Who cares? An ethnographic research on the workforce integration of first-generation immigrants in geriatric care in the Netherlands and Germany

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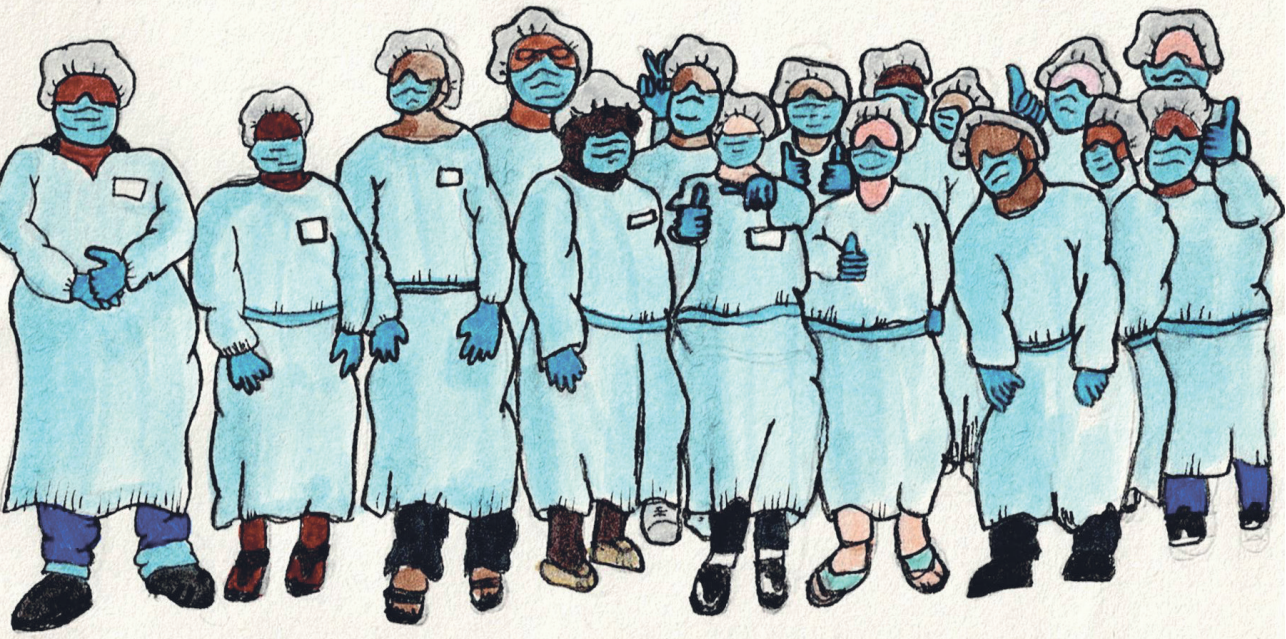


Chapter 1

INTRODUCTION. AN ETHNOGRAPHIC RESEARCH ON THE WORKFORCE INTEGRATION OF FIRST-GENERATION IMMIGRANTS IN GERIATRIC CARE IN THE NETHERLANDS AND GERMANY

"I want Kroten!"

It is 11.30 o'clock. Anna[1] checks the clock in the small staffroom. 'It's almost noon, come on', she tells her new Eritrean colleague Debesay[1], 'it's time to serve the soup'. 'Serving food is really hard', Debesay whispers to me, 'because I do not know the food and those Dutch names are really very difficult', she sighs as she pushes the food trolley down the hall. The 12 o'clock menu contains two dishes; chili con carne or beetroot with potatoes/mashed potatoes, the residents can choose. Debesay knocks on Mrs. Visser's door, she enters the room and asks Mrs Visser who sits on a chair: 'Good morning' Mrs. Visser, what do you like to eat today?' 'What's on the menu?' the old lady mumbles softly, almost inaudible. 'There are beans or beetroots', Debesay pronounces the words very slowly in Dutch. 'Oh', the old lady laughs. Despite the fact that Mrs. Visser does not see or smell the food because the trolley remains in the hallway, she says, [using a dialect word for beetroots]: 'Kroten *would be nice', and she looks at Debesay and smiles again. 'No', Debesay looks at her and she shakes her head, 'No', she repeats again,' we only have beans or beetroots'. 'I want kroten, the old lady says again and smiles. Debesay leaves the room and goes to Anna. 'And?', Anna says, standing behind the trolley with a spoon in her hand, ready to serve. 'What does she want to eat?'. 'She wants kroten', replies Debesay, repeating the old lady, 'but we do not have it, what can we do?'. Anna giggles and says: 'Kroot is beetroot, kroten is the dialect here in the village'. 'Yes', Anna continues, 'I didn't know that at first either. Because where I come from, [City in the Netherlands] you do not say kroten to beetroots either'. Anna giggles again and with a big spoon she serves the beetroots on a plate. With a large spoon the mashed potato is scooped out of another pan, together with a small piece of meat, served on a plate. Anna gives the plate to Debesay. Debesay rushes back into Mrs. Visser's room. 'There you go', says Debessay, putting the plate on the table in front of Mrs. Visser. 'Kroten', Debesay smiles, 'enjoy your meal'. Mrs. Visser laughs: ''Thank you and today you learned a new word'.*

After the so-called European 'refugee crisis' in 2015-2016 and to reduce the growing nursing shortage, two health care institutions in the Netherlands and Germany started their own integration project for first-generation immigrant[2]. The present dissertation contains the findings of an ethnographic research project that provides insight into the workforce integration in these two different residential homes. By following two groups of first-generation immigrants with a refugee[3] background, through ethnographic observations and participatory methods, their daily (inter) actions with residents and colleagues in the residential home are explored. What does integration in a residential home mean in daily practice? How do changes take place? Which tensions and conflicts arise between established[4] workers and newcomers? How do the established workers and newcomers enact caring activities such as washing, dressing, helping with food, toileting and other activities of daily living? This study shows the social processes and challenges faced by both the established health care workers and the immigrant workers in their day-to-day work. Behind the stories of 'integration' at the work place are stories of institutional change and organizational constraints, such as shortage of staff, different norms of professionalism, a heavy workload, experiences of pain and pleasure, feelings of resentment and the struggle how to become a caring team.

These stories show that there is no linear path to 'integration' in geriatric care practices. Instead, this study shows how behind the closed doors of care homes events unfold which are situated, complex and normative. It will become clear that different enactments of care help to shape daily life in the wards in different ways. On the one hand, established workers and newcomers distinguish themselves from each other through collective images of 'us versus them'; on the other hand, in daily practice they often manage to tinker in order to enact good care to the older residents in their residential home. This thesis aims to open up a field of reflexivity and evaluation. It offers different ways of thinking about "integration", about social processes and the enactment of care in daily practice, about how we take care of ourselves, each other and our older people in society. No claims are made in this study about the universal validity of its findings. Dynamic processes and ordinary practices of care in their situatedness are taken seriously.

This introduction will further explain the background, the theoretical framework and analytical strategies that are used to explore this issue. I start with sketching the background of ageing societies and shortage of staff in Western Europe and the recruitment and integration problems of immigrant care workers in general. I

will then describe the impact of the refugee crisis in 2015 and 2016 and its ensuing policies of workforce integration in the Netherlands and Germany. In the next section the aim and research questions are outlined and the theoretical background and sensitizing concepts are described. I elaborate on the ethnographical approach, the specifications of the two residential homes and how access was obtained, the research methods and the ethical considerations. I reflect on my background as a nurse and medical anthropologist, followed by an outline of the thesis.

AGEING SOCIETIES AND SHORTAGE OF NURSES IN WESTERN-EUROPE

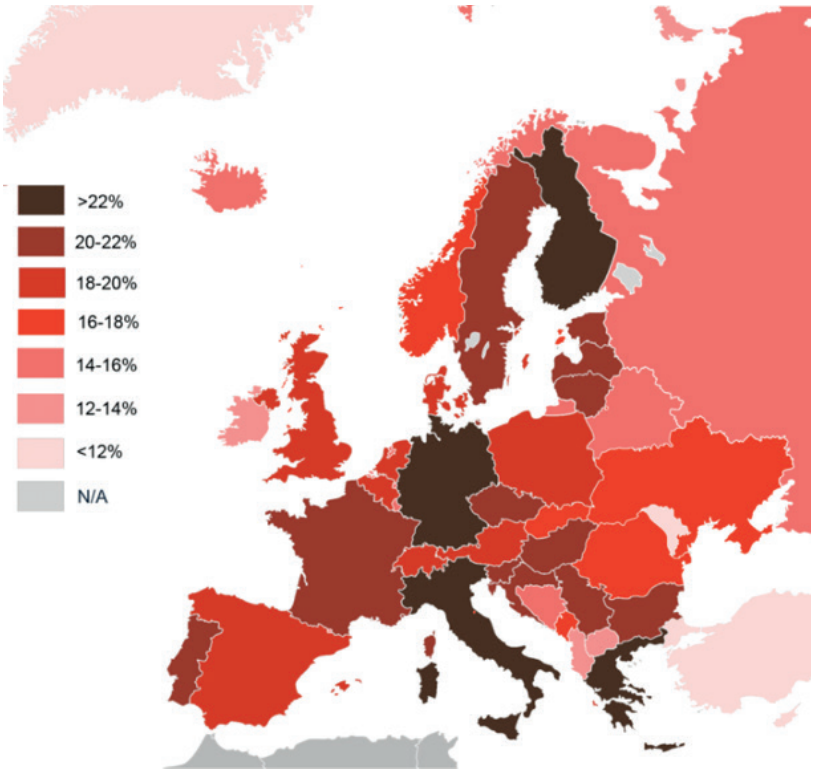
The world's population is ageing. In 2020, worldwide 727 million people were aged over 65. According to the United Nations Department of Economic and Social Affairs (2020), this number will have doubled by 2050.

In Europe, the increase in percentage of the population over 65, sometimes referred to as the *greying of Europe*, primarily results from three demographic processes: declining fertility rates, increased life expectancy and decreasing mortality rates (see also figure 1) (CBS, 2016a; World Health Organization [WHO] 2022). Germany is currently one of the most "super-aged" societies in the world (Federal Statistical Office [FSO], 2016). This *Demographischen Wandel* [demographic change] is caused by the fact that the population has been shrinking since 2003 as the birth rate has been lower than the death rate (Statistisches Bundesamt, 2021). It is expected that the number of people aged 65 or older will increase by 21.4 million in 2040 (FSO, 2016).

Similar demographic changes are happening in the Netherlands. There is a 'double ageing' of the population, i.e., more people live longer and the fertility rate is declining which results in an increase in the median age, a shift in the age structure. It is estimated that the number of people aged 65 or older in the Netherlands will increase from 2.4 million in 2020 to a maximum of 4.5 million in 2040 (CBS, 2021).

On top of this, it is expected that in Europe about one out of twenty people over the age of 65 will develop dementia and will need nursing care. Thus, it is predicted that in 2050 there will be 620.000 people with dementia in the Netherlands and up to three million in Germany (ABF Research, 2021, Statistics Germany, 2021).

Figure 1



Source: Percentage of the population over 65 in Europe in 2020 https://en.wikipedia.org/wiki/Ageing_of_Europe

These facts demand a competent nursing workforce to provide care for vulnerable older people. However, finding competent staff, such as doctors, nurses and health care assistants, is a major problem in many countries, especially in those ageing societies (WHO, 2020).

Since the early 1990s, the 'logic of the capitalist market' invaded residential homes in the Netherlands and Germany, i.e., private investors invested in this sector. This happened as the result of changed management and government policies in both countries that stimulated public-private partnerships, which gave more room for the market and less for the government. In order to achieve high returns (profit maximalization) organizations cut costs and forced caregivers to organize their work differently. Standards were based on the criteria of productivity, efficiency and profit (Böcker, Bruquetas-Callejo, Horn, Schweppe, 2020; Schweiger, 2011).

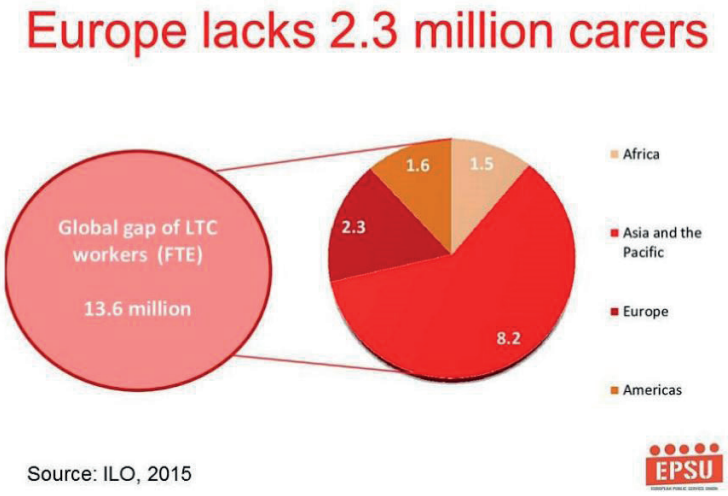
Shortage of staff is not new. Already since 2000 the German and the Dutch government tried to expand the labor workforce in health care and residential homes. However, the recruitment was not enough to reduce the high workload, especially due to the increase of ageing residents. Qualified nurses were still needed and shortage increased in the nursing sector according to the Dutch V&VN, the German BA's International Placement Services (ZAV, 2022) and the Gesellschaft für Internationale Zusammenarbeit (GIZ, 2015).

In 2008, due to the global financial crisis, the Dutch and German governments reduced even more budgets for the geriatric care sector. Residential homes felt forced to recruit fewer (international) nurses, cut the wages of employees, decrease their trainings and hire less qualified caregivers. At the same time, older people stayed at home longer and when they needed institutional care, they were in a more developed stage of their illness. As a result, caregivers in the geriatric care sector were increasingly stretched, as the tasks had to be performed with fewer people while the care-related tasks became more complex. This, in turn influenced the quality or care in the residential homes (Schweiger, 2011; The, 2008; The, 2017).

Nursing scholars argued that many health care institutions such as residential homes were maneuvered into neo-liberal policies with the tendency for commodification of work. Cost-effectiveness started to dominate, while conditions worsened due to the financial crisis. Staff members complained not only about low wages and staff shortage, but also about not being able to cope with the burden of work. They were dissatisfied with the quality of care they could provide for their residents (Müller, 2019; Perruchoud, et al, 2022).

According to the International Labour Organization (ILO), already in 2015 all countries worldwide reported a lack of skilled health care staff, with Asia and the Pacific facing the greatest shortage (8.2 million carers), followed by a shortage of 2.3 million in Europe, 1.6 million in America, and 1.5 million in Africa (see figure 2) (ILO, 2018).

Figure 2



In 2021, according to the Minster of Health in Germany 50.000 positions need to be filled. The German Nursing Council (DPR) predicts that 300.000 positions are needed within ten years (Statistisches bundesamt, 2021). A similar situation appears in the Netherlands, where there is already a shortage between 56.300 and 73.800 workers in the care and welfare sector; the forecast expects this to rise to at least 100.000, perhaps even 130.000 in 2030 (ACVZ, 2021a; Prognosemodel Zorg en Welzijn, [Forecast Healthcare & Welfare], 2021).

The discussions in German and Dutch society are nowadays shaped by debates about 'nursing emergency' and 'nursing standstill', especially in relation to residential homes (ACVZ, 2021; SER, 2020; Schweiger, 2015). This means that various players in the field, such as health care institutions, politicians, scientists and professionals are discussing the lack of staff in the geriatric care. The geriatric care sector in both countries is complex, not only due to the professionalization and specialization required for the more complex caring tasks, but also due to the privatization of the care industry (Muller, 2019; Schweiger, 2014).

Due to the above, working in residential homes got a bad reputation. As a result, residential homes are more than ever faced with a shortage of skilled workers, because fewer employees are willing to work in those institutions (GIZ, 2021; RVS, 2020; V&VN, 2021).

RECRUITMENT AND INTEGRATION PROBLEMS OF IMMIGRANT CARE WORKERS

One of the remedies of the shortage of staff in ageing societies is the recruitment of immigrant workers (ACVZ, 2021). This strategy is not new. In 2001, in the documentary *"Buitenkans"* (Exceptional opportunity), the Dutch documentary maker Ireen van Ditshuyzen filmed South African nurses who were recruited to remedy the shortage of staff in the Netherlands. The documentary showed how they were welcomed at the airport and given housing in the Amsterdam suburb De Bijlmer. However, a few weeks after they started working in the Dutch hospitals, it became clear that these international nurses, who had received their nursing training in another country, were getting frustrated because their tasks did not match their expectations and they felt unprepared for what the job entailed. There were misunderstandings about wages and taxes. Moreover, the new workers experienced racism. The documentary showed not only the struggles of these first-generation immigrants, but also of the established staff. The South African nurses reported that '*nursing in the Netherlands is a social profession; in South Africa it is technical*'.

The established Dutch colleagues reported that despite the fact that their new colleagues spoke 'Afrikaans', they experienced language difficulties and had not been able to bridge the two work cultures either. They furthermore disqualified the complaints about racism by their immigrant colleagues as overemotional, while denouncing their '*different way of working*' as unprofessional. They also mentioned educational disadvantages and the unfamiliarity with the Dutch health care system as major problems. In the end, it led most South African nurses to quit their jobs and return back to South Africa (Van Ditshuyzen, 2001).

Almost ten years later, in 2009 and 2010, to avoid canceling surgeries, 118 Indian nurses were recruited to work in operating theaters in Dutch hospitals. However, after a few weeks the Dutch established staff began to complain. It was rumored that the Indian nurses lacked knowledge, expertise and language skills. According to the Dutch staff their incompetence led to life-threatening situations to patients. An inspection by the Dutch government followed. Although the inspection report did not confirm these rumors, not all of them could stay. Less than half of the total number of Indian staff members were offered a three year contract. Only a few completed this contract, but follow-up contracts were not offered (Inspectie voor de Gezondheidszorg, 2012; Van den Broek, 2014, p. 25).

A recently published report in the Netherlands from the Advisory Committee on Migration Affairs [ACVZ] (2021) stated that only 0,5% of first-generation immigrants with overseas nursing diplomas (and who are registered at the nursing council[5]) are currently at work in Dutch health care. This is a very low percentage, certainly when compared with other OECD countries. In Germany, for example, the percentage of first-generation immigrant nurses at work is 7,9% (ACVZ, 2021).

The problem of foreign workers who need to adapt to a new work environment while established staff need to adapt to a more international and/or culturally diverse workforce, is widely recognized. Workforce diversity can improve performance in teams because of a wider use of perspectives. But divergent values and norms can also negatively influence group cohesion as well as work performance. Differences, for example regarding time management and punctuality, can create irritation. Misunderstandings and miscommunication can also occur, for example because of different religious holidays, or different expectations about mentoring support (Van den Broek, 2014).

International studies about interethnic relations in health care institutions showed similar results. For example, a study from Xiao et al. (2014) about international nurses working in Australia found that, on the one hand, those overseas trained nurses experienced institutional discrimination, because their expertise and skills were not acknowledged by the staff and they felt a lack of support from the established employees. On the other hand, the researcher found that positive interactions between established staff and international nurses could lead to positive team collaboration. For example, interactions taking place in the staff room where the nurses explored common areas of interests, created group cohesion. These scholars found that nursing management needed to facilitate institutional programs that promote reciprocity for all nurses (Xiao et al., 2014).

In 2008, a study about interethnic relations at work in different organizations in the Netherlands showed that first-generation immigrants face various problems at work, such as language difficulties and conscious and unconscious prejudice and discrimination. Sometimes religious differences affected their work performance too. Some workers with a Muslim background for instance, wanted to pray during shifts, which conflicted with the rules of the work environment. Cultural differences led to conflicts as well, for example, when male nurses refused to follow instructions from female staff (Schaafma, 2008).

Before this research started in 2015, I had a personal conversation with the job manager of the UAF[5] and with a diversity manager from an Academic Hospital in Amsterdam in the Netherlands. The UAF job manager said that, despite the fact that first-generation immigrants had completed a nursing training in the country of origin, had received a Dutch language course on B2 level and attended retrainings, a substantial number could not keep their job. Often within a year, the immigrants knocked on the door of the UAF again, with the request to be escorted back to employment (S.Maessen, personal conversation, 2 June 2015). The Dutch academic hospital was also willing to open its doors for more diversity and wanted to be inclusive for refugees with a medical or caring background. However, according to the diversity manager of the hospital, it is easy to be open for 'the other' if it concerns internships, but when it is about employment other priorities seem to play a role (M. Stockmann, personal conversation, 17 November, 2015).

Several immigrant health workers with a refugee background reported incidents of racism and discrimination when they started working in the health care sector. The UAF manager gave examples of a nurse from Eritrea who said that a Dutch patient refused his nursing care, and of an Iranian nurse whose contract was not prolonged when the established colleagues had complained that she did not unload the dishwasher machine or clean up the table after dinner. According to this UAF manager, it seems that racism and the skills of immigrant nurses are often not recognized within the Dutch healthcare sector.

This is in line with a recent study by Cottingham and Andringa (2020) who quote a Dutch nurse with Surinamese roots who experienced racism when one of her patients had asked her to leave by saying: "*they know that I don't want foreigners and especially not Negroes*" (Cottingham and Andringa, 2020, p.5).

In 2017, 490.000 first generation immigrants were registered by German labor agencies. Language classes and vocational education (re)training are offered to refugees throughout the country as a stepping stone to the German labor market (James, et al., 2020).

However, according to existing research in Germany, first-generation immigrants from outside the EU have similar experiences with regard to interethnic relationships as mentioned in the above Dutch studies. For example, a recent study conducted by James, et al. (2020) about labor market integration of first-generation immigrants with a refugee background, showed that German

instructors experienced how different values and norms between refugees and the Germans hampered communication, for example about time management. The immigrants, in turn, did not only experience a lack of support to promote positive interactions with their German counterparts, but were also unable to improve their German language skills, due to the limited opportunities to practice the new language with the natives. In addition, the immigrants said that they often received negative feedback from the German teachers and felt treated like children when they received comments on their being late or inattentive. The Germans regularly evaluated the performance of these first-generation immigrants in the light of what was lacking, for example their inadequate German language skills, or their lack of knowledge and education. Their bi-or multilingual skills were never perceived as a strength. The established staff expected high loyalty from their immigrant colleagues as they should be grateful for the 'German welcoming culture', their vocational training and their new work environment (James, et al., 2020).

The aim of German Health care institutions is to provide optimal conditions for a diverse workforce and to create opportunities for refugees to get a job in the health care sector (ILO, 2018). Once at work in a German healthcare organization, first-generation immigrants indeed face huge challenges. For example, in a study from Schilgen, et al. (2019), the language barrier was reported as a challenge and as causing major stress. The established staff and the newcomers both said that language skills were required for effective communication with patients and colleagues. Moreover, they were necessary for everyday encounters, patient safety and administrative work. Lack of language skills negatively affected their mutual understanding and nurse-client relationships, which caused irritation and frustration on both sides. However, these scholars also found that despite different cultural backgrounds, the established staff members and immigrants also saw commonalities, such as pursuing the same care goals and using similar coping strategies to master the workload and institutional burdens. They also experienced similarities regarding time pressure and lack of appreciation by their supervisors. Both groups coped with these burdens through the mutual support of peers. Commonalities created positive relationships and a sense of belonging which fostered group cohesion in the nursing teams (Schilgen, et al., 2019).

Thus, in the Netherlands and Germany first-generation immigrants from outside Europe experience serious institutional challenges. It seems that the talents of first-generation immigrants are often not recognized (Federal Ministry of Education and

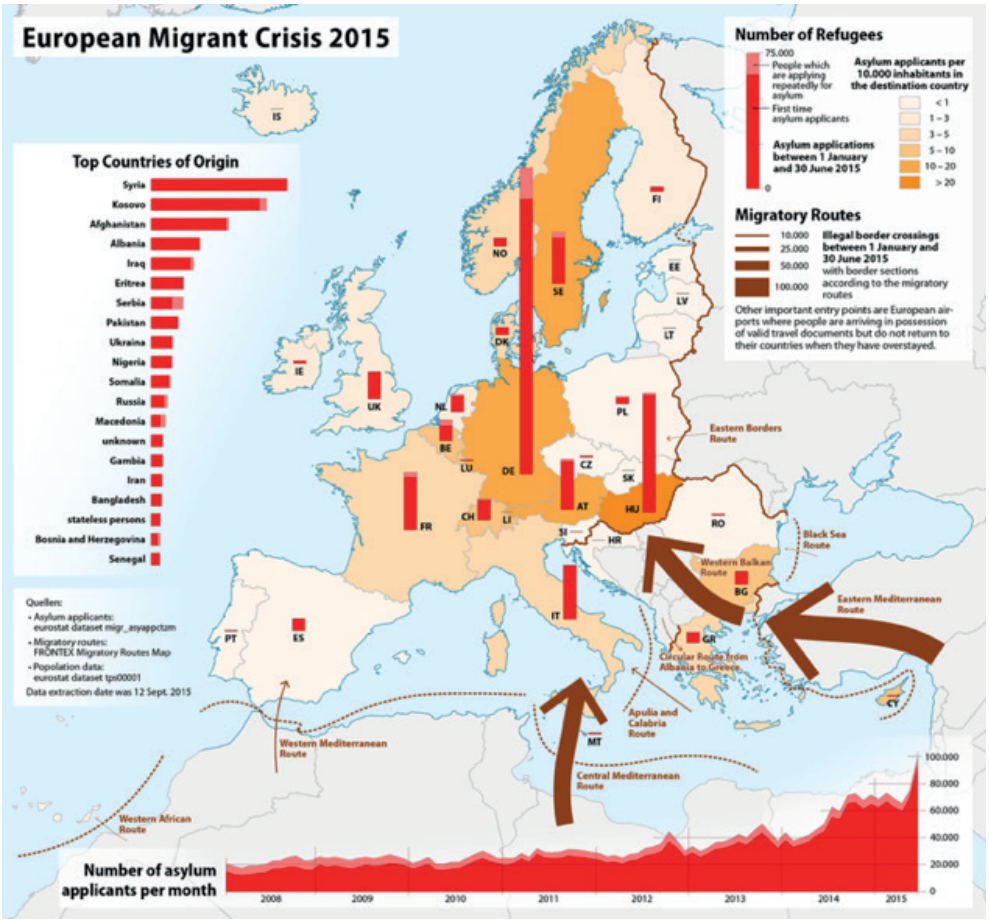
Research, 2017; Tangermann and Grote, 2018) even if health care institutions are very willing to open their doors for more diverse personnel. Both Dutch job support centers and German labour agencies have often reported mis-matches between established staff and first-generation immigrants with a nursing background in the workplace.

It is often claimed that increasing diversity, or a mixed composition workgroups in organizations, leads not only to a better use of talent, but also to more innovation. This is sometimes referred to as innoversity, i.e., when diverse people are able to learn from each other and combine their knowledge and skills, new ideas and capacities can be created (Justesen, 2007, p. 34). This is in line with findings from the Dutch Scientific Council for Government Policy (WRR, 2018) and the Advisory Council for Science, Technology and Innovation (AWTI, 2017) who argued that in many organizations diversity and creativity lead to innovation and a greater problem-solving ability of teams (For reviews, see also Van Knippenberg, Nishii and Dwertmann, 2020; Yadav and Lenka, 2020). However, in health care institutions other processes seem to dominate.

THE REFUGEE CRISIS IN 2015 AND 2016 AND NEW INITIATIVES

In 2015 and 2016, due to the Syrian civil war and conflicts in Afghanistan, Iraq and Eritrea many refugees were seeking protection in EU countries, Norway and Switzerland. About 3 million refugees have been registered within the European Union since 2015 (see figure 3). People arrived either via dangerous sea routes, or overland through Southeast Europe, the so-called ‘Balkan route’ (Eurostat, 2021).

Figure 3



source: https://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_quarterly_report

Among these refugees, the larger group were Syrians, who entered the Netherlands with roughly 18.700 people, followed by the second group of Eritreans, with about 7.400 people. In 2015, around 44.000 asylum seekers requested a resident permit in the Netherlands (CBS, 2016b). Germany received mostly refugees from Syria, Iraq and Afghanistan. While some countries took in more people than others, Germany recorded the highest number of refugees and applications for asylum (Jobst, et al., 2018). The UK and France received fewer refugees, because many asylum seekers arrived through the 'Balkan route'. Germany was known for its 'Welcome Culture', i.e., its hospitality toward refugees (Fleischmann and Steinhilper, 2017, p. 17). The

number of first-time asylum applicants in Germany was 442.000 in 2015, which was the highest number of immigrants in Germany since the start of the registration in 1950 (Federal Office for Migration and Refugees, 2015).

It was expected that many of these first-generation immigrants with a refugee background would start their integration process[6] in society as soon as possible (WRR, 2015). The Organization for Economic Cooperation and Development ([OECD] (2019), reported that societal participation and paid work further the integration process of immigrants. Although in most European countries asylum seekers and refugees are being made responsible for their own integration process, there are also many organizations, municipal councils, foundations and volunteers who support them (Fleischmann & Steinhilper, 2017; Ghorashi and Rast, 2017; Verwey Jonker Instituut, 2020). The Scientific Council for Government Policy (WRR, 2015) in the Netherlands for example, argued that there was 'no time to lose', meaning that the newcomers should be enabled to start immediately with their integration process in the new society (WRR, 2015).

Although many refugees want to work, they often have difficulty finding a job. Even for those with caring diplomas, access to the Dutch health care sector is difficult. In a recent report: *From asylum-seeker to care provider*, the Dutch Advisory Committee for Immigrant Affairs (ACVZ, 2021) has identified different obstacles. Firstly, there are many rules and regulations and immigration procedures are slow. This in turn slows down other procedures, for example to be admitted to language classes and integration courses, which in turn slows down access to work. Secondly, diplomas and competences obtained in the country of origin are often not recognized in the Netherlands, or to get them recognized requires a lengthy bureaucratic procedure. Thirdly, the culture in the workplace is perceived as a barrier, for example, established staff and newcomers have different norms and manners, and the newcomers often experience discrimination by clients and staff members (ACVZ, 2021).

It is clear that, although national and local institutions in Germany and in the Netherlands actively promote integration processes of refugees and stimulate participation through (paid) work, in practice first-generation immigrants face huge problems. In the Netherlands, for example, the labor market position of especially non-European minority[7] members is relatively unfavorable (ACVZ, 2021). Even though employment of non-European newcomers has increased over the

years, the average unemployment levels among first-generation immigrants with a refugee background in 2020 was still 3-5 times higher than among the Dutch native population (SCP, 2020). Furthermore, long-term unemployment is still high among first generation newcomers and if they get a job, it is on average in low-status jobs with lower wages, even if they had higher education in their country of origin (Damelang, et al., 2021; Eijberts, 2013; SCP, WODC, RIVM, CBS, 2021).

This study

In this study the focus is on two countries, the Netherlands and Germany. A Dutch-German comparison is interesting because they are neighboring countries with, as indicated earlier, similar demographic changes with ageing populations. Both countries are struggling with a shortage of health care staff and have recruited international nurses in the past and both had a high influx of refugees in 2015 and 2016. Moreover, the Dutch often refer to German policies to legitimize changes, for example with regard to immigration policies or to stimulate a diverse workforce. However, there are also differences between the Netherlands and Germany, such as the Netherlands' colonial history. In the Netherlands, nurses were recruited from former Dutch colonies such as Surinam, Indonesia and South Africa (CBS, 2021). In Germany, the fall of the Berlin wall (1989) created opportunities for care workers from the east to get employment in Western Germany. Different German health care institutions recruited caring staff from Serbia, Bosnia and Herzegovina, but also from South Korea, the Philippines and Tunisia (GIZ, 2013; ZAV, 2022).

Both the Netherlands and Germany suffer from shortage of care personnel in the residential homes and face an increase of the complexity in the conditions of older people. Moreover, both countries recruited international nurses, which was sometimes more, sometimes less successful. In 2015 and 2016, both countries saw an increase of non-EU immigrants, the majority of whom were willing to integrate. The shortage of staff in the care industry in the Netherlands and Germany could be an opportunity for recently arrived immigrants, while their presence could also be beneficial for health care institutions. This could therefore result in a win-win situation (ACVZ, 2021).

Nowadays, many European health care institutions provide language courses and (re)educational training to first generation immigrants from outside the EU, so that new employees can successfully enter the workforce. However, little attention has

been paid to the question why relationships at the work place between established workers and first-generation immigrants are often so challenging. What are the sources of their mutual (mis) understandings in day-to-day care practices? What does the arrival of new groups of employees mean for the group dynamics in the setting of a residential home? How is care *practiced* by established health care workers and first-generation immigrants in the workplace of residential homes? This research tries to answers these questions by looking at the interactions in daily care practice.

Most research on immigrant integration at the work place focuses on people's cultural competences. However, the definitions that are used are different. For example, according to Purnell et al, cultural competence is about the ability to understand people across cultures in intercultural settings (Purnell, et al., 2021), while Deardorff' defines it as: 'the ability to communicate effectively and behave appropriately in intercultural situations based on one's intercultural knowledge, skills, and attitudes' (Deardorff, 2006, pp. 247-248). Some research is focused on how to guide culturally competent organizations (Purnell et al., 2021), other studies focus on how to assess one's own and others' cultural competences (Bartel-Radic & Giannelloni, 2017; Belt, et al., 2015, pp. 107-108; Halabi, et al., 2021; Lee, et al., 2020; Shen, 2015). However, how people actually act or relate to others can only be studied by looking at everyday practice, i.e., at the way in which people actually behave in face-to-face interactions with people from a different (cultural, ethnic, racial) background.

This research differs from previous studies on workforce integration in health care in the following respects.

Firstly, most studies are based on interviews, and as a consequence focus primarily on the feelings of care workers and their interpretations of their work experiences. Little attention is paid to the context and conditions they worked in, or to what actually took place in the events they reported about in the residential home. To fully grasp what actually happens at the work place, their situations and interactions should be studied. Therefore, the present research makes use of **ethnographic methods** that gather data on what is actually going on 'in the field'. It will not only be based on (in-depth) interviews, but also on extensive fieldwork, i.e., participant observation and focus groups meeting. Peoples' (inter)actions and accounts are studied *in situ,* both in the (re)training sessions and in the everyday care practices in the residential home.

Secondly, little research has been done on how first-generation immigrants with a refugee background experience and assess the health care practices in their new country. Alfred Schutz has pointed out that 'strangers' acquire an outlook not normally available to 'natives', due to which aspects that are considered of no importance suddenly may acquire great significance (Schütz, 1944, p. 499). In line with this, the present research assumes that taking a **reversed gaze (**i.e., the outsider-perspective of immigrant care workers) more seriously, may provide interesting, critical insights in the pros and cons of the taken for granted routines and habits in Western residential homes.

Thirdly, if national policies resonate in people's perceptions (Broer, 2006, p. 9), then employees in different political and institutional circumstances will in all likelihood experience newcomers differently. That is why this is a **comparative research project**, that looks at two residential homes, one in the Netherlands and one in Germany. My aim is not to analyze the two settings in terms of "better" or "worse", but to see whether different circumstances would lead to different social processes and if and how this would affect the enactment of care. Thus, this study focuses on two locations in two countries.

OBJECTIVES AND RESEARCH QUESTION

The **aim of this thesis** is to develop an in-depth understanding of social processes in institutions for geriatric care where first-generation immigrant workers and established staff members start working together, in order to investigate how their interactions influence the enactment of care. More specifically, it seeks to advance the understanding of the social dynamics between established staff and newcomers in their daily care practices in a Dutch and a German residential home, in order to improve job opportunities for first-generation immigrants with a refugee background in nursing care institutions.

The **relevance of this research** lies mainly in creating awareness of the social processes that occur when a group of new care workers arrives in a residential home, uncovering the organizational context of that home and the implicit values related to the enactment of care. This study shows how certain patterns and processes in care institutions can affect new and established workers in their ability to *enact* good care to older residents.

The main objectives of this research lead to the following central question and sub-questions:

How do social processes and values of care affect the interactions between first-generation immigrants and established health care workers, and how do these dynamics influence the enactment of good care?

The main research question is divided into two sub-questions:

1. What are the social processes affecting the workforce integration of first-generation immigrant health care workers in a residential home in a Dutch and German residential home?
2. How are values of care enacted by established health care workers and first-generation immigrants in a Dutch and a German residential home?

THEORETICAL FRAMEWORK AND SENSITIZING CONCEPTS

In order to analyze the empirical data on group processes in health care institutions and the enactment of geriatric care, the use of sensitizing concepts can be an important starting point to suggest not so much what to see, but rather 'directions along which to look' (Blumer, 1954, p. 7). According to the sociologist Blumer, sensitizing concepts do not lead the researcher directly to the relevant content, but provide a deeper perception or ways to understand the data by drawing attention to important characteristics or social interactions in specific environments (Blumer, 1954). In this study three clusters of sensitizing concepts will be used.

The established and outsiders

Understanding what happens in an organization and at the work place cannot be fully understood without attention to processes of group dynamics. The sociologist Norbert Elias (1897–1990) argued that individuals, groups and organizations in a society cannot function independently but are interconnected with each other (Elias, 2000).

In a classical study from Elias and Scotson, *The Established and the Outsiders* (1965) they clarify social processes that took place in a suburban community – more specifically how an established group treated the members of a newly arrived

group. It appeared that tensions and inequalities between people were based on the established-outsiders configuration, a figuration that implies inequality of power between the groups concerned (Elias and Scotson, 1965, p. 157). The core of human behavior is influenced by these social configurations, i.e., networks of interdependent relations between people (Elias and Scotson, 1965, p. 170).

The communal control of the established group consisted of excluding members of the other group by stigmatization and gossip. This occurred, even though the newcomers did not differ from the established group members in any other way (Elias and Scotson, 1965, p. 158). Elias & Scotson argue that groups with power tend to experience themselves as morally better than groups in the margins. In their study this could be explained by the fact that the dominant group was already there first, thus by place and length of residence, and consequently had more access to different resources, such as knowledge, networks, etc. This strengthened the division between them and the other group ("us" versus "them") (Elias and Scotson, 1965, p. xlviii).

In 1975, Elias further elaborated the theory of the established and outsiders' relation in adding a theoretical essay (Elias, 1994 [1976]. Elias explicitly argues that this figuration can also be applicable to relations between other social groups, for example between men and women, or ethnic relations, such as 'white and blacks', because the same patterns of exclusion and stigmatization can be observed by dominant groups in relation to other (outsider) groups (Elias and Scotson, 1994 [1976] p. xxx). Elias and Scotson argued that group dynamics might not just be triggered by conflicts about ethnicity, class or religion, but 'simply' by established - outsiders relations of a particular type: 'they are always balance-of-power struggles' (Elias and Scotson, 1965, [1976], p. xxxvii).

In 1990 and 1994, in relation to the changing circumstances of race (and racism) in the United States, Elias pointed out that structural inequalities are based on power relations between people. The focus needs to be on the communal control of one group to integrate into other groups an on the degree of internal cohesion. When a dominant group excludes members of the other group. According to Elias prejudice is a product of groups within a particular figuration of power and not of individual persons who are, for instance racially prejudiced about other individuals (Elias, 1994/2002 [1990].

The established -outsider framework is very helpful in showing how group figurations and relations of interdependence work. Elias and Scotsons' established

and outsiders theory has been frequently used to understand community dynamics because it demonstrated the significance of looking beyond both individuality and structure when analyzing group processes and dynamics (Albeda, et al., 2017; Hogenstijn, et al., 2008a; Hogenstijn and Van Middelkoop, 2008b, Petintseva, 2015).

Thus, this theory can also be useful to understand what happens when immigrant workers come to work in an established institution, such as a residential home. With the help of the 'established and outsiders' framework, in this study I would like to draw attention to social processes and the role of power differences.

Elias and Scotson's established and outsiders' framework (1965/1994/2002) was used to describe processes between residents in a town, not between workers in an institution. By adding notions of Bourdieu's practice theory, especially the concepts of 'habitus' and 'feel for the game', I will be able to get a better insight in how first-generation immigrants and established workers (inter)act within health care institutions.

Habitus and feel for the game

According to the French sociologist Pierre Bourdieu (1930 -2002) there are different fields in society, such as the fields of politics, education, health, science and art. Each field is structured by certain power dynamics, authority forms, rules and regulations. The field structures internally the behavior of the players in that particular (sub)-field. For example, national politics (field) influences local politics (sub-field) which in turn influences the people in that field (players). Players in each field need certain forms of capital that determine their social status and power (positions).

Bourdieu distinguishes three fundamental types of capital, i.e., economic, social and cultural capital (Anheier, et al., 1995; Bourdieu, 1986; Bourdieu, 1980/1990; Bourdieu, 1992/1977). Each form of capital influences other forms of capitals and can be used to achieve different goals within different fields. *Economic capital* refers to money, property and other financial resources, and can turn into symbolic capital, which endows one with social status, power, recognition and appreciation. Symbolic capital is a sub type of *social capital,* which is about social networks embedded in personal or professional relationships. *Cultural capital* comes in three forms: in an objectified, an embodied or an institutionalized form. Objectified cultural capital consist of cultural goods, such as books, machines, instruments. Embodied

cultural capital refers to person's knowledge, skills but also ('good') tastes, postures, ('refined') cloths, ('civilised') manners and beliefs. In its institutionalized form cultural capital refers to education and qualifications. Cultural capital enables one to acquire social and economic mobility, which confers social status and power (Bourdieu in Richardson, 1986, p. 241; Smith, 2020)

Bourdieu's' capital theory can be utilized to better understand the integration process of first-generation immigrants. When first generation immigrants arrive in the new country, they need to gather *social capital*, i.e., build up social relationships and professional networks, which in turn will affect their *economic capital*, that will help them get access to the labor market. Finding a job increases one's status in society (*symbolic capital*). To gain *cultural capital* means to develop sufficient language skills and acquire educational papers, which in turn, may again increase one's *social capital*, having a professional network to build on (Bourdieu, 1977; Bourdieu, 1989a; Bourdieu, 1989b; Joy et al., 2018). Gaining capital is not a linear process and capital takes time to accumulate (Paulle et al., 2012, p. 74).

In many studies, first-generation immigrants are portrayed as 'passive victims' or as 'having lacks and deficiencies' (Zanoni and Janssens, 2007, p. 1371). The problem with a deficiencies approach, however, is that it unintentionally yields a static interpretation of situations or institutions that are actually quite dynamic. Newcomers find themselves imbedded in institutional structures and practices that are full of ambiguities, contractions and lacunae. Therefore, in the present study newcomers are not regarded as deficient people but as acting subjects who in their countries of origin have accumulated a significant amount of economic, social, cultural, linguistic and symbolic capital.

Newcomers also do not come to this field of the (Dutch or German) geriatric health care as a blank slate. They were born and raised, socialized and gained experienced in particular fields, such as the field of education and health care, in their country of origin (Glastra and Vedder, 2010). To capture this, Bourdieu uses the term habitus, which he defined as a system of durable and transferable deep-seated habits, skills and dispositions. According to Bourdieu the habitus:

> "could be considered as a subjective but not individual system of internalized structures, schemes of perception, conception, and action common to all members of the same group or class and constituting the precondition for all objectification and apperception: and the objective coordination of

> practices and the sharing of a world-view could be founded on the perfect impersonality and interchangeability of singular practices and views" (Bourdieu, 1990, p. 60).

In other words, one's habitus can be seen as a system of dispositions, 'manners of being, seeing, acting and thinking, a system of long lasting structures of perception, conception and action' (Bourdieu in Hillier and Rocksby 2005, p. 43). Thus, field and habitus are in a circular relationship: each actor in the field shapes the habitus, which once involved, reproduces the field (Bourdieu and Wacquant, 1992, p. 133).

Habitus is a socially learned, partly unconscious way of acting, thinking, and perceiving and is experienced within a specific socially constructed field. Socio-cultural patterns and structures are internalized as part of an individual's thinking and behavior. The more frequently certain behavior occurs in the field, the more it becomes an internalized preference or habitual state, i.e. a way of relational being (Smith, 2020). A habitual state is relational and social practices are influenced by social structures and the property of actors (Smith, 2020). Thus, when people find themselves in similar circumstances, such as in a particular organization, they are more likely to share experiences and perceptions with each other, that are translated into similar practices and representations (Bourdieu 1989; Vaughan 2008).

With the concept of habitus Bourdieu captured the way in which power gets performed in human bodies and in social practices. He also shows how power is embodied and regulates people, and in turn, how people actually practice their rules and regulations. Accordingly, humans are not entirely free agents as they are prone to certain actions, to go along with or mimic the habitus in that particular field (Smith, 2020). To describe the adjudgment to the demands of a field, Bourdieu used the metaphor of the game:

> "The objective structures within which it is played out, the feel for the game is what gives the game a subjective sense, a meaning and a *raison d'être*, but also a direction, an orientation, an impending outcome, for those who take part and therefore acknowledge what is at stake (this is *illusio* in the sense of investment in the game and the outcome, interest in the game, commitment to the presuppositions -doxa- of the game)" (Bourdieu, 1990, pp. 66-67).

Applied to the current project, it can be said that aspiring care providers need to get a feel for the game of care during their training and work experience in the new

environmental field. Because habitus is an internalized, relational state of being, transformation of a habitus takes time and usually develops step by step. Within the confines of shared rules and regulations in a health care organization, each individual care worker has the ability to represent herself creatively or to improvise in the field. In most of her actions she will be unconsciously guided by particular rules and regulations, that is the system of dispositions, i.e., subconscious structures that guide nursing practice in the organization (Lalleman, et al., 2016, p. 180). Thus, by constantly negotiating with others in the health care organization (field), with a "feel for the game" the ingrained habitual state of actors will change, which in turn influences the field (Lalleman, et al., 2016, p. 179).

To provide insight into the situational and organizational factors within the field of geriatric health care, in this study the everyday context is taken seriously. This means that the actions and accounts of both established health care workers and newcomers are studied in daily practice. In doing so, an attempt is made to avoid a one-dimensional or de-contextual analysis.

Tinkering and the enactment of (good) care

It is unclear how newcomers and established staff in health care institutions differ regarding their concepts (values) and ingrained habits of care.

We may assume that health care workers worldwide wish to provide good care. Different views of what is considered 'good' care can reflect different values within different cultures, as well as different ways of ordering reality. According to Mol et al.,(2010), good care is uncertain and precarious. To enact good care requires a constant *tinkering* between the different "goods" in connection with those who care and those who are cared for (Mol, 2008: p. 85). This tinkering means that they attune the different goods that matter most at that particular time, context and place (Mol, 2008, p. 85; 2010, p. 228; 2021, p. 86). Each tinkering frames a world in which certain activities can be thought of as 'good' in specific situations (Mol, et al., 2010, p.14; Stuhkamp, 2004, p. 139). In situations in which different "goods" are juxtaposed, such as physical health or psychosocial well-being, health care workers will often tinker in order to enact good care. *Tinkering* in this study can thus be understood as a social and embodied practice, as an iterative process that is situationally enacted in close relationships in day-to-day (care) practices. Each form of care is a way of enacting care in a particular way. For example, not all health care

workers subscribe to the current belief in evidence-based nursing, some doubt whether criteria of evidence-based nursing offer the desired level of context- based or tailor-made nursing care. Instead of spending time on paperwork they prefer to attend to their patients (Knops, et al., 2009, p. 1353). Thus, enacting care is based on this tinkering, which is a dynamic, relational and processual activity.

Thus, each enactment of care depends on certain *situations* in care practices, on people and things, on subjects and objects. In these enactments certain aspects of care are addressed and at the same time others are left out, disregarded or dismissed. The enactment of care can be based on particular concepts of care, that is to say that certain norms are pursued at a certain moment, which means that other norms cannot be addressed in that situation at that particular time. Moreover, certain norms may take different forms. For example, in a rehabilitation institution to set certain goals for a patient is usually approached as a good practice. Goals setting can for instance involve preparing the institutionalized patient to return to the home environment. However, institutional norms can clash with individual norms. For example, in a study of Struhkamp (2004) the institutional rehabilitation goal had the aim to stimulate patients to be active. However, one patient did not want to be active in practice, because she believed that her fate was in God's hands. Struhkamp concluded that in daily practice, institutional goals are often not achieved, or they are changed or disputed and can even create tension for individual patients (Struhkamp, 2004, p. 131). In practice different norms can be enacted in similar situations, and similar norms in different situations (Mol et al., 2010; Nordenfelt, 2004; Pols, 2005; Pols, 2013; Struhkamp, 2004).

Kleinman & van der Geest (2009) define care as an interpersonal *experience* that is 'about acknowledgement, concern, affirmation, assistance, responsibility, solidarity, and emotional and practical acts that enable life' (Kleinman & van der Geest, 2009, p. 159). Care is to assist others with real or anticipated needs in an effort to improve a human condition of concern, or to face death. What is 'good care', is not merely a matter of *judgment* – it is also *performed* in daily practice (Kleinman & van der Geest, 2009, p. 161).

Yakhlef and Essen (2013) showed in their study in geriatric care practice, how care workers enact care on the basis of their embodied and lived understanding, i.e., based on what they hear, see and feel, that what makes sense in that particular situation. For example, in one situation the care worker responds to an older person

who does not want to shower, and in another situation the care worker follows the service plan. Sometimes their situational enactment of care leads to practical changes. Residents who refused food, for example, did eat when caregivers also had lunch, so they ate together (Yakhlef and Essen, 2013, pp. 894-895).

According to nursing scholars, enacting care in practice means that health care workers *embody* certain practices of good nursing care. For Benner (2000, p. 5) this means that caring practices invite care workers 'to embody caring practices that meet, comfort and empower vulnerable others'. Being good and doing good (*phronesis*) are caregivers' embodied moralities: they always try to enact good from within and improve for the better. Their morality is embodied and socially embedded in relationships (Benner, 2000, p. 17).

The nursing scholars Molterer, Hoyer and Steyaert (2020), who did ethnographic research in a German residential home for older people, made a distinction between a *professional* and a *relational logic of care*. In a professional logic of care, principles, such as justice (equity) and non-maleficence (avoidance of harm) are essential. Health care workers use protocols, guidelines, certain standards of good care with the aim to systemize their work and make it transparent, measurable and accountable. The relational logic of care, on the other hand, is based on the interaction and connectivity between people, attending to the relational quality of care. in this logic, care is a matter of tinkering, described as a combination of 'intuitive deliberation', 'situated assessment' and 'affective juggling' (ibid, p. 99). Intuitive deliberation means that the response of health care workers to their patients is based on spontaneous actions, feelings and emotions, on unreflectively doing. Situated assessment is based on health care workers' embodied knowledge and their past experiences. Their actions and interactions with their patients are based on the assessment of the situation at hand. The third component, affective juggling, means that health care workers have the ability to be flexible, they improvise in their social environment without being guided by protocols, guidelines, rules or instructions and they can respond adequately when circumstances are changing (ibid, p.110).

Thus, this study will examine the tinkering with various notions of good care between established carers and newcomers in two residential homes, with the aim to articulate the different *enactments of care* that result from this tinkering.

The following section explains why I opted for ethnographic research, how access was obtained in both residential homes and how data was collected. In addition,

I will reflect on aspects that are particularly relevant to this study, especially its ethical and methodological considerations, and my role as a participant observer. These reflections can contribute to the transparency of the research process and give insight in how social, practical and biographical contingencies may have affected the research results.

ETHNOGRAPHY IN TWO RESIDENTIAL HOMES

Ever since my nursing and anthropology studies my attention has focused on the impact of ethnic and cultural diversity within healthcare institutions. In 2009, I wrote my Master thesis in anthropology on an ethnographic research project I conducted in a rehabilitation center in the Netherlands about the complexity of diversity related to staff and patient care in daily practice. The current PhD study about the integration of first-generation immigrant nurses working in health care institutions continues on this path.

Specifications of the Dutch and German residential homes

In this study my focus is on a residential home in the Netherlands and a home in Germany. In the years 2015 to 2020, both institutions opened their doors for recently arrived immigrants with a refugee background. Although there were many similarities between the two settings and sites, there were also many differences.

The Dutch residential home provided services in the area of housing, welfare and care. The personal centered care institution provided care at home (400 inhabitants for domestic help), district nursing (215 clients) and residential housing for older people (a total of 242 residents). The service aim was that older people could stay as long as possible in their own environment. Only when living at home was no longer possible, the elder was cared for in one of the recently renovated residential care centers. There were residential homes in four different locations, one hospice and one meeting center for older adults. A total of 830 employees and 470 volunteers worked at the institution. There were in total 242 residents in the residential housing, thus each location held around 60 older residents. The majority of the established employees were born and raised in the village. At the time of this study, the residential home had no experience with immigrant or non-native Dutch staff, nor was there a diversity policy in the home.

The German residential home was part of an operating company of a larger group with hospitals, psychiatric clinics, health centers, a rehabilitation clinic, numerous services for older people and people with disabilities, as well as two training academies. A total of 5.600 employees from 68 nations were working in these companies.

During the time of research, the German residential home had been recently renovated, while the Dutch residential home was due to be renovated within a few years. The German geriatric institution held a psychogeriatric outpatient department, a day clinic for 15 people with dementia and depression, a research, counselling and education department, short-term care (for 10 clients) on the ground floor, a residential area with private rooms for 80 people with dementia at the two upper floors and a palliative care department. Moreover, on the ground floor there was one meeting center for older people in the neighborhood, for activities such as concerts, sports or movies. Around 700 employees worked in the residential home and no volunteers. Most employees had lived and worked in Germany already for many years. The German residential home provided care to residents with dementia and Alzheimer and other complexities, such as schizophrenia, or older people with down syndrome in combination with dementia or Alzheimer.

Both homes provided care to ageing citizens and both care institutions had a Christian identity, resp. Protestant (Netherlands) and Catholic (Germany). Both homes were located on the edge of a city. Both houses had started an integration project in which they offered first-generation immigrants from outside Europe a (re)training in nursing care, which consisted of basic knowledge about geriatric care, language courses (on B1/B2 level) and work placements/ internships. Both residential homes recruited immigrants through local labor agencies and through the nearest asylum centers. The immigrants then had to apply, after which an interview with the project managers followed. The latter was also similar in both homes.

In the Netherlands, if the immigrants had obtained a nursing diploma in their country of origin and wanted to work as a nurse[8] (level 3-6) or nurse assistant (level 3) in the care sector, *a nurse registration* was needed. Nursing is a protected profession in the Netherlands to guarantee quality and patient safety. Nursing registration is obligated in the BIG[9] [*Beroepen Individuele Gezondheid* Professional Individual Health]-register.

In Germany there was not such a national registration system for nurses. If the immigrants wanted to work as a nurse [Gesundheits-und Krankenpfleger/in], their professional qualification needed to be recognized (i.e., also a process with rules and regulations) by the Federal Ministry of Education and Research (2021).

In 2016, the Dutch residential home initiated a project where in total ten immigrants were recruited, most of them with a nursing background. They were from Syria, Uganda and Eritrea. The home provided the new arrivals with a Dutch vocational qualification retraining program into nursing (HCP level 3)[9] and Dutch language lessons (B2).

In 2017, the German residential home started a project called *Asylbewerber und Flüchtlinge als Potenzialträger (AFP) in Deutschland, ein Modellprojekt im Sozialwesen* [Asylumseekers and Refugees as High Potentials in Germany, an exemplary project in Social affairs]. The aim of the project was to provide refugees and asylumseekers with the opportunity to explore if they would like to work in a residential home. The project also offered participants German language lessons (B2).

Because the human resource managers faced difficulties finding immigrants with nursing backgrounds, they decided to recruit people with different educational backgrounds, such as teachers, engineers, philosophers, interpreters, etc. They conducted five projects with each 15-18 immigrants. Each project lasted 3 months. A total of 69 immigrants participated, who originated from countries in the Middle-East, like Syria, Afghanistan, Iraq, Iran, and Kurdistan; from African countries like Burundi, Nigeria, Togo and Eritrea; and from Eastern European nations, e.g., Macedonia and Kosovo. At the time of this study most of the participants were awaiting the decision on their asylum application and had not received a residence permit.

The German residential home was much more seriously affected by the shortage of caring staff than the Dutch home. Already since 2000, the German home had recruited caregivers from countries outside Germany, such as Poland, Yugoslavia, Bulgaria, Russia, Turkey and the Philippines. Therefore, the residential home already had experience with diversity management, while the Dutch residential home did not have any experience with diversity in staff or management. The German residential home provided all the established staff members (on all hierarchical levels) a culture-sensitive 12-meeting course before the newcomers' project started.

My research focus was on social processes and the interactions between research participants. I used a wide range of research methods to collect the data, such

as participant observations, in-depth interviews, informal conversations and focusgroups. Social practices and relationships between participants are partly shaped by the way they interpret these practices and relationships. As a trained anthropologist, in analyzing and interpreting these social practices, I tried to find a balance between proximity and distance, for instance by using emic and etic concepts (Hammersley and Atkinson, 2019, p.16; Prins, 2010, p. 44).

Qualitative researchers must be transparent in their research. In this study I clearly describe which steps I have taken. *Reflexivity* is an ongoing process (Hammersley and Atkinson, 2019, pp. 15-18). Because I am my own research instrument, I needed to articulate my own role and place in the context of the two residential homes (ibid, 2019, p. 17). In this sense, this research is partly *auto-ethnographic*, embracing my subjectivity as an anthropologist. This means that I did not have the naive illusion or expectation that my own experiences, feelings and background were irrelevant in my interactions with the participants in the research field (ibid, 2019, p. 204). At the same time, it is not my intention to put myself in the foreground in this research. My personal narrative and self-reflexive remarks should be rather understood as a methodical reflection on my position in the research field.

In addition, just because I am likely to have an effect on the participants I studied, this does not automatically mean that the *validity* of my findings is limited to the data-triggering situations (ibid, 2019, p.16). How people react to unknown situations (like the presence of the researcher) can be just as informative as how they react to unfamiliar others/ situations (Hammersley and Atkinson, 2019). My background, experiences and methodology, combined with my habitus and feel for the game of healthcare, and the *triangulation* in methods and observations, have resulted in more information-rich data (ibid, 2019, p. 165).

Obtaining access to the Dutch residential home

Obtaining access to a residential home is not an easy matter. Not every health care institution is willing to open up for a researcher who could be acting as a *Peeping Tom.* The selection of setting and sites in this study was in many ways a matter of (happy) coincidences. I came across the residential home in the Netherlands after one of my colleagues at The Hague University of Applied Science told me about an article in the newspaper. The article reported about a small project of 10 immigrant health care workers with a refugee background, who were invited to

start with nursing education and internships in a Dutch residential home for older people. I contacted the director of this residential home by email who immediately welcomed the idea of a researcher monitoring this innovative project.

Getting permission from this *gatekeeper* was the very first step in getting access. The ethical procedure (Hammersley and Atkinson, 2019, p. 27) involves seeking and obtaining consent by all members within the organization. So when I was invited to the management team, I explained again my research project and the purpose of the study. After sending an information letter and an informed consent form, I got the permission of the management team and was invited to a meeting of the nursing managers department. I explained again the objectives of the research project. These gatekeepers opened the doors to different people, such as the human resource manager, the teachers of the re-training program, and the nursing department managers. In all cases, the managers were very willing to participate in this study. The HRM manager and the department-manager said they would inform the different departments. I then requested a meeting with the newcomers. When they were in class I explained my research, talked about opt-in consent and the right of withdrawal at any time, and then handed out written forms asking for their consent. Eight newcomers signed the consent forms, two declined. After the eight newcomers' permission, I asked the names of their so-called buddies, the established staff members who had volunteered to support the newcomers. I contacted them by Whats-App, requesting their emails. I introduced myself and wrote about the research project. I talked about opt-in consent and the right of withdrawal at any time, gave them written consent forms, asking their permission. I then asked those established staff members, if I could join them [buddy & newcomer] during their shift. They agreed. But gaining trust takes time.

> *My first day of fieldwork in the residential home. I am picked up by Debesay, the new immigrant colleague. We greet each other and I follow her to the staff canteen, where I would also meet Sofie, Debesay's buddy. The canteen is packed with about 20 people, all white, some young, but mostly women in their mid-40s, in blue and pink jackets. On entering we immediately have the attention of the established staff members, their eyes follow us. 'There she is', Debesay whispers and she is pointing to a young blond girl, with long hair tied up in a ponytail, wearing a blue jacket. The women in the canteen mute their voices and look at us with wide eyes. I introduce myself to Sofie and feel their eyes upon me. I decide to introduce myself to all the*

established staff team members in the canteen. 'Yes, you might think..... who is this....so let me introduce myself, my name is Anita, I work today with Debesay and Sofie, I am a researcher from the Hague University of Applied Science.....'. I stop for a moment and look around; the whole canteen is quiet...no one says anything..... I am particularly interested in students like Debesay', and I point to Debesay, 'how they work here... So, you'll see me more often', I say cheerfully. But I feel an enormous tension, an extremely unpleasant feeling inside, as if I am part of a play..... 'Do you have any questions?' I ask, as if I'm teaching. It's deadly silent now.... They stare at me, open mouthed, say nothing...Suddenly a lady, in her late forties, responds by saying: 'Why don't WE know this?', with the emphasis on 'we'. I hear irritation in her voice. I respond calmly and say that I have spoken to the director and that I have been given permission. 'Well, I think it's strange, that we don't know.....'. Quiet... eyes staring, you can hear the silence...Then, chairs are pushed, some people get up, very slowly the crowd moves and leaves the canteen....I walk behind Debesay, feeling quite uncomfortable.

Access to the residential home in Germany

Regarding the German home, I was asked by a German colleague anthropologist whom I had informed about my research project, if I would be interested to follow a group of refugees in a residential home in Germany. She worked as a project manager in this home and had initiated a refugee and asylum seekers project, which showed similarities with the project I researched in the Netherlands. This was a great opportunity, as the German *gatekeeper* would open doors. In order to assure the quality of this study, I took an intensive course in German at Regina Coeli Language Institute, in Vught, the Netherlands.

I sent an official letter with information and informed consent letters about the research in German by email to the project manager. The project manager meanwhile talked about my research project with people higher up in the hierarchy in the organization, such as the board members, directors and unit managers. This way I received permission to enter the organization.

During the first meeting with the immigrant participants, I provided information about the research project, explained the opt-in consent and the right of withdrawal at any time. I did not ask for papers to be signed, as I had learned from one of the participants in the Dutch residential home that signing papers for people with a

refugee background can be stressful. I 'simply' explained who I was and why I was there, gave some information on the research and research aim, and asked their permission. In this way I received verbal permission from the refugees in class and the staff in the wards.

The first day I visited the residential home was when the 'graduation' ceremony of the second group of immigrants took place. The third group of immigrants, who would start their orientation course the next week, were also invited. After the graduation ceremony, I joined this third group of newcomers and chatted with them, asked them questions and told them about my research. A week later, I met them again in class and again I re-explained my research project. I was with them in class for two months, two or three days a week.

After two months in the classroom, I asked three immigrants (two with a nursing diploma (from Iraq and Afghanistan) and one with nursing experiences in Syria) if I could join them in their internships on the ward. After their agreement, I contacted them via Whats-App to find out more about their working hours. Entering the wards, I introduced myself to the established staff members who were working in the department; the established care workers, the social workers and other professionals, such as doctors and cleaners, as well as the residents and their relatives.

METHOD

Data collection

In collecting the data different research methods were used, such as participant observation, in-depth interviews, focusgroups, informal conversations, and document reviews. This *methodical triangulation* is utilized as a strategy to add depth to be able to get a richer understanding of the data (Green and Thorogood, 2018, p. 207). Norman Denzin uses the metaphor of the kaleidoscope to explain this:

> ….each method implies a different line of action toward reality - and hence each will reveal different aspect of it, much as a kaleidoscope, depending on the angle at which it is held, will reveal different colours and configurations of objects to the viewer. Methods are like the kaleidoscope: depending on how they are approached, held, and acted toward, different observations will be revealed'. (Denzin cited in Green and Thorogood, 2018, p. 208).

The aim was to get insight into the dynamics of the daily interactions between established staff and newcomers. Their interactions and enactment of care were studied in their natural environment. To gain in-depth insight into their daily lives, in events or situations, which were meaningful or more challenging for them. The aim was to elicit an emic perspective (the perspective of 'insiders') and link this in a meaningful way with an etic viewpoint (the perspective from 'outsiders,' such as the researcher) (Hammersley and Atkinson, 2019, pp. 194-195).

Although I did not 'sit quietly' in the ward, I did try to adopt an open attitude throughout the process of collecting data. I watched what happened, listened to what was said and asked questions through informal and informal conversations in everyday contexts. Like doctor and medical anthropologist Zaman characterized his approach in his hospital ethnography: collecting data is like 'catching a butterfly: if you run after it, it flees, but if you sit quietly, the butterfly sits right on your head' (Zaman, 2005, p. 34).

Participants and sampling

One group of ten newcomers (in the Netherlands) and one group of seventeen (In Germany) first generation immigrant health care workers in the residential homes were each followed for a total of about 305 hours over a period of two years. The fieldwork in the Dutch residential home took place between September 2015 and March 2016 and in the German home from July 2018 till September 2018. The aim was to gather an in-depth understanding of the social processes and daily interactions, to see the differences between the two residential homes and to physically experience situations where the staff was involved.

I did not classify the participants in categories such as class, age, ethnicity or other identity groups, as I did not want to start from the premise that such categories of social identities are of significance for answering the research questions. Different categories work according to different logics, and I consider social differences *as in the making*: 'Differences do not always materialize in bodies. They are relational, they can be made durable, but can also be forgotten – they can be fragile or made solid. They are the effect of interferences in social situations' (Krebbekx, Spronk and M'charek, 2017, p. 638).

Participant observation

This study used ethnographic methods. Ethnographic research aims to understand a group of people and/or their practices by fieldwork in the social context in which these practices take place. This approach enabled me to focus on social processes and daily interactions which gave me in-depth insights into what people say they do and how they actually interact and behave. Using ethnographic methods provided me with actual observations of the dynamics and interactions of established staff and newcomers at the site.

In ethnographic research, participant observation implies observing social interactions, as well as actively being part of these interactions. Three aspects are characteristic of any social situation, namely place, actors and activities (Spradley, 1980, p. 39).

The first aspect *place* refers to the social setting. Spradley meant with place, the physical place(s) where people are involved in activities (Spradley, 1980 p. 40). In this study the social settings were two residential homes in two different countries. People can change their behavior within a single kind of place, and in different locations behave differently too. For example, health care workers can behave differently in a patients' room than in the nursing office.

The second aspect concerned the *actors* in the residential homes. Participants can be actors in the field (of nursing) or informants about that field. The established care workers, the managers, the residents, immigrant newcomers and participating and recording their actions and accounts in the residential homes in detailed fieldnotes. It is important to give actors in the field space to formulate their own views and perspectives with regard to particular situations. Moreover, in a residential home one can see various types of actors, such as established staff, newcomers, residents, relatives, visitors, but also the 'kind of actors people become' due to their different roles in different situations (Spradley, 1980, p. 41)

The third aspect was that I was able to observe the actors' *activities* in their 'natural' work situations in daily practice. After repeated observations, the different acts transfer in familiar patterns of behavior, in activities such as washing, eating and drinking or toileting. A combination of activities that are linked to larger patterns is called 'structure of events' (Spradley, 1980, p. 41).

In the Dutch home, I shadowed three newcomers when they started with the

project, when they were working alone or with their buddies, established staff members who coached the newcomers. Participant observation was conducted for two to three days per week, during introduction meetings, during class and on their internship, during morning and evening shifts, during meetings and breaks (tea/ lunch/ dinner), or when they were in the ward in the nursing office and at the end of the project, during their graduation ceremony.

In the German residential home, I followed three newcomers, two had a nursing background and one had gained nursing experience in their home countries. I observed them during class, meetings, internships and (graduation) celebrations.

The observations were elaborated in detailed field notes in order to be able to craft 'thick descriptions' (Silverman 2013, p. 449) of their activities and interactions of participants and how these were embedded in the context of care. I also often described my own activities or position in the field notes, as the situation was sometimes influenced by my presence. Sometimes, for example, I assisted in the washing of a resident together with an established carer or a newcomer.

Observations have three different types, resp. the *descriptive*, *focused* and *selective* observations (Spradley, 1980, pp. 32-33). In this study the observations in the residential home started with descriptive questions, such as: what people are here, what are they doing, what is the setting and what is the situation? After recording and analyzing the fieldnotes more focused observations took place, guided by more structural and contrast questions, such as: what are the daily patterns and regularities in the residential homes? What are similarities and difference between the workers? In the final stage, while the previous cycle of recording and analyzing continued, more data collection took place by making more selective observations based on questions such as: what are opportunities and challenges when health care workers enact care to older residents? What are deviant and problematic events and situations in the residential homes?

Informal conversations

Data has also been obtained through informal conversations with established staff and newcomers. These conversations took place during work activities, in the ward, during coffee or lunch breaks, intermediate shifts, breaks from class and meetings, during lunch, the moments before the newcomers started with class or duty, during the first meeting with newcomers and established staff in

the residential homes or at the end of a graduation ceremony. Sometimes I drove home alone (after duty), sometimes together with staff members. I had small talk and conversations over the phone and via text in WhatsApp. These informal conversations took place throughout the fieldwork periods. The advantage of these casual chats and conversations was that people did not feel the pressure of an interview and were usually open, sharing their opinions and talking about situations and their experiences. I recorded these informal conversation in field notes and memos.

In-depth interviews

In both residential homes I conducted in total 44 in-depth and semi-structured interviews, with established staff members, the just arrived health care workers, project managers, directors, teachers, policy workers, etc. I had a number of topics of conversation: the newcomers project, mutual learning and adaption, geriatric care, challenges and barriers in the project and collaboration in teams. I opted for an in-depth and semi-structured setup. The questions were not fixed, so I could connect to the narratives of the participants and I could ask in-depth questions after unclear answers. On the one hand that meant that I could deal with topics that could provide direction in the conversation, on the other hand, I could make sure that there was enough space for the participants to speak freely about what they felt was important. I asked in-depth questions about the events they were talking about in order to understand respondents' problems, opportunities or difficulties related to specific events that happened in the department. The participants expressed their own perspectives, vision and feelings related to specific situations. The duration of the interviews ranged from one to two hours. All interviews were conducted with the participants' knowledge of recording, and transcribed verbatim, in Dutch, English or German.

Focusgroups

Focusgroup discussion (FGD) is an method for understanding the meanings, opinions and concerns of the participants exploring their values and norms, their diverse views and attitudes (Ryan, et al., 2014, p. 332). In the Dutch residential home, I held two FGD's, one with eight newcomers and one with six established staff members. In Germany, two FGD's were conducted too, one with six newcomers and one with six established employees. The topics were not imposed beforehand

but were generated from the observations and interviews, such as their ideas about the project and institutional processes, their views about similarities and differences between established HCP's and first-generation immigrants, their ideas about whether and if so, how (mutual) learning and adaptation was taking place, and what they considered to be the major challenges and barriers in newcomers project and their notions of good care.

In addition, the collected data were discussed with the participants in the FGD for member checking, or rather, member *reflection*. This latter means that the preliminary results were presented to the participants for input, elaboration and validation (Stenfors, 2020, et al., p. 597). This way I could ask for reflection and provide sufficient space for input and feedback on the preliminary results. I frequently emphasized that these data were my findings and interpretations, and that I was curious about how the participants looked at the data and interpreted this. There were moments in the FGD were I could switch from the role as moderator to the role as observer by listening, note writing and noticing how the participants interacted with each other and introduced all kinds of topics, like events that had happened in the residential home and how they responded to that. I could observe how they communicated with each other, how they talked about the project and how they constructed themselves and others in the residential home.

The FGDs were held in the residential homes and lasted between 90 and 120 minutes. The sessions were audio-recorded and transcribed verbatim in Dutch or German.

Analysis

In this ethnographic research the analysis of data started in the pre-fieldwork phase and continued throughout the process of data collection and writing, so that findings in one stage influenced another stage of the research process. First, the ethnographic fieldnotes and transcripts were read repeatedly to familiarize with the data. Following this approach, frequently occurring observations were *open coded* attaching a label to each part. Second, *axial coding* took place to understand and interpret the data. To find similarities and differences, codes were compared with earlier data coding. Some codes were merged, grouped and labelled, using the Atlas-ti analytic instrument. Finally, to generate more abstract core concepts and categories, *selective coding* took place to gain a deeper understanding of

the social processes and daily interactions between the established staff and the newcomers. Rather than being entirely determined by the concepts from the outset, the analysis was carried out as a continuous *iterative process* during the entire period. This *iterative process* meant that my focus was more on the activity than on striving to follow the above strict procedure. I read my fieldnotes, transcripts and memo's several times.

In this study, due to the first phase of my research data, I used the theoretical sensitizing concepts from Elias and Scotson *the established and outsiders* which was also gradually developed from the data in the residential homes, to give me a general sense of guidance in the empirical material. It soon became apparent from the next phase of my data analysis (the codes and categories that I merged together, et cetera) that the empirical findings were too complex to be consistent with Elias and Scotson's theoretical framework alone. The data obtained from the interim analyses showed paradoxes and different outputs. While in the exploration phase the central concepts *the established and outsiders* were utilized in the analysis, I added Bourdieu's sensitizing concepts of *habitus* and *feel for the game* to understand the more routinized manners and the fluid interpretations of the interaction processes. By juggling with the sensitizing concept of *tinkering*, I got a grip on how the established staff members and the newcomers interacted with each other and how they played with the different values of care in daily practice. I created a sensitivity to the different situations within institutional processes and gained more insight into the empirical field. By applying the comparative analysis method, I saw more differences and similarities between the various concepts and also in the research categories. I read the categories associated with particular codes and looked for the connection between the main codes. I saw the intersections and coherence between social processes and interactions and hierarchical positions and identified how the participants interpreted specific situations and acted upon these interpretations (Hammersley and Atkinson, 2019, p. 164). The comparative analysis between and within the research categories showed nuances, divergent ambivalences and contradictions.

Glaser and Strauss argued that theorizing is an activity, in order to make sense of the data, connections made between ideas, theory and data as well as the other way around, between data, theories and ideas (Glaser and Strauss in Hammersley and Atkinson, 2019, p. 158). A peer audit was established in which the coding and outcomes were discussed with fellow researchers to gain a deeper and more refined

analysis of the data (Silverman, 2013, p. 298). With this combination of inductive and deductive analysis, I gained a deeper understanding of social processes and daily interactions between health care workers.

Ethical considerations

My research proposal was approved by the Medical Ethics Review Committee of the Leiden University Medical Center in the Netherlands (code P16.087). This means that the basic ethical principles of doing good (beneficence), avoiding harm (non-maleficence), and protecting the autonomy, wellbeing, safety and dignity of all research participants were met. To protect privacy, the residential homes and all the participants were assigned pseudonyms.

The anthropologist as research instrument

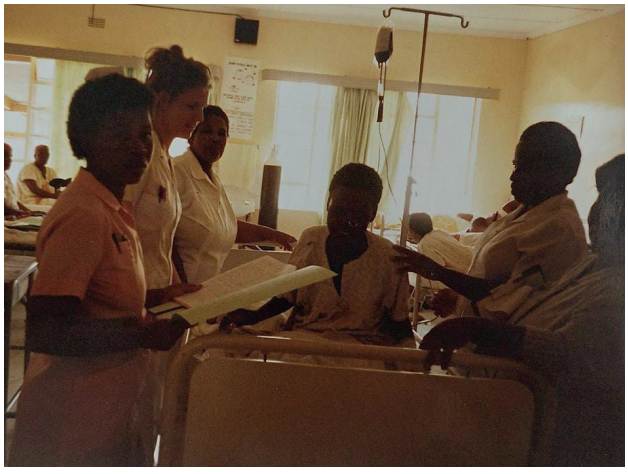
Contextual features, such as political, economic, social, cultural and religious aspects, impact who we are, what we perceive and how we are perceived. My personal and my nursing experiences influenced the research topics I chose and how I analyzed the data. In this paragraph I will describe my adventures, struggles and joys of being 'native' when I conducted an 'anthropology at home' in the Netherlands and being a 'stranger' when conducting research in Germany. As a trained nurse who has worked in several hospitals and in different health care environments, the nursing field in itself was rather familiar to me. However, residential homes were less familiar to me. In the following, I will describe my adventures during my own nursing study and my struggles related with the categorization of people before and during this study. I will first relate this to some aspects of my personal background, and reflect on the anthropologist as research instrument.

Background: The stranger in me

Born in the Netherlands, I grew up in a small village as a Dutch native, where people knew each other and formed a closed knit community. My strictly religious parents, both born during WOII, and members of the Christian reformed church, my father never had the opportunity to go to school after primary school. My mother went for two years to a domestic school, to learn how to become a good housewife, her parents had said. They now would be classified as educationally disadvantaged. Children whose parents are poorly educated, often receive less

support with school at home, which might influence their educational career (Stam, 2018, p.15). That might be one of the reasons that my primary school advice was to continue with Lower Administrative and Economic Education (leao), similar to the current preparatory secondary vocational education (vmbo), which was almost at the bottom of the hierarchy of the intricate Dutch education system.[10] This advice prepared me for a career in the lower segments of the labor market. Another reason for this advice from this Christian school might have been my behavior, because I rebelled against my strictly religious environment. I did not tell anyone about my educational career, for fear of being stigmatized as 'dumb'.

At the age of 17, I moved to the city as an 'internal migrant', i.e., a person who moves to other districts within the borders of the same country, to train as a social worker at the secondary vocational education level (MBO). After graduation, I subsequently worked at a vineyard in Switzerland, at a chicken farm in Israel, at a childcare home in a Kibbutz in Beersheba (Israel) and as a housekeeper in a hotel in Tel Aviv. I traveled a couple of years through European, Asian and Africa countries. Arriving back in the Netherlands, I started the Bachelor of Nursing at the University of Applied Science (in Dutch: Higher Professional Education, HBO) in Groningen. During the last year of this study, I went to Botswana, Africa, for an internship in a district hospital in a small village, called Mochudi. This internship lasted 6 months.



Internship in the hospital in Mochudi.

In Botswana, officially I was an international exchange student.[11] However, no Botswana nurse ever went to the Netherlands, so a real exchange did not take place. In the hospital, I was the only white female nursing student and I struggled with the Setswana language. I sometimes felt like the one white girl in class with only black students who felt herself like "a peppermint in a bag of liquorice" (Stam, 2018, p.154). My body was different from my Botswana colleagues. I was taller and the different color of my skin made me feel noticed in the ward. I sometimes experienced moments of racial exclusion. For instance, when I worked in the emergency department, two of my 'black' colleagues [a doctor and nurse from Zimbabwe] did not speak to me. This happened during each shift when we were working together. Later, I found out that they were very active in Zimbabwean politics. Maybe they, due to my 'white' skin, saw me as a 'privileged[12]' person, I do not know. Whereas in my youth I felt I was not taken seriously by people from the upper class because of my 'lower' educational background, in these situations I felt the pain of being ignored because of my 'other' physical appearance. As I was shy and low in the medical hierarchy, I did not speak out. However, I was not systematically oppressed because of the color of my skin, as people of color often experience in the Netherlands. In fact, because of my posture, my height and the color of my skin, patients sometimes assumed I was a doctor and ascribed to me the associated authority.

I wondered how the local nurses could laugh so hard and could sit for hours in the nursing office waiting for the patients' relatives to arrive. I discovered that biomedicine and the work of nurses in Botswana was different than what I was used to. Nursing in the Netherlands was care-oriented, in Botswana it was cure-focused. In the Netherlands, there were many rules and procedures, in Botswana we worked by improvising. Family members played an essential role in life of Botswana patients in the ward. The medical treatment was for the nurses; the daily care was for the relatives.

I worked with the Botswana locals and with other international colleagues, especially nurses from Zimbabwe, Zambia, Tanzania and South Africa. With the foreign nurses we formed a close-knit community. With some I worked together, others shared their knowledge and answered my questions about treating patients with diseases unknown to me.

In the rural community there was a shortage of houses, so we lived in old mobile homes on the hospital compound, in contrast with the native staff, who lived in houses in the village.

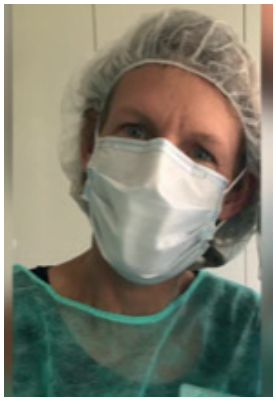
After six months of internship, I graduated from the Dutch University of Applied Science and applied for an English registration at the British nursing council. This international registration opened doors, as I now was an 'internationally registered nurse[13]' in Great Britain, and in the Botswana nursing council more specifically, a general "registered nurse" (RN). After three years in Botswana, I moved to the United Arabic Emirates to work in the Tawam hospital, a local hospital in the region of the Emirate Abu Dhabi, near the border of Oman. This Tawam hospital in Al Ain [مَدِيْنَة ٱلْحَدِيْقَة], offered me a job on the VIP/Royalty department. Compared to the hospital in Botswana, there was wealth and abundance in Tawam. Usually, relatives employed a live-in migrant care worker, mostly from Bangladesh, Indonesia or the Philippines who provided round-the-clock-care and stayed 24-hours with the patient in the room.

In addition, in Botswana, I had struggled with the Setswana language, now with the Arab language was an obstacle. However, in Tawam, during each shift I had the privilege to work with a Lebanese interpreter, who translated my English into Arabic and residents' Arabic into English.

On arrival in the UAE, I had no friends or relatives. My position was very much like that of a 'first-generation immigrant' nurse. My colleagues, all women, were from Finland, Denmark, Norway, Scotland, India and Australia, we were the non-Muslim minorities. In our nursing team in the ward, there were no multicultural or religious problems, we discussed shared problems, such as the overflowed cupboards. We were convinced that the working conditions of the live-in migrants resembled modern day slavery. But we did not know where to report this and had no power to change this. After all, our position in the hospital was similar to that of the live-in migrants, we were 'just' useful migrant workers.

From the above, it will be clear that in the present study personal experiences resonate on various levels. Knowing variations in nursing patterns across and within societies and the significance for understanding social processes brought me to the topic of this research.

Tawam hospital UAE, me as a nurse



Residential home Germany, me as anthropologist

Some qualitative researchers argue that 'shared experiences –regardless of their disclosure to the participants- can give the researcher a deeper insight into the participants' experiences and may affect the researchers' understanding' (Gerrits, 2008, p. 41; Reis, 1998, p. 295). I do not share the experience of being a refugee with the newcomers in my study. But I have lived and worked as a nurse in hospitals in other countries, and had my share of experiences with language difficulties, with being the racial 'Other', with differences in working conditions and differences in professional habits and expectations. Also, in the Netherlands, I have worked as a nurse in a medical health office with refugees and asylum seekers from countries around the world.

My international work experiences combined with insights from critical anthropology, for instance taught me that autonomy and free choice are values linked to Western cultures, which are often cultivated as a desirable outcome of health care. I learned that these values are not shared everywhere, that they have no universal validity in that sense, this means that I am aware of the situatedness of my own insights. Theories and practices are never developed in isolation, but influenced by each other. However, my experiences with and knowledge about differences between cultures and class differences informed my understanding for the newcomers with a refugee background and their precarious situation. Although I started at almost the 'lowest' level of the Dutch system of education, I was able to climb up to the 'highest' level of the university. Having undergone different *rite of passages* and various *liminal phases* have, so I believe, also

strengthened my understanding of the disadvantaged positions not only of the first-generation immigrants, but also of the established native health care workers in residential homes, many of whom were members of the ('white) working class' (Williams, 2019, p. 4), who are often invisible, but whose contributions are crucial and essential to our societies (Meyer, 2021, p. 6).

OUTLINE OF THE THESIS

Chapter two In this chapter the reader gets a glimpse of social processes affecting the workforce integration of first-generation immigrant health care professionals in ageing citizens in the Netherlands. A Dutch residential home initiated a project for ten first-generation immigrants with refugee background, some had gained a nursing diploma in their land of origin. The prevailing workforce culture in the residential home was challenged by these new personnel, which caused institutional change. The aim of this study was to examine social processes affecting the workforce integration of these newcomers. This study identified various processes that affected the care in the residential home, such as the imposing of norms related to good care, the use of weapons of the weak, mutual suspicions of indifference, and collective images of "us versus them". Both groups conceived the others as the source of their discomfort, however, both had pain of not mattering. To understand those group-processes, sensitizing concepts, such as the 'established and outsiders' from Elias and Scotson (1965/1994) were used to analyze the data.

Chapter three This chapter aims to gain a deeper understanding of the interactions of established workers and newcomers in their care for older residents in a Dutch residential home. Their interactions were influenced by norms, rules and regulations, policies and protocols. Sensitizing concepts, such as 'tinkering' (Mol, 2010) 'habitus' and 'feel for the game' from Bourdieu (1990) were used to get a general sense of guidance to the data. It appears that good care does not always depend on compromises between goods. Nurses' enactments of care are embedded in care givers habitus, this is related to their personal and professional socialization, their education and previous work experiences. Some established staff tinkered, adjusted their own way of working in such a way that this created room for newcomers. However, there were also obstacles that prevented newcomers from full participation in care situations. Due to organizational constraints, like staff shortage, strict timeframes, and the imposition of local standards, there was

little space of time to face these challenges. The refusal of care by some residents was also an obstacle, which affected the newcomers' ability to participate in care practice and affected the established nurse normalized daily practices. However, despite these obstacles, there was room to make small changes in the rules of the game of nursing. Established staff members and newcomers sometimes navigated between, and mixed elements from two work cultures. These moments of tinkering gave room to the evolvement of hybrid professional identities.

Chapter four shows the results of a study that was conducted in Germany and focusses on the social dynamics and concepts of good care affecting the interaction between established employees and newcomers in a German residential home. Due to the so-called "refugee crisis" in 2015 and nursing shortage, the residential home provided first-generation immigrants a nursing program and cultural awareness and sensitivity training to established personnel. The aim of this ethnographic study was to examine the social processes at the work place affecting the integration of immigrant care workers. It appeared that all participants experience tensions, irritations, and frustrations in daily practice. Various institutional obstacles affirmed and reinforces group divisions and collective images of 'us versus them'. Both groups distinguished themselves in a positive way from others by gossip, referring to their length of residence in the country or to their professionalism in order to improve situations and maintain control and self-respect. However, both had pain of indifference and neglect by management.

Chapter five is about the enactment of geriatric care by newcomers in that same German residential home. New care workers often tinker in situations where different 'goods' (values) are contrasted, such as institutional accountability or personal well-being and tranquility or dignity. Efficiency care can have carelessness effects and what appears as tinkering can lead to thoughtlessness. The organizational constrains, such as the structural shortages of staff, the scarcity of resources and the complexity of the residents caused an increasing workload. With unfinished tasks and an increased workload, the staff can feel powerless, indifferent and demotivated. This inhibited all workers at times to be able to enact good care practices. Thus, structural, institutional and political constraints can affect the quality of geriatric care.

Chapter six returns to the main question how social processes and values of care affect the interactions between first-generation immigrants and established

health care workers and how do these dynamics influence the enactment of good care. This study shows that different social processes are affecting the workforce integration of first-generation immigrant workers. At first glance the data can be interpreted as shortcomings of the newcomers, such as language difficulties, lack of qualifications and professional norms. Or the data could be interpreted as adaption problems of the established staff who would be blind to institutional racism, the (white) working class who harbor resentment and has problems with alterity. This study cannot deny the above persisting problems, such as institutional racism and feelings of resentment that needs attention. However, the reciprocal allegations hide their *mutual structural problems* faced by all health care workers in today's residential homes. Talking about 'integration' ignores the fact under what circumstances and conditions people have to integrate.

Care workers in Dutch and German residential homes faced organizational constraints, such as the shortage of staff, lack of resources, increased workload and a decreased level of education, which had an impact on daily practice. This multitude of situations were beyond their influences. When a group of newcomers arrived and had to integrate on top of a heavy workload, social processes were activated. In order to improve situations and maintain control and self-respect, group members distinguished themselves from others through collective images of 'us versus them'. Both conceived 'others' as the source of their discomfort, however, both felt the pain of not mattering. Workload that builds up and is never finished affects motivation. Moreover, employees sometimes felt powerless and indifferent. Nevertheless, this research showed that care workers were not defenseless victims of "the system" or were "powerless" at the mercy of the organization. The staff had also fun and pleasure when things took a different run and most careworkers cared as if the older residents were their own family, always tried to improve for the better. When looking beyond integration, room can be created for the evolution of hybrid professional identities who care for themselves, each other and our older people in society. In the German residential home, this study takes another turn. When we zoom in on daily interactions behind the closed doors of residential home, it becomes clear that the professional habitus of established workers and the newcomers stimulated them to tinker among each other as well as with the different, sometimes conflicting, values of care in daily practice to enact good care to the older adults. With less staff and sometimes limited resources, they enact care with a feel for the game when taking care for the older residents. What

counts as good care is therefore situational, relational and contextual. However, the findings also show that the established staff and the newcomers struggled, when the workload gets too high that it is impossible to perform all tasks properly. As a consequence, staff can become demotivated and indifferent to the point that they are numbed, act thoughtlessly and thereby harm the older residents. So, we should not be surprised that the "good" got lost sometimes in residential homes.

In this study it will become clear that various social processes and institutional constraints have a serious impact on the care workers and the older people, but also on the workforce integration of new immigrant care workers and the enactment of care. This study highlights the crucial role of the organizational and institutional context in shaping social processes at the workplace. Those dynamic social processes and long-term structural problems in geriatric care might create even greater fundamental institutional obstacles as societies are ageing.

The most recent data on which this study is based was collected between 2015 and 2018 to provide a picture of life in two residential homes before the Covid-19 crisis. The Covid-19 virus has hit vulnerable older people hard inside and outside residential homes. The spread of the virus has put pressure on the residents' quality of life. Since the situation presented in this PhD has been overtaken by the developments of Covid-19, this study offers relevant insights into how residential care was before Covid-19 happened to all of us.

In this study I sometimes use different terms for the same group of people, such as first-generation immigrants/ newcomers, elderly/ older people, nursing homes/ residential homes, etc. I try to avoid inappropriate language and stereotypical representations of individuals or groups, and to use inclusive language that acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. So, plural nouns are used when possible in order to seek gender neutrality ("residents, patients /clients") whereas the use of descriptors that refer to attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability or health condition are used only when relevant and valid for this study.

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Notes

1. All names of the participants in this thesis are pseudonyms.

2. The term 'first-generation immigrants' refers to people who are born abroad and moved across symbolic or political boundaries into a new residential area (CBS, 2021).

3. Refugees are people who make an 'application' for asylum request as a refugee. Asylum requests are submitted by persons who have fled their country for various reasons to seek protection or asylum in another country.

4. The term established worker/nurse is used for the workers who are born, raised and received a diploma/bachelor in nursing in the host country or for someone who knows the job well, based on long history of experience. The term 'established' is also based on the classic study of Elias and Scotson (1963) the Established and Outsiders.

5. The University Asylum Fund (UAF) is the oldest refugee organization in the Netherlands. In 1948 this foundation was established with the aim to provide the necessary retraining, supervision and moral assistance to help refugees find a place in the labor market that matches their education (https://www.uaf.nl/).

6. The integration of first-generation immigrants with a refugee background start with a residence permit. The next step is a mandatory integration course (about local customs and language level B1 according Common European Framework of Reference for Languages (CEFR) completed with an exam. When they want to integrate in the health care sector, they require validation of educational papers from non-EU diplomas, a nursing registration (BIG) and a certificate of conduct [Verklaring Omtrent Gedrag). They can request a VOG certificate when they have a citizen service number [Burgerservicenummer, [BSN]). The latter can only be received after registration with the municipality in the basic registration of personal data [Basisregistratie persoonsgegevens, BRP]. A similar procedure in Germany: they need a compulsory integration courses, the required language skills (B1/B2 level), the validation of diplomas and acertificate of conduct [Führungszeugnis].

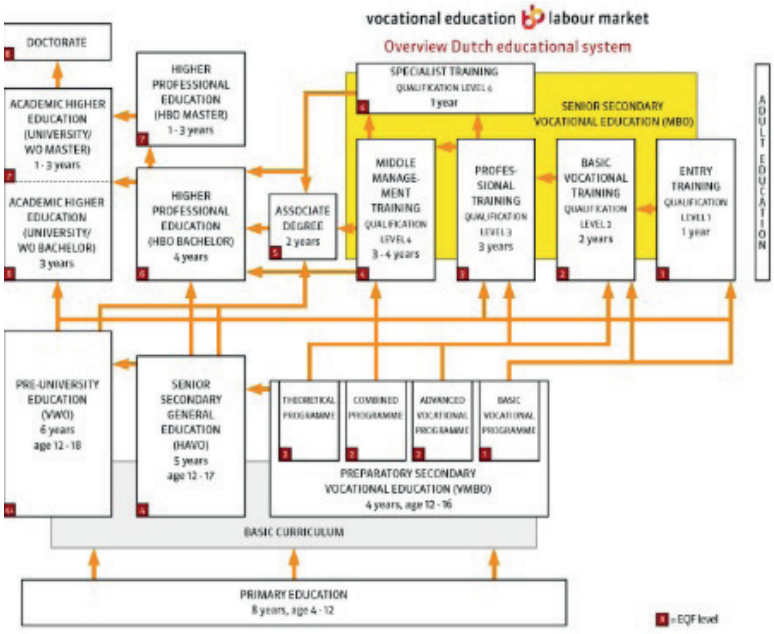
7. Minority is a term applied to social groups that are oppressed or stigmatized on the basis of racial, ethnic, biological, religion or other characteristics. Mostly it is distinguished in the numbers of the group and those which are marginal in terms of their access to power (Scott and Marshall, 2005).

8. In the Netherlands nursing education consists of a training of 0.1-1 year (nurse aide

[zorghulp]) up to 4 years (bachelor educated nurse [HBO verpleegkundige]). A nurse assistant [helpende] 2 years and a certified nurse [verzorgende] 3 years, followed by a vocationally registered trained nurse [MBO verpleegkundige], or 4 years bachelor educated nurse [HBO verpleegkundige]. In Germany the training of an Alltagsbegeleiter für Menschen met Demenz (nurse aide) lasts 12 weeks, the training of a Plegerassistentin (nurse assistant) or Altenpflegerhelfer/in (care assistant) lasts 1 year; the training of an Altenpfleger/in (geriatric nurse) lasts 3 year after vocational training; See also: https://eurodiaconia.org/wordpress/wp-content/uploads/2016/08/the-education-training-and-qualifications-of -nursing-and-care-assistants-across-Eirope-Final.pdf.

9. In the Netherlands nurses need to register at the Nursing Council for Professions Individual Health (Beroepen Individuele Gezondheid, BIG). After registration the nurse is authorized by the appropriate authority to practice nursing. In Germany nurses do not need a national nurse registration, but need to have a sufficient knowledge of the German language (B2 or B1), an appropriate state of health and a German certificate of conduct. See also https://www.make-it-in-germany.com/en/jobs/professions-in-demand/nursing/

10. The Dutch education system (Onstenk & Blokhuis, 2007):



11. An international exchange student follows an international course and does an internship abroad. Mostly the university try to attract foreign students by cross-border university cooperation (See also Belt, et al., 2015).

12. 'White' *noun* means the white color of the skin. 'White privileged people' defined by the Oxford dictionary are people in privileged positions; inherent advantages possessed by a white person on the basis of their race in a society characterized by racial inequality and injustice. The color of the skin benefits white people over non-white people even if they otherwise live under the same social, political, or economic circumstances. White and whiteness in the Dutch society is mostly referred to as a criteria for inclusion but is associated with innocence. White privilege has developed historical in European colonialism, imperialism and Atlantic slave trade (see also Wekker 2016; Essed 2008; Stam, 2018: pp. 168-169)

13. International registered nurse. See also the international council of nurses at http://www.icn.ch