue, however, that the decline in nurses' *social health* describes more precisely the way the relationship between residents and nurses transformed during the pandemic: It became too close for nurses to provide the level of comfort residents needed. Put simply, pandemic regulations thwarted the type and level of care that nurses held paramount, undermining the ethical commitments they made when entering the profession.

5 Summary

The COVID-19 pandemic revealed important ethical dilemmas and other challenges to providing person-centered care for the residents of long-term care facilities. In addition to the effects of the pandemic on residents' physical and social health, the social health of the nurses themselves was on the line. If social health encompasses all relationships, then the relationship between caregiver and residents represents a key factor for nurses in long-term care facilities. Unlike an acute setting – where patients come and go in hours, days, or weeks – nursing home residents are most often long-term. Thus, the relationship between nurses and residents is likely to have a strong impact on the social health of both parties. Yet, our research shows that strains on this relationship during times of crisis (notably the COVID-19 pandemic and the logistical and ethical dilemmas it posed) had deleterious effects on nurses' social health. To support the provision of care and the health of caregivers themselves, additional research is needed to investigate how social health and other aspects of nursing practice were transformed by the pandemic. Additionally, the German Nursing Council developed guidelines for long-term care institutions in the fall of 2022 to prepare for the next wave of COVID-19 infections.

62 Deutscher Pflegerat 2022.
63 Altintas et al. 2022.
64 Hower et al. 2020; Rothgang et al. 2020; Wolf-Ostermann et al. 2020.

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Historiographic and Biographic Accounts of Danish Deaconesses Serving in the Faroe Islands 1897–1948

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Abstract

The Faroe Islands are an archipelago of 18 islands situated in the middle of the North Atlantic Ocean. Basic organized nursing there began in the late 1890s with arrival of two Danish deaconesses sent to the islands to improve the population's health and move Faroese nursing and nurse education closer to international standards. Twenty-five Danish deaconesses served in the Faroe Islands during the first half of the 1900s. The overall aim of this article is to contribute to nursing history about the deaconesses in the Faroe Islands. In caring and historic contexts, and using historiographic and biographic approaches, we present and discuss excerpts of letters from some of the Danish deaconesses, in which they discuss their daily work, life, and ethical dilemmas while in the Faroe Islands. Findings demonstrate that the deaconesses were nurse pioneers, establishing professional nursing and nurse education following Danish rules and regulations of the time. We conclude by emphasizing the meaning of the deaconesses for modern Faroese nursing and nursing education, and the importance of keeping the history of nursing in mind.

Keywords: Caring, Danish Deaconesses, Ethics, Faroe Islands, Nursing History, Nursing Education

1 Introduction

In 1897, two Danish deaconesses from the Danish Deaconess Foundation in Copenhagen, Denmark, arrived in the Faroe Islands which at that time were a Danish county.[1] Their task was to introduce and organize nursing in this small society spread across several islands in the middle of the North Atlantic. The two Lutheran deaconesses were to work at the local hospital, train Faroese girls in skilled nursing, and work as community nurses. In 1948, the last deaconess returned to Denmark, and trained Faroese nurses took over the professional nursing activities. A total of 25 Danish deaconesses had by this time worked in the Faroe Islands.[2] As in other countries where deaconesses pioneered nursing and nurse education,[3] the Danish deaconesses led the professionalization of nursing in the Faroe Islands. In this article, we present personal accounts from some of the Danish deaconesses about their lives, nursing care and work in the Faroe Islands as reported in letters to their motherhouse in Denmark.

2 Background

The impetus for the study is a long-standing interest in nursing history, Faroe Islands and Faroese nursing[4] combined with an assumption that knowledge of nursing history helps to develop nursing identity in today's combination of academia and practical training.[5] Likewise, we as authors are students of caring sciences scholars,[6] which colors our understanding of what is essential in nursing.

1 Hauge 1963, pp. 209–210.
2 Malchau Dietz 2013, p. 312.
3 Nelson 2001, pp. 151–164.
4 Malchau 1998; Malchau Dietz 2013; Hall 1997; 2008; Joensen/Hall 2015; Dam/Hall 2020.
5 Toman/Thifault 2012; Wolf/Bailey 2016; Berthelsen/Hølge-Hazelton 2017; 2018.
6 Benner/Wrubel 1989; Scheel 2005; Martinsen 2006; Eriksson 2006.

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Additionally, we take the phenomenological view that there is, to some extent, something universal in anecdotes because the past is perceived in the present and governs the future.[7] These assumptions of ours provide context for the story of the Danish deaconesses in the Faroe Islands. The overall aim is therefore to contribute to nursing history about the deaconesses in the Faroe Islands. The deaconesses' history in the Nordic countries[8] and elsewhere[9] has interested nurses and historians in general, and they have documented the deaconesses' life and work and their meaning for the nursing profession. The deaconesses' service in the Faroe Islands is, however, sparsely described. The aim of this article is, therefore, in caring and historic context, to enlighten readers with a selection of descriptions of Danish deaconesses' everyday life while serving in the Faroe Islands. As far as we know, this story has not yet been told internationally; it therefore adds to the state of the art regarding the history of nursing and the history of deaconesses.

The article takes both a historiographical and a biographical approach. It is historiographic because it is a study of nursing history and builds on selected primary and secondary deaconess history sources in archives and books.[10] And it is biographical because the most important sources are letters from some of the deaconesses to the lady superintendent or the principal pastor at the Danish Deaconess Foundation (Diakonissestiftelsen) in Copenhagen. These letters were private and personal written accounts and their contents were therefore used with care, taking into consideration their private nature.[11] In the letters, the sisters talked about their daily life and service in the Faroe Islands; they revealed their inner religious life, their obedience to God and to the medical authority. Their dedication to their duties and worry about patients and the sisters were obvious, though accounts of basic patient care and bedside nursing were absent in the letters.

The deaconesses came from Diakonissestiftelsen in Copenhagen, which was established in 1863. It was part of a deaconess movement that was founded in Kaiserswerth, Germany, in 1836 and soon grew to be an almost worldwide movement. The deaconesses became local, national, and international caring agents. Their attitude, based on strict training, was that body and spirit formed an inseparable entity, and that sickness, poverty and other social ills were sins that could be prevented and should be treated through caring for body and spirit.[12] Caring for the body and the spirit should go hand in hand.[13] Thus, the Protestant Lutheran deaconesses played a critical role in the history of nursing in many European countries until the middle of the last century,[14] and among them were the Danish deaconesses.[15] The idea that a principal pastor and a lady superintendent called Mother led the motherhouses and the training, and that the sisters were treated as their daughters, was appealing. The "daughters" started with a period as probationers, followed by formal training as nurses and social workers. The deaconesses who passed the period of complete training were consecrated and then sent out to serve in hospitals, district nursing and parish work.[16]

7 Van Manen 1990, pp. 35–46.
8 Markkola 2000; Christiansson 2006; Elstad/Hamran 2006; Green 2011; Malchau Dietz 2013; Austgard 2019.
9 Kreutzer 2010; Schweikardt 2010; Fullerton 2012.
10 Sarnecky 1990.
11 Halldorsdóttir 2007, pp. 35–49.
12 Kreutzer 2010.
13 Malchau Dietz 2013, p. 87; Austgard 2019.
14 Nolte 2013; Kreutzer 2019.
15 Malchau Dietz 2016.
16 Malchau Dietz 2013, pp. 13–15.

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The initiative to establish a deaconess foundation in Denmark came from Queen Louise of Denmark (1817–1898) as part of her royal welfare activities,[17] and she appointed Miss Louise Conring (1824–1891) to be the first lady superintendent of the Danish Deaconess Foundation.[18] Both ladies had German families and had, through private sources, heard about this possible, acceptable position for Protestant middle class women as an alternative to marriage. To acquire knowledge for the leading position in Denmark, Louise Conring visited deaconess motherhouses in Stockholm, Strasburg and Darmstadt, and also the so-called grandmother house in Kaiserswerth. At all houses, she became acquainted with the philosophy, rules, organization, and training programs. She was finally consecrated as a deaconess in Kaiserswerth in 1863.

The motherhouse in Copenhagen consisted of 80 Danish deaconesses in 1880 and 185 in 1891.[19] Thus, at the time of the deaconesses' arrival in the Faroe Islands, the deaconess institution was well established in Denmark, and Danish deaconesses were working all over the country, in homes, parishes and local hospitals. Their work was strictly based on written contracts and detailed terms of conduct. The deaconess should be the head nurse for the nursing staff, should do and note what the physician asked her to do, was not supposed to work night shifts or clean dirty bandages, and should have 14 days of vacation per year. She was not allowed to accept any payment or gift for her service, which instead went to the motherhouse, and her lodging should be free and working conditions safe.[20]

It was the physicians and the clergymen in the Faroe Islands who, in the mid-1800s, drew attention to the need for trained people from abroad to care for their sick and poor and to help modernize the healthcare system in the Faroe Islands. The needs were obvious, as described in an article (1896) in the Faroese newspaper *Dimmalaetting* by the top public health officer (*physicus*), the Danish physician Carl Strüwing Boeg. He wrote:

> While all over the civilized world there are trained nurses not only at the hospitals but also outside them, nursing in this country is still at the same level it has been at for a lifetime. It's time for change.[21]

In the article, physicus Boeg expressed a desire to align Faroese nursing more closely with international standards; he argued for the need for obedient trained nurses who would do exactly what the physician prescribed; and he called for improvements to hospital and home nursing and to Faroese patients' care and nutrition. Consequently, the arrival of Danish deaconesses was welcomed in the Faroe Islands, unlike in Iceland, where sisters from the deaconess movement were rejected in favor of the Roman Catholic nursing order Sisters of Saint Joseph of Chambéry and secular educated nurses.[22] Expectations regarding their contribution to the healthcare system were high.

When the deaconesses arrived in the Faroe Islands, a group of 18 mountainous islands between Norway, Iceland and Scotland, the Faroese people numbered less than half of today's population of 54,000.[23] They lived on 16 of the islands in small communities, villages, and hamlets along the shores

17 Jørsing Kristensen 2017; Malchau-Dietz 2013, p. 25.
18 Malchau Dietz 2013, pp. 31–44.
19 Koch 1938, p. 260.
20 Petersen 1998, pp. 9–11.
21 Boeg 1896.
22 Bjørnsdottir/Malchau 2004.
23 Hagstova.fo.

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of deep fjords, with fishing as the main male occupation and the women taking care of household chores and children. The people spoke the local language, Faroese, and a little Danish because, following the Treaty of Kiel, the country was a Danish county from 1814 to 1948 and followed Danish rules and regulations.[24] The remote geographic location in the middle of the North Atlantic presented many challenges for the Faroese community. The Faroese people became a resilient and religious population[25] as Christianity had played a key role in Faroese culture and life for centuries.[26] The country was remote and isolated. During the deaconess era, transportation from Denmark to the Faroe Islands was by ship in the spring and summer seasons. During the winter it was too stormy to sail. The journey took days, sometimes weeks, and could be quite unpleasant. In several letters from the deaconesses, the voyage is mentioned as a major challenge to be overcome.

3 The Deaconesses as Pioneers of Nursing

The first Danish deaconess to arrive in the Faroe Islands was Sister Mette Katrine Thomsen (1870–1959). Sister Mette Katrine became a deaconess in 1890 and had previously cared for sick family members and for patients at a Danish hospital. In 1897, at the age of 27, Sister Mette Katrine was sent to the Faroe Islands with orders to work as a hospital and home care nurse and to train young Faroese women in nursing tasks. The long-term objective was to improve the health and nursing care of the patients by educating Faroese young women. Expectations were high, as reported in the Faroese newspaper Dimmalaetting on July 26, 1897, only a few weeks after Sister Mette Katrine's arrival.

> We hope that the reform with a trained and competent nurse will make Faroese girls interested in caring for the sick and make them apply for nursing training, a training that they might use later both in their own home and in the village where they settle in the future.

However, the hospital administration saw nurse trainees as an economic advantage: "instead of two paid young women, it will be a cut-back in public spending to have young village women in unpaid nursing training."[27]

The Faroe County Hospital that Sister Mette Katrine arrived at in 1897 had been built in 1829 and could accommodate nine and later 20 patients, which was not nearly enough. The hospital conditions were poor. The walls were leaking, the doors thin and at night rats would eat any remaining patient food.[28] When Sister Mette Katrine arrived, there were nine patients being cared for day and night by a single attendant. In a letter to the motherhouse soon after her arrival, Sister Mette Katrine wrote that she had taught a young woman to wipe the floor with proper equipment; she had arranged for a new stove at the hospital; and she had established two 12-hour day and night shifts, instead of the 24-hour shift managed by one attendant. Her singing was soothing the patients, she

[24] Debes 1995; Kjærgaard 2016, p. 23; Sølvará 2020, pp. 12–20.
[25] Cortzen 2016, pp. 326–356.
[26] West 1974, pp. 223–225.
[27] Dimmalaetting June 27, 1896.
[28] Petersen 1998, p. 74; Landssjúkrahúsid 80 år.

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wrote, and through kindness and singing she overcame language problems with the Faroese-speaking attendants.[29]

Sister Mette Katrine worked in the Faroe Islands for 18 years, both at the hospital and in home care. At the hospital, and according to the written contract, she was the head nurse for the young women who took care of the bedside nursing. From pictures we learn that the patients ranged from women in labor to sailors with broken arms and earaches.[30] From her three years in home care, we know that important duties included caring for children, visiting old people when she had time, and delivering clothes and food to poor families in the villages. To do that she walked long distances up and down the mountains, often dressed in an oilskin coat to cope with the shifting weather in the Faroe Islands.[31]

Even though the physician was the official medical authority and gave the basic instructions about patient care and expected total obedience from the nurses, we consider Sister Mette Katrine to be a pioneer in the early 1900s in the area of proper hospital and home care nursing in the Faroe Islands. The normative ethical standards of nursing practice at that time required a nurse to be a morally strong and good woman, including "neatness, punctuality, courtesy and quiet attendance on the physician".[32] Based on her deaconess training, Sister Mette Katrine appears to be the first to display these demanding virtues. Furthermore, she was the first home care nurse in the Faroe Islands, described as a resilient, active, and patient nurse and social worker. She was loved by the people she met, helped, and cared for.[33] Her position though, might have threatened the physician in his professional work. Traditionally, he was the authority surrounded by an obedient staff. A deaconess head nurse might not have conformed to the submissive female gender role of the time. Her appearance in a strict, neat dress and cap radiated authority as well as compassion. In a letter to the Danish superintendent, pastor Dalhoff, in 1908, Sister Mette Katrine, with reference to another sister, stated: "The physician has not talked to her [...] but he obviously wants to get rid of her as he did with me in the old days".[34]

One of the deaconesses who served in the Faroe Islands together with Sister Mette Katrine for some years was Sister Adelheid Larsen (1881–1958). Sister Adelheid began her very first letter to the lady superintendent stating: "I am really surprised how easily and fast I have settled down up here. When working, I feel as if I have been here for a year and not a month."[35] Sister Adelheid's well-being was quite visible in the following excerpt from her first letter. Here she talks about her work, what she is doing, her household chores and leisure activities hour by hour. The excerpt from her letter shown in Box 1 reveals that her duties mostly consisted of well-organized household chores.

29 Letter from Sister Mette Katrine, July 12, 1897, A-DDF.
30 Petersen 1998, p. 23.
31 Petersen 1998, pp. 22–28.
32 Fry 1994, p. 67.
33 Petersen 1998, pp. 30–32.
34 Petersen 1998, pp. 26–29.
35 Letter from Sister Adelheild Larsen, August 27, 1912, A-DDF.

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As a rule, I get up at 6 am. The patients get their tea just before 7 am, then the chickens are fed and sent outside. At 7.15 we are together for tea and morning prayer. Then we heat water in the boiler to sterilize instruments and bandages. And we make our oatmeal porridge which the patients and the servant-girls get at 8.30 am. We, however, get a small open sandwich and coffee. Straight after, we begin preparing the luncheon. The beef here is poor, often I make minced meat of it. We have nice fish and lamb. At noon, the patients get their luncheon and half an hour later we have luncheon. Then we tidy up the kitchen and I usually take a walk in the garden to pick some berries. The other day I picked three pounds of red currants, it was not much but they tasted good, and I pickled them. At 3 pm we have coffee or tea. At 5 pm we start making the open sandwiches. At 8 pm we are finished with the tea. Every second evening I like to prepare a white bread dough which I bake next morning. When we are finished for the day, we usually take a walk along the shore looking out over the sea. And we talk about our dear home and Sister Mette Katrine counts the months until she can see it again. At about 11 pm we go to bed.

Box 1. Excerpt from Sister Adelheid's first letter about her daily work in 1912, shortly after her arrival in the Faroe Islands.

It is clear then that a decade after the arrival of the first deaconess, and probably earlier, the daily nursing chores were meticulously organized. The improvement in the standard of nursing care that the physicus had asked for in 1896 seems to have been achieved, thanks not only to the deaconesses, but also to young Faroese women's bedside nursing. Pictures of the staff taken in the early 1910s show Sister Mette Katrine and Sister Adelheid together with a handful of young women dressed in white aprons.[36] The working conditions varied however. In letters from 1913, Sister Adelheid said that they had only five patients in the early summer, but by the end of the summer they were quite busy with several critically ill patients. Sister Adelheid stayed in the Faroe Islands for five years. She was an outgoing person who was open to the Faroese culture; she participated in the social life and mentioned that she was invited to spend her day off with the pastor's family on another island, to which they traveled by ferry.

Nursing at this time included both bedside and household tasks. The nurses introduced the household tasks, such as cleaning and cooking, to the institutions. Allegedly, the first deaconesses on the Faroe Islands had to give priority to the household and domestic tasks. However, it was also common for deaconesses to function as matrons in small institutions.[37] Furthermore, Sister Mette Katrine and Sister Adelheid seem to be examples of deaconesses who adapted with ease to the living and working conditions in the Faroe Islands in the early 1900s. It was not new for them. They were experienced deaconesses who lived up to their calling to help the weak and poor wherever they were stationed.

36 Petersen 1998, pp. 22–23.
37 Elstad/Hamran 2006, ch. 11–12.

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However, life, hard work and long hours far from home were not easy for all the deaconesses who served in the Faroe Islands. Letters from Sister Emilie Møller (1896–1925) tell a rather different story than those of Sister Mette Katrine and Sister Adelheid.

Sister Emilie Møller was a probationer and not fully trained when she was sent to serve in the Faroe Islands in the early 1920s. It was her first mission, and it seems that she was mainly working under the supervision of a senior deaconess, Sister Agnes Petersen. From a couple of letters to the Danish lady superintendent, written February 13 and March 23, 1923, we know that Sister Emilie had a miserable time during her service at the old hospital. She had no-one to talk to, had low self-confidence, felt deceived by God, and also perceived herself as a burden for the senior deaconess, Sister Agnes. In the long, touching letters, she wrote about how difficult life was and how she asked God for help to do what was right and be a good servant to God.

> If I only could talk to you in person […]. I have been so sad in the last months, as being lured by Satan. Thanks to God I was released. Now I am free and get strength from above […] the biggest desire of my heart is that Sister Agnes and the motherhouse will become more satisfied with me […].[38]

Thus, for Sister Emilie, life and working demands represented a lonely struggle, and her letters were a cry for help; they revealed an inexperienced young woman who wanted to do well but seemed unprepared for working long hours and the hard life far from home in a foreign country with a harsh climate, new culture and language. We cannot but wonder why an inexperienced probationer was sent to these faraway islands. Did she get the help and support from her superior that she really needed?

Recognizing that in line with the social structure of those days, the community of sisters was divided hierarchically into classes, almost in a military fashion, and that the management style was at times merciless with sharp reprimands, bullying and harassment of the young sisters,[39] we suppose that the relationship between Sister Mette Katrine and Sister Adelheid was a companionable one and that they got on well together. By contrast, the relationship between the senior Sister Agnes and the probationer Sister Emilie was strained and far from caring and compassionate. It was obvious that Sister Emilie had been rebuked and was left lonely. Metaphorically she was thrown into deep water and drowned. The story ended there because Sister Emilie returned to Denmark, where she worked in home nursing. However, one year later, at the age of 29, she died of tuberculosis,[40] a sickness quite common at that time, both in Denmark and in the Faroe Islands.[41]

There could be several explanations for Sister Emilie's unhappiness. One answer was that tuberculosis was a slow killer and probably a reason that Sister Emilie felt unwell during her stay in the Faroe Islands. Another reason could be that Sister Emilie was frail, even before her illness, too religious, without a sense of reality, and not morally mature. A third reason could be the presence of the first Faroese nurse trainees. The Danish deaconesses were expected to train young Faroese women in nursing, with the objective for them to become self-supporting and establish a school of nursing of their own. The first milestone in this endeavor was reached in 1920 when the first young Faroese

38 Letter from Sister Emilie Møller, February 13, 1923, A-DDF.
39 Malchau Dietz 2013, pp. 73–86; Svensmark 2018, pp. 47–49.
40 Diakonissestiftelsens årbog 1926, p. 95.
41 Rasmussen 1931; Nielsen et al. 1968, p. 149.

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woman started as nurse trainee at the old hospital. In the following years, the nursing school accepted two to four trainees each year. The training consisted of practical bedside care with sparse theoretical teaching. The nurse trainees more or less served as unpaid hospital workers. The deaconesses on duty and the physician were supposed to take part in their practical training and theoretical education, which always took place at night after working long hours.[42] It could be that the probationer Sister Emilie felt put aside in favor of the Faroese trainees. Furthermore, she served in the Faroe Islands at a time when there was an extremely heavy workload, and in a time of transition with confusing hospital and healthcare conditions because patients and staff were due to move to a new hospital. A bigger, modern hospital was under construction and the old hospital was to be abandoned. These transitions seemed to be affecting them all, as clearly demonstrated in a letter (dated July 15, 1923) by the above-mentioned Sister Agnes Petersen.[43]

Sister Agnes Petersen (1886–1959) served in the Faroe Islands from 1917 to 1924. She was serving when the first nurse training was established and during the planning for the move to a new hospital. The old hospital was overcrowded. Its capacity was 20 patients but, with 40–50 patients per day, they had to rent rooms in the town and use barracks for patients with epidemic diseases. In a letter from 1923 to the superintendent, Sister Agnes talked about the upcoming move to the new hospital and the bustle and confusion this was causing. The move finally took place on February 23, 1924, when the first patient was admitted. Her letter shows that Sister Agnes was a head nurse who cared for the young nursing staff, especially the Faroese nurse trainees, who had a long working day and a large workload and could not be stretched further. Sister Agnes also wrote that the physician had difficulty seeing that the staff was overloaded. He did not understand until he was told directly, she reported. For this reason, she asked the Danish superintendent for permission not to take vacation in 1923, the last year at the old hospital, which had become "the year of confusion" as she called it. "I dread the time that I must be away from the Faroe Islands. Somebody might end up being worked to death."[44] Sister Agnes left the Faroe Islands in 1924 after seven years of service.

4 Service in the Faroe Islands Between the Two World Wars

Despite 1923 being a year of confusion, according to Sister Agnes' letter, in many ways the 1920s were good years. The Faroe Islands progressed socially, the population was growing, and, importantly, the first nurse trainees graduated, and a new hospital was opened. The new hospital was named Queen Alexandrine's Hospital after the Danish queen. It could accommodate 52 patients (quite a number at the time), and in the first year the hospital staff consisted of 28 people in total. Among them were one senior consultant, one assistant physician, some nurses and a couple of Faroese nurse trainees.[45] A few years later, a special unit for tuberculosis patients was added, and in 1933 a unit for epidemiologic patients and a children's unit were opened.

Unlike the 1920s, the 1930s was a paradoxical decade. On the one hand, nursing standards were rising because of common rules and legislation for Danish nurse education,[46] rules that also applied in the Faroe Islands. On the other hand, it was a decade of depression, stagnation, and staff short-

42 Petersen 1998, pp. 42–48.
43 Letter from Sister Agnes Petersen, 15. July 1923, A-DDF.
44 Letter from Sister Agnes Petersen, 15. July 1923, A-DDF.
45 Dronning Alexandrines Hospital, Torshavn 1924.
46 Malchau Dietz 2013, pp. 222–228.

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ages because of poor and hardworking conditions.[47] One deaconess who had to face these demands was Sister Ingeborg Hansen (1886–1966), matron at Queen Alexandrine's Hospital.

Sister Ingeborg Hansen served in the Faroe Islands for 20 years, from 1928 to 1948.[48] The story we summarize here is a short compilation of her letters to the leaders of the motherhouse in Copenhagen over two decades. It appears from the letters that Sister Ingeborg had an open, bright, and positive mind. She was the oldest of eight siblings and before being admitted as a deaconess at the age of 31 years, and after her mother's death, she had cared for her siblings.[49] Throughout her years as matron she had close contact to her family in Denmark. It was obvious in the letters that she was used to caring for family and friends. As a "surrogate mother" she was concerned about the health of the other Danish deaconesses in the Faroe Islands; she closely followed what was going on at the hospital as well as in the community at large and among its people; and she was a human being who trusted in God and considered God to have a hand in everything. Generally, she was happy to work in the Faroe Islands and she loved the people.

The first letter from Sister Ingeborg about her position as a matron in the Faroe Islands was written at the beginning of 1928, when she held a position as matron at the hospital in the Danish town of Odense. She replied to a query from the lady superintendent who asked her to serve in the Faroe Islands as the matron at Queen Alexandrine's Hospital in Torshavn, the capital of the Faroe Islands. The previous matron, Sister Karen Morthensen, had returned to Denmark due to illness. Sister Ingeborg's answer was, in the beginning, polite and humble; she was hesitant, had a modest estimation of her qualifications for such a big position, and she was in doubt because of her commitment to the Danish patients and the physician in Odense. Obedience to God and her calling were the deciding factors, so finally she expressed her gratitude for the confidence in her and the honor. She was not asked but ordered – and therefore obliged to submit to rule number one: obedience to the motherhouse. The letter ended with blessings and hope for the sick matron's early return to Torshavn. "[…] I will ask God to arrange everything about this matter and hope Sister Karen is able to return to her work."[50] Clearly, Sister Ingeborg was anticipating a short stay in the Faroe Islands standing in for the matron, Sister Karen. However, this is not what happened. Two months later, in July 1928, Sister Ingeborg arrived in the Faroe Islands and began 20 years of service as matron at Queen Alexandrine's Hospital.

Sister Ingeborg arrived at a hospital in a phase of growth and development. More and more Faroese nurse trainees were accepted, more staff members were employed. We believe that Sister Ingeborg participated in employment, management, teaching, and administration; and we know that she, as matron, oversaw arrangements for the nurse trainees to supplement their education at Danish hospitals,[51] and that the trainees considered her to be a good teacher and a caring mother.[52] She also cared for her sister deaconesses' health and well-being, the ones at the hospital as well as the ones working as home nurses in the remote villages. And we know from nurse trainees' stories[53] that

47 Sigvaldsen 1995, pp. 19–23; Wingender 1999, pp. 30–34.
48 Diakonissestiftelsens årbog 1967, pp. 40–41.
49 Diakonissestiftelsens årbog 1967, p. 41.
50 Letter from Sister Ingeborg, March 7, 1928, A-DDF.
51 Petersen 1998, p. 116.
52 Petersen 1998, p. 113.
53 Petersen 1998, pp.70–72.

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when a patient was dying, the matron was to be called, day or night.[54] Spiritual care was an important issue for the deaconesses and no patient was to die alone. To comfort and ease worried souls was a natural part of the deaconesses' calling, training and charity.[55] Sister Ingeborg's last letter before World War II and the occupation was dated February 2, 1940. Then her worries concerned the ongoing staff shortages in the hospital and the well-being of deaconesses in poor health. She was stunned to hear that the Helsinki Deaconess Foundation had been bombed, and was most grateful for everyday life. "Here we do not suffer from any needs. And we must appreciate how good things are. It could get worse here too."[56]

5 The Last Decade of the Deaconess Era in the Faroe Islands

Sister Ingeborg's last years in the Faroe Islands coincided with World War II and the post-war years up to the Faroese Home Rule Act of 1948. These were years of great political upheaval in the Faroe Islands, as well as other parts of the world, and they brought challenges that were felt in all parts of the country.[57] During World War II (1939–1945), Denmark and Norway were occupied by the Germans from April 9, 1940 to the end of the war in Europe, in May 1945. A few days after the German occupation of the two Nordic countries, Britain occupied the Faroe Islands to protect them from being used as a German base. The British occupation meant that all shipping transport between Denmark and the Faroe Islands ceased. There were no letters, packages, food deliveries, shipping, or visits to or from Denmark.[58] The cessation of transportation meant that Faroese nurse trainees who were in Denmark to supplement their training, and Faroese nurses who were working in Denmark had to stay there all through the war, instead of just for a few months as planned.[59] The occupation also meant that Faroese patients with mental health problems who had been cared for at psychiatric hospitals in Denmark before the war, had to stay in the Faroe Islands in miserable conditions. Because of unsafe sea conditions with mines and torpedoes, they could not be transferred to psychiatric hospitals in England or Scotland until the last year of the war.[60]

When the war ended in May 1945, the Faroe Islands was a country in rebellion. During the five years of war, the country and its people had managed without Denmark. They had suffered, along with the rest of Europe, and had lost many ships and about 200 sailing fishermen. So the cost had been huge but, at the same time, the country had tasted independence and managed reasonably well without the Danish administration. As a result, the Faroese politicians now wanted to take over and govern as an independent country, as Iceland had in 1944.[61] The rebellion was felt all over the country, and even in the hospital administration. Consequently, Sister Ingeborg did not feel at ease. Her letters repeatedly mention that she missed order and proper hospital management. In one letter though, dated October 28, 1945, she writes in detail about how medical and nursing staff walked over the mountains in a heavy storm to perform surgery on a patient with appendicitis. The weather

54 Here it is worth remembering that all nurses, even the matron, had accommodation in the hospital attic so as to be close to the patients.
55 Malchau Dietz 2013, pp. 13–18.
56 Letter from Sister Ingeborg, February 2, 1940, A-DDF.
57 West 1974, pp. 161–172.
58 Svensmark 2018, pp. 53–55.
59 Felagið Føroyskir Sjúkrarøktarfrøðingar 2007; Svensmark 2018.
60 Petersen 1998, p. 99.
61 Sølverá 2020, pp. 61–65.

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was so stormy that the doctor boat could not sail. "This is how things can be," she stated. The story provides another example of the working conditions a nurse in the Faroe Islands could face in the 1940s (excerpts from the letter are translated in Box 2). The matron, Sister Ingeborg, told this story with true pride. It might have been an exception, but her staff, doctors and nurses, managed well together. In a few words she communicated what they were facing professionally and how they managed despite the shortage of staff, the harsh climate and extreme surgery conditions. The story also revealed close collaboration between the hospital and home care services.

The senior consultant, a physician, and an OR nurse were in Westmanhavn and operated on a patient with appendicitis. – Thursday evening, we got the alarm, but the weather was so bad that the doctor boat could not go and fetch the patient. The only choice was to walk to Westmanhavn. So, the three of them, each with a backpack filled with instruments and stuff, walked over the mountain in a tremendous storm. None of them had walked there before and there was no real path to follow. It was dark with no moon. Around 9 am they came to Koldefjord where an automobile was waiting and took them to Westmanhavn. The surgery went well. They made sure the patient was doing well and in good hands with a local nurse, and they had some rest. Finally on Saturday, when the weather was better, they came home with the doctor boat. But first they had to go east along the Skulefjord and fetch a patient who was to be admitted to the hospital. At 9 pm Saturday they returned, radiant with pleasure and filled with experiences. But they had just arrived when the physician on duty received a message from a southern island, about a sick child. And so, one of the doctors who had taken part in the expedition, the doctor boat and its crew had to go out again, this time to the island of Sandoy. – Yes, this is also how things can be here!

Box 2. Sister Ingeborg's story about acute medical and nursing care on the Faroe Islands in stormy weather, October 1945.

In 1945, Sister Ingeborg had two weeks' vacation in Denmark with her family. After returning to the Faroe Islands, she was pleased to see that the hospital building was returning to normal after the war: It had been painted and looked as new. However, her letters also reveal that she was now less happy about her job as matron. There was political commotion in the country, the hospital was extremely busy with many patients, and the nurses and nurse trainees, who were still working 12 hours a day, were demanding shorter working hours – a demand she understood but could do nothing about because of a lack of space. The hospital could not accommodate more nurses and trainees. As can be seen in the following quote, Sister Ingeborg was in a serious dilemma, and experienced some ambiguity in her call to service and to God.

> I think it is a difficult time to be in. I am becoming a pessimist. Things are so difficult, and I wonder if there could be a substitute for me soon. At the same time, I am filled with awe when thinking about another sister coming up and taking over. I feel like I am trudging through mud. There is nobody to keep order, everything is blurred and I want to say goodbye. – But then it comes – Who is to take over? It will hurt me if someone who cannot manage takes over. You must love your work and the people to endure. And I

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> think: God will find a suitable nurse and if it is his will that it is a deaconess, he will take care of this too.[62]

It is obvious that Sister Ingeborg's mind was filled with doubts about what was right and wrong, and she asked for a substitute. She had served for two decades, and she wanted to retire. However, Sister Ingeborg stayed another year, returning to Denmark for good in the summer of 1948. Before leaving, she knew that no deaconess was going to succeed her, and the goodbyes after all these years were described as heartbreaking on both sides.[63] Back in Denmark, at the age of 62, Sister Ingeborg served as hostess at the deaconess guesthouse for a further eight years. She spent her last years at Sister Sophie's Memory, the nursing home for deaconesses in Copenhagen.[64]

6 Conclusion

The five deaconesses' biographies and letters included in this article paint a small picture of the nursing care, work, and ethical dilemmas faced by the 25 deaconesses in the Faroe Islands during the first half of the 1900s. The article demonstrates that the Danish deaconesses were the first to introduce skilled nursing in hospitals and home care settings in the Faroe Islands. Importantly, they established a formal nurse training program for young Faroese women and, as leaders and matrons, they set the nursing standard at that time and for the future. They remained on the nursing path during harsh working conditions, and not even World War II could change their professional attitude. The deaconesses also managed to be at the forefront in terms of societal development and the position of women in general, and so were able to set the standards for qualified nursing care.

The article provides examples of how some deaconesses adapted with ease and stayed for decades and how others had to give up and return to Denmark. Nevertheless, the deaconesses in the Faroe Islands were nursing pioneers when it came to establishing skilled nursing. Their contribution to trained and organized nursing and to building a healthcare system in the Faroe Islands should be included in the profession's history and not be forgotten. The deaconesses worked according to a Lutheran Protestant religious philosophy and under strict obedience to their motherhouse. They followed the standards for ethical nursing behavior of the time, and they did it with skill and obedience and always with God's will in mind. For them, nursing was a calling.

This article is among the first to provide examples of nursing care and work during the deaconess era in the Faroe Islands, which lasted from 1897 to 1948. The article also adds to the body of knowledge about the history of nursing in the Nordic countries. We are aware that further and more detailed research on the history of nursing in the Faroe Islands is needed, including on Faroese nursing from the perspective of the Faroese women, and characteristics and conditions of the shifting training program in theory and practice. The Faroe Islands, a small remote country in the North Atlantic, most likely had to redefine Nordic and international nursing standards to fit their cultural context. Therefore, it is important to establish comparative studies to trace similarities and differences between Faroese nursing programs and the programs in Denmark and other Nordic countries – to continue exploring the educational and professional issues that have emerged over time in the Faroese nursing programs.

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62 Letter from Sister Ingeborg, April 21, 1947, A-DDF.
63 Diakonissestiftelsens årbog 1967, p. 41.
64 Diakonissestiftelsens årbog 1967, p. 41.

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